STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium at Navesink Harbor, The	40 Riverside Avenue Red Bank, NJ 07701

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation and interview it was determined the the facility failed to ensure that the Dietary staff had the appropriate skill sets and competencies to ensure a) staff maintained a sanitary dietary environment, b) a process was in place to ensure recipes were followed to ensure nutrition adequacy of fortified foods, and appropriate physician ordered diets were provided to residents, c) cooking temperatures were consistently monitored, d) staff were competent in utilizing food temperature measuring devices, e) infection control practices were consistently implemented with glove use and hand hygiene, and f) foods were appropriately labeled, dated and discarded by use by dates. The deficient practice places all resident at risk for potential food borne illness, affected all residents who resided at the facility and was evidenced by the following:Refer to F812, F804, and F805 On 02/18/26 at 8:24 AM, the surveyor toured the kitchen with the Executive Chef (EC), and the Director of Dining Services (DDS) observed that refrigerated and potentially hazardous foods were not consistently labeled with a use by date, and foods were also observed in use and had expired Discard Dates. Observations included, but were not limited to the following: -The EC exited the refrigerated walk- in box and did not have all his facial hair covered.-The [NAME] was also observed cooking food and he did not have all of his facial hair covered, and when asked if it should be covered, he confirmed that the facial hair should be covered.-The walls, ceilings and floor throughout the walk-in box had visible debris, including splatter type debris, and crumb type debris was observed under the food racks, debris was also embedded on the green racks which also appeared rusted in several areas. When the surveyor showed the EC the observations and asked the EC if it looked clean, he confirmed it did not, and he stated it should be cleaned daily.- A jar of strawberry topping, was labeled Opened, 2/13/26 and Discard 2/16/26.- A container of sauerkraut was opened, splatter observed on outside of the container and it was not labeled with a use by date, the vender sticker was dated 1/2/26 and the EC confirmed there was no use by date.- Corned Beef was wrapped in plastic and was on the shelf, with a label affixed, Opened 2/14/26- Discard- 2/14/27. The EC stated the sticker was placed on by the staff and it was the wrong information on the label because the staff had a hard time understanding.-A container of fresh peeled shallots, was labeled with a sticker Opened 2/11/26 and Discard 2/14/26, the EC again acknowledged the item was past the expiration date and stated the item was incorrectly dated.-A jar of capers had a label, Opened 2/15/26 and Discard 2/15/27-A white container of opened kalamata olives pitted, with splatter on the exterior, did not have a use by date.-A partially opened container of soft Boursin cheese was visibly soiled around the rim of the container and was labeled as Opened 2/8/26 and Discard 2/14/26.-A bag of sundried tomatoes, was labeled Opened 2/14/26 and Discard 2/17/26.-A metal pan was located on top of the meat area in the refrigerator, when asked what the item was, the DDS proceeded to remove what was identified as defrosting fish, which was loosely wrapped. When the item was pulled off of the top shelf, a fluid spilled onto the floor.-A raw pork loin was wrapped in plastic wrap and placed directly on top of a shelf, over a box with a blue bag that had raw chicken inside. -A cardboard box contained a blue bag of raw chicken, and was located next to a plastic container with a lid, and another cardboard box. All three containers contained raw chicken. When asked about any dates that were affixed to the items, (continued on next page)

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

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and when they were pulled from the freezer, or what the use by date was, or any dates at all. The EC stated, obviously they were not dated.-Four white bins were stored underneath a stainless-steel shelf opposite the walk-in refrigerator, and contained flour, breadcrumbs stored inside the bags, and thickener. The bins were visibly soiled on the lids with debris on the outside of the bins.-The stainless-steel table contained 4 loaves of French style bread that were stored on top of a plastic lid for a bin. Three of the loaves were completely uncovered and stored adjacent to non-stick canned spray. The EC stated the loaves were defrosting.- The plastic wrap container was also visibly soiled with grease type stains.-The can opener that was affixed to the same stainless-steel table had visible metal shavings around the blade and when asked when the blade was last changed, the EC stated that the whole opener would be thrown out and the blade would not get changed.-Clean knives were also stored underneath a visibly soiled blackened sink pipe, in an open container by the hand washing sink.-The dry storage room contained a dented can on the rack and the bottles of gravy making product had visible dark colored debris on the outside.-The green food storage racks in the dry storage room were visibly rusted through and were missing a finish in several areas, had embedded food type debris on the racks, and the floor in the dry storage room was visibly soiled.-The juice dispenser was visibly soiled by the three nozzles and there was visible spatter on the exterior of the machine.-The gasket for the healthcare refrigeration reach in refrigerator was soiled.-A multi-tiered gray cart was also observed by the reach in refrigeration unit and was visibly soiled with various colored debris throughout the cart.-Eight cutting boards that were white, green and red were visibly stained, soiled and appeared to have deep grooves. The DDS stated they were all worn and removed the cutting boards.-The pass though stainless-steel shelf underside, between the steam table and where the meals were plated and passed through was heavily soiled with debris.-The plate dolly was stored by the entrance to the kitchen and the plates were stored upright and not uncovered.-The oven was heavily soiled with caked on dark grease like debris inside the interior and by the oven door.-There were two snack carts by the entrance to the kitchen and the staff stated they were from the previous and had debris on them.-When asked the DDS for the cleaning schedules for the kitchen, he stated the kitchen should look better and then showed the surveyor an Equipment Cleaning Log for the Week of 2/18/26 which was incomplete and did not include all the above areas. On 02/18/26 at 12:14 PM, the surveyor began an observation of the meal service in the 3rd floor food service pantry and the following observations included, but were not limited to the following: -A person was observed in the pantry with their hair not fully covered and one side was hanging outside of the hair net. They identified themself as the Senior Director of Nutrition, Registered Dietitian (SRD) for the management company. When brought to their attention, they restrained all their hair and confirmed it should all be covered. The SRD then proceeded to wash her hands in the sink, used a paper towel to dry her hands, then used the same paper towel to wipe the water off the area surrounding the sink. When the surveyor asked her what role was regarding the meal, she stated QA (quality assurance) and exited the pantry. At that time the surveyor observed another staff member, who identified herself as the Healthcare Supervisor (HCS) and was at the steam table in the pantry. When asked about the mealtime, as residents were seated in the dining room, she stated that the crab cakes and the rice did not come up from the kitchen at the appropriate temperatures and were sent back down to be reheated. - The surveyor then observed the storage refrigerator in the pantry. The lower freezer drawer was observed with two plates of taco salad, one plate was identified as a mechanical soft salad which contained ground beef, beans, cheese, tomato, over lettuce, a scoop of sour cream, and was wrapped in plastic wrap and on top of ice cream containers. A second salad was a regular consistency taco salad that also contained ground beef, sour cream, beans, and was wrapped in plastic and stored directly on top of the ice cream containers in the freezer. The surveyor asked the HCS if the beef was supposed to be hot and was that the normal process to store a salad in the freezer? The HCS stated that the SRD thought that the salads would not hold temperature and instructed the HCS to place the salads in the freezer. The HCS stated that was not how the salads (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should have been stored as the beef would normally be served hot. -The HCS did not perform hand hygiene (HH) and used her bare hands and removed the containers of reheated rice, crab cake, lima beans, puree beans, puree crab cake in the steam table and then observed the that the HCS failed to perform HH prior to glove use, used here bare hands to take food temperatures and reused an alcohol wipe that was left on top of a worn cutting board to wipe a thermometer probe. At one point the HCS placed gloves on her hands without washing her hands first and proceeded to use the same alcohol wipe that was sitting on the cutting board and inserted the probe into additional food items. After taking the temperatures, she washed hands with less than 20 seconds of friction and then rinsed and placed gloves on her hands to serve the food. The HCS removed gloves, exited the pantry and placed a meal plate in front of a resident. The HCS then returned to the pantry and washed hands for 6 seconds of friction after soap applied and rinsed in water. On 02/18/26 at 12:35 PM, the surveyor observed the Health Care Supervisor (HCS) plate puree meals that were served to residents. The plates had three food items on each plate, all touching one another. One food item was peach colored; one food item was white, and the other food item was light green in color. All the items appeared loose and did not hold shape on the plate when they were plated up by the HCS and served to the residents in the dining room. The HCS stated the puree consisted of puree salmon, rice and lima beans. At 12:42 PM, the HC supervisor began setting up meal trays for room service and the surveyor observed that the HCS uses a slotted spoon (not a portion spoon) to scoop the puree salmon out of a metal container, and the puree item also appeared runny and did not hold shape. The surveyor asked about the portion size of the puree salmon and the spoon that was used. The HCS stated, that she would usually used a portion black handled scoop, but because the food was not hot enough and had to be sent back to the kitchen, the slotted spoon was left in the metal pan when the food was sent back up, and that was what she used. The HCS removed the mechanical soft salad from the freezer and the surveyor asked her what the temperature was prior to serving the resident and the HCS used the thermometer to check the temperature and informed the surveyor that the temperature of the beef was 57 degrees Farenheight. On 02/18/26 at 12:50 PM, the surveyor interviewed the Assistant Director of Dining (ADD), in main kitchen regarding if recipes were used for the puree items. The ADD looked through a recipe book located in the kitchen and was unable to locate recipes for the puree items and exited the kitchen. The surveyor then interviewed the [NAME] who prepared the lunch meal and asked him if he had used any recipes for any of the puree items that were observed during the lunch meal. The cook stated, no, he did not use recipes. When asked how he knew how to prepare the puree items, and how would he know how much thickener to use for the puree items, he stated, I usually just eyeball and stated he was culinary trained. Another person interjected and stated he was the Regional Director of Operations (RDO) for the food service management company and stated, we have recipes. At that time the ADD returned with other books and was attempting to locate recipes for the puree food items. On 02/18/26 at 1:01 PM, the surveyor interviewed the ADD again regarding using recipes and asked if recipes should be utilized for the puree items. The ADD stated yes, it was important to use recipes for consistency and portion sizes. When asked was it also important for nutritional adequacy he stated, yes, and to make sure it was prepared correctly. At that time the ADD was unable to locate any recipes for the puree items. When asked if puree items should be liquid- like and run together on the plate, the ADD stated, no, and then confirmed that he did not have a recipe for the puree salmon, puree crab cake, puree rice or puree lima beans. On 02/18/26 at 1:13 PM, the surveyor interviewed the [NAME] who prepared the lunch meal that the surveyor observed on the third floor. The [NAME] confirmed that he prepared the lunch meal and the surveyor requested to see the food temperature log for the meal. The [NAME] showed the surveyor a clipboard with a blank log listing all of the items that were prepared and were observed served for the Wednesday lunch, The [NAME] stated, no temps (temperatures) were written down for lunch and in the presence of the surveyor, started to fill in the log and stated, I'm doing now. When asked where the temperature documentation was located, he stated it was all in his head. When asked whether it was important to (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	record food temperatures at the same time the food was prepared, he stated, yes, to make sure the food was safe. The surveyor then asked the ADD about the food temperatures for hot food at the point of service. The ADD stated at the point of service the hot food should be over 150 degrees Farenheight (F) and stated there should be no hot foods served between 40 to 140 degrees F. The ADD was made aware of the surveyor concerns regarding the ground beef on top of the taco salad in the freezer and stated that the taco salad beef was a hot item and will provide a copy of the recipe. On 02/18/26 at 1:22 PM, the RDO confirmed that the taco salad was a hot salad (Beef) and provided a recipe. When asked why the salad was stored in the freezer, he stated he had been there for only three weeks and he didn't know why as it did not match the taco salad recipe. A review of the Taco Beef Corn Tortilla recipe that was provided by the RDO, did not match the item observed by the surveyor, and revealed the taco beef filling should be held at 140 degrees F. The recipe did not identify the salad, cheese, sour cream or beans that were observed and held in the freezer. On 02/18/26 at 2:07 PM, the surveyor interviewed the Director of Operations (DO) for the Food Management Company who stated the expiration dates should follow the policy. On 02/20/26 at 8:43 AM, the surveyor continued the observation and then asked the resident if the surveyor could look at the meal ticket and the resident handed the ticket to the surveyor. The meal ticket had Texture: Mechanical Soft and GR. Canadian Bacon listed. On 2/20/26 at 8:44 AM, a Certified Nurse Aide (CNA) entered the room, and began cutting up the meal, which was sausage, and cut the sausage into circles, and put the spoon in the resident's hand. Surveyor then interviewed the CNA about the meal ticket and asked what does GR. Canadian Bacon mean and the CNA stated she was not sure but the resident had sausage not Canadian bacon. On 2/20/26 at 9:33 AM, the surveyor interviewed the EC and DDS regarding a recipe for the super cereal that the surveyor observed a loose in appearance, milky like super cereal in a bowl. The [NAME] was present also, and when asked what recipe they used for the super cereal, he stated he did not use a recipe, while the kitchen the EC looked through a book for the recipe and then confirmed he did not use a recipe and the EC could not locate a recipe for the super cereal. The DDS confirmed the purpose of using the super cereal was for someone who needs to gain weight.On 2/20/26 at 9:35 AM, the surveyor interviewed the DDS, while in the main kitchen, regarding the process to check the temperatures of the food. The DDS stated that an alcohol swab was used to wipe the probe, then place the thermometer in the thickest part of the food, then the process would be repeated. When asked if the alcohol swab was reused, he stated no. When asked if HH would be performed, he stated, of course, before any task and glove use. The DDS then stated that hands were always washed prior to placing gloves on hands and then the task would be completed. The surveyor asked if temperatures could be taken without wearing gloves, and could the alcohol wipe be reused? The DDS stated, bare hands could not be used, and if the thermometer was not clean the food could become contaminated. The DDS stated that a single alcohol wipe had to be used for each temperature taken and could not reuse the wipe. When asked if after hands were washed it was okay to wipe the sink with the same paper towel, the DDS stated no. The surveyor then reviewed above observations with the DDS. When asked if the Dietary staff were trained. The DDS stated staff were trained. When asked if competencies were assessed, he stated there no competencies assessed and he had been there for three months. The DDS stated, for training they gave out printed material and it would be reviewed.On 02/20/26 at 5:30 PM, the surveyor reviewed the Facility Assessment (FA) provided on 2/18/26 revealed Consider competencies and there were no competencies or integration related to the contracted food service department. On 02/25/26 at 8:41 AM, during an interview with the Licensed Nursing Home Administrator (LNHS) she confirmed there was no training/competencies identified for the Dietary staff included in the FA. A review of the Assistance with Meal Service Policy Revised 1/15/26 revealed: 4. For all residents, hot foods shall be held at a temperature of 135 degrees or above until served. Cold foods shall be held at 41 degrees or below until served . 6. All employees who provide residents assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	practices and safe food handling. A review of the Sanitation and Infection Prevention Policy, Issued 5/1995 revealed: In the Food & Nutrition Services Department: All associates associated with the handling of food shall wash hands with soap and water at the following times . Before handling food or clean utensils/ dishes/ equipment; Before putting on gloves, After removing gloves, After any other activity that may contaminate the hands. Hands must be washed with soap and water when plating food on patient/resident units. Alcohol-based hand sanitizer is only used to decontaminate hands when delivering trays and there is no visible soiling of the hands (food or other materials). When hands are visibly soiled with food or other materials, hands are washed with soap and water.Procedures: All food handlers: Use only sinks designated for hand washing .All hand wash sinks should be easily accessible with nothing blocking their access in food production, food service and dishwashing areas. Hand washing sinks .should be clean and stocked with soap, paper towels, a covered waste receptacle, and a Hand Wash sign ., Wet hands with warm water and apply a disinfectant soap, lathering up to mid arm. Work later into hands for 20 seconds, including areas under fingernails, between fingers, on the inside and outside of hands. Keep hands away from sides of sink. Rinse thoroughly under warm running water, allowing the water to flow from the arms, down top the fingertips. Use a paper towel to turn off the faucet to avoid contact with faucet germs. Dry hands with a single use, disposable towel. Do not use common towels for drying or wiping hands. The Uniform Dress Code Policy, issued 5/1995 revealed: Associates working with food: Wear the approved hair restraint when on duty regardless of length or presence of hair. Restrain all facial hair with a beard net/restraint. The Food Contact Surfaces Policy Issued 5/1995 revealed: Food Contact Surfaces: Food contact surfaces are in good condition, made of non-toxic material and are easily cleanable . The food contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. Discard any food contact surfaces with chips, nicks or broken pieces .which cannot be cleaned properly. Nonfood Contact Surfaces: Food carts are sanitized after each meal. Nonfood contact surfaces of equipment, such as handles on reach in units, sides of sinks, gaskets on cooler and freezer doors .shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. The Food and Supply Policy, Issues 5/1995 revealed: All food, non-food items and supplies used in food preparations shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Procedures: .Date and rotate items: first in, first out. Discard food past the sue by date or expiration date. Cover, label and date, any unused portions of open packages .Products are good through the close of business on the date noted on the label. Dry Storage: Store foods in their original packages. Foods that must be opened must be stored in NSF (National Sanitation Foundation certified food safe) approved containers that have tight-fitting lids. Label both the bin and the lid. On 02/24/26 at 2:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations (RDO), [NAME] President of Health Services (VPHS), and Regional Corporate Nurse (RCN) to discuss the above concerns. NJAC 8:36-17.1(a)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and document review, it was determined that the facility failed to ensure a process was in place to ensure a) modified texture foods were prepared utilizing standardized recipes to ensure adequate nutritional content and appropriate modified food texture, b) appropriate portions were provided for all texture modified foods and c) ensure all foods were served at appropriate temperatures. The deficient practice was observed during a meal observation and affected 6 of 6 residents who received puree diets and 4 of 4 residents who received mechanical soft diets, and was evidenced by the following: On 02/18/26 at 12:14 PM, the surveyor observed the meal service in the 3rd floor food service pantry and observed the following: A person was observed in the pantry with their hair not fully covered and one side was hanging outside of the hair net. They identified themself as the Senior Director of Nutrition, Registered Dietitian (SRD) for the management company. When the surveyor asked her what role was regarding the meal, she stated QA (quality assurance) and exited the pantry. At that time the surveyor observed another staff member, who identified herself as the Healthcare Supervisor (HCS) and was at the steam table in the pantry. When asked about the mealtime, as residents were seated in the dining room, she stated that the crab cakes and the rice did not come up from the kitchen at the appropriate temperatures and were sent back down to be reheated. The surveyor then observed the storage refrigerator in the pantry. The lower freezer drawer was observed with two plates of taco salad, one plate was identified as a mechanical soft salad which contained beef, beans, cheese, tomato, over lettuce, a scoop of sour cream, and was wrapped in plastic wrap and on top of ice cream containers. A second salad was a regular consistency taco salad that also contained ground beef, sour cream, beans, and was wrapped in plastic and stored directly on top of the ice cream containers in the freezer. The surveyor asked the HCS if the beef was supposed to be hot and was that the normal process to store a salad in the freezer? The HCS stated that the SRD thought that the salads would not hold temperature and instructed the HCS to put the salads in the freezer. The HCS stated that was not how the salads should have been stored as the beef would be hot. On 02/18/26 at 12:35 PM, the surveyor observed the Health Care Supervisor (HCS) plate puree meals that were served to residents. The plates had three food items on each plate. One food item was peach colored; one food item was white, and the other food item was light green in color. All the items appeared loose and did not hold shape on the plate when they were plated up by the HCS and served to the residents in the dining room. The HCS stated the puree consisted of puree salmon, rice and lima beans. At 12:42 PM, the HC supervisor began setting up meal trays for room service and the surveyor observed that the HCS uses a slotted spoon (not a portion spoon) to scoop the puree salmon out of a metal container, and the puree item also appeared runny and did not hold shape. The surveyor asked about the portion size of the puree salmon and the spoon that was used. The HCS stated, that she would usually used a portion black handled scoop, but because the food was not hot enough and had to be sent back to the kitchen, the slotted spoon was left in the metal pan when the food was sent back up, and that was what she used. The HCS removed the mechanical soft salad from the freezer and the surveyor asked her what the temperature was prior to serving the resident and the HCS used the thermometer to check the temperature and informed the surveyor that the temperature of the beef was 57 degrees Farenheight. On 02/18/26 at 12:50 PM, the surveyor interviewed the Assistant Director of Dining (ADD), in main kitchen regarding if recipes were used for the puree items. The ADD looked through a recipe book located in the kitchen and was unable to locate recipes for the puree items and exited the kitchen. The surveyor then interviewed the [NAME] who prepared the lunch meal and asked him if he had used any recipes for any of the puree items that were observed during the lunch meal. The cook stated, no, he did not use recipes. When asked how he knew how to prepare the puree items, and how would he know how much thickener to use for the puree items, he stated, I usually just eyeball and stated he was culinary trained. Another person interjected and stated he was the Regional Director of (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Operations (RDO) for the food service management company and stated, we have recipes. At that time the ADD returned with other books and was attempting to locate recipes for the puree food items. On 02/18/26 at 1:01 PM, the surveyor interviewed the ADD again regarding using recipes and asked if recipes should be utilized for the puree items. The ADD stated yes, it was important to use recipes for consistency and portion sizes. When asked was it also important for nutritional adequacy he stated, yes, and to make sure it was prepared correctly. At that time the ADD was unable to locate any recipes for the puree items. When asked if puree items should be liquid like and run together on the plate, the ADD stated, no, and then confirmed that he did not have a recipe for the puree salmon, puree crab cake, puree rice or puree lima beans. On 02/18/26 at 1:13 PM, the surveyor interviewed the [NAME] who prepared the lunch meal that the surveyor observed on the third floor. The [NAME] confirmed that he prepared the lunch meal and the surveyor requested to see the food temperature log for the meal. The [NAME] showed the surveyor a clipboard with a blank log listing all of the items that were prepared and were observed served for the Wednesday lunch, The [NAME] stated, no temps (temperatures) were written down for lunch and in the presence of the surveyor, started to fill in the log and stated, I'm doing now. When asked where the temperature documentation was located, he stated it was all in his head. When asked whether it was important to record food temperatures at the same time the food was prepared, he stated, yes, to make sure the food was safe. The surveyor then asked the ADD about the food temperatures for hot food at the point of service. The ADD stated at the point of service the hot food should be over 150 degrees Farenheight (F) and stated there should be no hot foods served between 40 to 140 degrees F. The ADD was made aware of the surveyor concerns regarding the ground beef on top of the taco salad in the freezer and stated that the taco salad beef was a hot item and will provide a copy of the recipe. On 02/18/26 at 1:22 PM, the RDO confirmed that the taco salad was a hot salad (Beef) and provided a recipe. When asked why the salad was stored in the freezer, he stated he had been there for only three weeks and he didn't know why as it did not match the taco salad recipe.A review of the Taco Beef Corn Tortilla recipe that was provided by the RDO, did not match the item observed by the surveyor, and revealed the taco beef filling should be held at 140 degrees F. The recipe did not identify the salad, cheese, sour cream or beans that were observed and held in the freezer. The surveyor reviewed the menus and portion sizes provided to the survey team on 2/18/26 at 11:35 AM which revealed the portion size of the puree shellfish was 4 ounces, the puree salmon was not listed. On 02/24/26 at 2:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations (RDO), [NAME] President of Health Services (VPHS), and Regional Corporate Nurse (RCN) to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with DON, RCN, LNHA and RDO and the facility had no additional information to provide. NJAC 8:39-17.4(a)2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium at Navesink Harbor, The	40 Riverside Avenue Red Bank, NJ 07701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review it was determined that the facility failed to ensure a) all food was appropriately stored and food temperatures were monitored in a manner to prevent foodborne illness, b) all kitchen equipment and the environment in the main kitchen and remote service kitchen was maintained in a clean and sanitary manner, c) staff practiced hand hygiene and restrained their hair appropriately. This deficient practice affected all residents and increased the potential for the development of food borne illness, the potential from contamination from foreign substances and was evidenced by the following: On 02/18/26 at 8:24 AM, the surveyor toured the kitchen with the Executive Chef (EC), the Director of Dining Services (DDS) and observed the following: -The EC exited the refrigerated walk- in box and did not have all his facial hair covered. -The [NAME] was cooking and he did not have all of his facial hair covered. When asked if it should be covered, he confirmed that the facial hair should be covered. Inside the refrigerated walk-in box:-Two stacks of fresh food items were in boxes, including produce, and were stored directly on the floor.-Walls, ceilings and floor throughout had visible debris, including splatter type debris, and crumb type debris was observed under the food racks, and also embedded on the green racks which appeared rusted in several areas. When the surveyor showed the EC the observations and asked the EC if it looked clean? The EC confirmed it did not appear clean, and he stated it should be cleaned daily.- A jar of strawberry topping, was labeled Opened, 2/13/26 and Discard 2/16/26.- A container of sauerkraut was opened, splatter was observed on the outside of the container and the container was not labeled with a use by date, the vender sticker was dated 1/2/26 and the EC confirmed there was no use by date.- Corned Beef was wrapped in plastic and was directly on the shelf, with a label affixed, Opened 2/14/26- Discard- 2/14/27. The EC stated the sticker was placed on by the staff and it was the wrong information on the label because the staff had a hard time understanding.-A container of fresh peeled shallots, was labeled with a sticker Opened 2/11/26 and Discard 2/14/26, the EC again, acknowledged the item was past the expiration date and stated the item was incorrectly dated.-A jar of capers had a label affixed, Opened 2/15/26 and Discard 2/15/27-A package of unopened cheddar cheese was in the corner on the floor in the walk in refrigerator. When asked about the package, the EC stated it fell off the shelf.-A bag of liquid eggs was stored directly on top of shelled eggs which were inside of a box on a shelf.-A white container of opened pitted kalamata olives, had splatter on the exterior and did not contain a use by date. -A partially opened container (lid ajar) of soft Boursin cheese was visibly soiled around the rim of the container. The container was labeled as Opened 2/8/26 and Discard 2/14/26.-A bag of sundried tomatoes was labeled Opened 2/14/26 and and Discard 2/17/26.-A metal pan was located on a top shelf of the meat area. When asked what the item was, the DDS proceeded to remove, what was identified as defrosting fish which was loosely wrapped with plastic. When the item was pulled off of the top shelf the fluid spilled onto the floor and onto the DDS. -A raw pork loin was wrapped in plastic wrap and located directly on top of a shelf, over a box with a blue bag that contained raw chicken inside.-A cardboard box contained a blue bag of raw chicken, which was located next to a plastic container with a lid, and another cardboard box. All three containers contained raw chicken. When asked about any dates that the items were pulled from the freezer, or what the use by date was, or any dates that were located on the items. The EC stated, obviously not dated. -Four white bins were stored underneath a stainless-steel shelf opposite the walk-in refrigerator, and contained flour, breadcrumbs in the bags, and thickener. The bins were visibly soiled on the lids with debris on the outside of the bins.-The stainless- steel table contained 4 loaves of French style bread that were stored on top of a plastic lid for a bin. Three of the loaves were completely uncovered and stored adjacent to non-stick spray. The EC said the loaves were defrosting. -A visibly soiled, with grease type stains, plastic wrap container was located on the same table.-The can opener that was affixed to the same stainless-steel table had (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	visible metal shavings around the blade. When asked when the blade was last changed, the EC stated that the whole opener would be thrown out and the blade would not get changed.-Two knife storage racks were affixed to the wall over the stainless-steel table and had visible crumb type debris inside the plastic type covering to the racks where the knives were stored. One of the racks was dripping liquid as if the knives were placed in the racks wet.-Clean knives were also stored underneath a visibly soiled with black debris sink pipe (white pipe), in an open container under he hand washing sink.-The garbage can for the hand washing sink by the walk-in refrigerator, was not located next to the sink, and it was visibly soiled on the exterior. -The dry storage room contained a dented can on the rack, and the bottles of gravy making product had visible dark colored debris on the outside of the bottle.-The green food storage racks in the dry storage room were visibly rusted through, and were missing a finish in several areas. There was embedded food type debris affixed to the the racks.-The floor in the dry storage room was visibly soiled with debris under the racks. -The juice dispenser was visibly soiled by the three nozzles, and there was visible spatter on the exterior of the machine.-The 4-ounce insulated cups were stored in an open bin on a lower shelf by the juice machine, there were visible crumbs, and debris including an artificial sugar packet in the bin. Mugs were also stored in a bin in the same area, next to the cup bin, and were stored on top of another.-The handwashing sink by the healthcare preparation side had food debris inside the sink, and the garbage can did not have a liner inside. There was visible debris on the floor by the garbage can.-The gasket for the healthcare refrigeration reach -in refrigerator was soiled. -A multi-tiered gray cart was also observed by the reach- in refrigeration unit and was visibly soiled with various colored debris throughout the cart. -Eight cutting boards that were white, green and red were visibly stained, soiled and appeared to have deep grooves. The DDS stated they were all worn and removed the cutting boards. -There was an empty red sanitizer bucket by the cutting boards on a shelf with debris affixed to it, and the window ledge in the area appeared soiled with dust like debris.-The pass though stainless-steel shelf underside, between the steam table and where the meals were plated and passed through was heavily soiled with debris.-The plate dolly was stored by the entrance to the kitchen and the plates were stored upright and uncovered.-The oven was soiled with heavily caked on dark grease like debris inside the interior and by the oven door.-There were two snack carts by the entrance to the kitchen and the staff stated they were from the previous night, and had debris on them and food items.-When asked the DDS for the cleaning schedules for the kitchen, he stated the kitchen should look better. The DDS then showed the surveyor an Equipment Cleaning Log for the Week of 2/18/26 which was incomplete and did not identify all areas observed by the surveyor.- The ice cream utensil was sitting in running water next to the ice cream freezer. There were flies affixed to the white microwave in that area. On 02/18/26 at 12:14 PM, the surveyor observed the meal service in the 3rd floor food service pantry and observed the following: -A person was observed in the pantry with their hair not fully covered and one side was hanging outside of the hair net. They identified themself as the Senior Director of Nutrition, Registered Dietitian (SRD) for the management company. When brought to their attention, they restrained all their hair and confirmed it should all be covered. The SRD then proceeded to wash her hands in the sink, used a paper towel to dry her hands, then used the same paper towel to wipe the water off the area surrounding the sink. When the surveyor asked her what role was regarding the meal, she stated QA (quality assurance) and exited the pantry. At that time the surveyor observed another staff member, who identified herself as the Healthcare Supervisor (HCS) and was at the steam table in the pantry. When asked about the mealtime, as residents were seated in the dining room, she stated that the crab cakes and the rice did not come up from the kitchen at the appropriate temperatures and were sent back down to be reheated. On 2/18/26 at 12:27 PM, the food cart arrived at the pantry and the surveyor observed the HCS did not perform hand hygiene (HH) and used her bare hands and removed the containers of rice, crab cake, lima beans, puree beans, puree crab cake in the steam table and observed the following: - The HCS, without performing HH, proceeded to wipe the thermometer probe with an alcohol wipe, and left the wipe on the visibly worn, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stained cutting board affixed to the steam table, and the temperature of the lima beans. -The HCS then, without using HH, picked up the same wipe that was on the cutting board with her bare hands used, without first performing HH and wiped the thermometer probe, and then tested the temperature of the rice. -The HCS, then after the rice, placed gloves on her hands without first washing her hands and proceeded to use the same wipe that was left on the cutting board to test the temperature of the crab cake, puree crab cake and puree lima beans. -The HCS then after taking the temperatures, she washed hands with hands for less than 20 seconds of friction and then rinsed and placed gloves on her hands to serve the food. On 02/18/26 at 12:35 PM, the surveyor observed the HCS remove gloves, exit the pantry and place a meal plate in front of a resident. The HCS then returned to the pantry and washed hands for 6 seconds of friction after soap applied and rinsed in water. On 02/18/26 at 12:42 PM, the HC supervisor began setting up meal trays for room service, removed both gloves and placed a new pair of gloves on her hands without first performing HH. On 02/18/26 at 12:46 PM, the surveyor exited the pantry and observed a pile of insulated mugs and bowls stacked up on top of one another on a tray next to lemonade type drink. The bowls were observed with crumb like debris in two of the bowls. The surveyor asked the HCS if the bowls were clean and HCS stated the bowls were clean. On 02/18/26 at 1:13 PM, the surveyor interviewed the [NAME] who prepared the lunch meal that the surveyor observed on the third floor. The [NAME] confirmed that he prepared the lunch meal and the surveyor requested to see the food temperature log for the meal. The [NAME] showed the surveyor a clipboard with a blank log listing all of he items that were prepared and were observed served for the Wednesday lunch,. The [NAME] stated, no temps (temperatures) were written down for lunch and in the presence of the surveyor, started to fill in the log and stated, I'm doing now. When asked where was the temperature documentation located, he stated it is all in his head. When asked was it important to record food temperatures at the same time the food was prepared, he stated, yes, to make sure the food was safe. On 02/18/26 at 2:07 PM, the surveyor interviewed the Director of Operations (DO) for the Food Management Company who stated the expiration dates should follow the policy. On 2/20/26 at 9:35 AM, the surveyor interviewed the DDS, while in the main kitchen, regarding the process to check the temperatures of the food. The DDS stated that an alcohol swab was used to wipe the probe, then place the thermometer in the thickest part of the food, then the process would be repeated. When asked if the alcohol swab was reused, he stated no. When asked if HH would be performed, he stated, of course, before any task and glove use. The DDS stated that hands are always washed prior to placing gloves on hands and then the task would be completed. The surveyor asked if temperatures could be taken without wearing gloves, and could the alcohol wipe be reused? The DDS stated, bare hands could not be used, and if the thermometer was not clean the food could become contaminated. The DDS stated that a single alcohol wipe had to be used for each temperature taken and could not reuse the wipe. When asked if after hands were washed it was okay to wipe the sink with the same paper towel, the DDS stated no. The surveyor then reviewed above observations with the DDS.On 2/20/26 at 9:35 AM, the surveyor observed that the clean plates were still stored in the entry way of the kitchen, and remained uncovered.A review of the Assistance with Meal Service Policy Revised 1/15/26 revealed: 4. For all residents, hot foods shall be held at a temperature of 135 degrees or above until served. Cold foods shall be held at 41 degrees or below until served . 6. All employees who provide residents assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. A review of the Sanitation and Infection Prevention Policy, Issued 5/1995 revealed: In the Food & Nutrition Services Department: All associates associated with the handling of food shall wash hands with soap and water at the following times . Before handling food or clean utensils/ dishes/ equipment; Before putting on gloves, After removing gloves, After any other activity that may contaminate the hands. Hands must be washed with soap and water when plating food on patient/resident units. Alcohol-based hand sanitizer is only used to decontaminate hands when delivering trays and there is no visible soiling of the hands (food or other materials). When hands are (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	visibly soiled with food or other materials, hands are washed with soap and water.Procedures: All food handlers: Use only sinks designated for hand washing .All hand wash sinks should be easily accessible with nothing blocking their access in food production, food service and dishwashing areas. Hand washing sinks .should be clean and stocked with soap, paper towels, a covered waste receptacle, and a Hand Wash sign ., Wet hands with warm water and apply a disinfectant soap, lathering up to mid arm. Work later into hands for 20 seconds, including areas under fingernails, between fingers, on the inside and outside of hands. Keep hands away from sides of sink. Rinse thoroughly under warm running water, allowing the water to flow from the arms, down top the fingertips. Use a paper towel to turn off the faucet to avoid contact with faucet germs. Dry hands with a single use, disposable towel. Do not use common towels for drying or wiping hands. The Uniform Dress Code Policy, Issued 5/1995 revealed: Associates working with food: Wear the approved hair restraint when on duty regardless of length or presence of hair. Restrain all facial hair with a beard net/restraint. The Food Contact Surfaces Policy Issued 5/1995 revealed: Food Contact Surfaces: Food contact surfaces are in good condition, made of non-toxic material and are easily cleanable . The food contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. Discard any food contact surfaces with chips, nicks or broken pieces .which cannot be cleaned properly. Nonfood Contact Surfaces: Food carts are sanitized after each meal. Nonfood contact surfaces of equipment, such as handles on reach in units, sides of sinks, gaskets on cooler and freezer doors .shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. The Food and Supply Policy, Issues 5/1995 revealed: All food, non-food items and supplies used in food preparations shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Procedures: .Date and rotate items: first in, first out. Discard food past the sue by date or expiration date. Cover, label and date, any unused portions of open packages .Products are good through the close of business on the date noted on the label. Dry Storage: Store foods in their original packages. Foods that must be opened must be stored in NSF (National Sanitation Foundation certified food safe) approved containers that have tight-fitting lids. Label both the bin and the lid. On 02/24/26 at 2:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations (RDO), [NAME] President of Health Services (VPHS), and Regional Corporate Nurse (RCN) to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with the DON, RCN, LNHA and RDO and the facility had no additional information to provide. NJAC 8:39- 17.(1);2(a)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview it was determined that the facility failed to ensure that garbage was properly contained in dumpsters and ensure cardboard was properly disposed of and the garbage area was maintained in a clean and sanitary manner to prevent the harborage and feeding of pests. The deficient practice affected all residents who resided at the facility and was evidenced by the following: On 2/18/26 at 8:54 AM, during the initial tour of the kitchen with the Executive Chef (EC), the surveyor observed an alcove area prior to the exit from the kitchen toward the dumpster area. The area had cardboard boxes strewn about and were piled up on the floor, and were against the walls. The cardboard boxes were also covering a black bin that appeared to have broken down cardboard boxes inside. Immediately outside the exit door revealed that multiple large garbage bags were piled up in a garbage can, the blue dumpster was overflowing with what appeared to be cardboard boxes, in clear bags which were lifting up the lid the the dumpster, the adjacent dumpsters were also overflowing with black garbage bags that were not exposed. The EC stated there was no garbage pick up on Monday due to a holiday (2 days prior). On 02/19/26 at 9:53 AM, the surveyor interviewed the Director of Facility Management (DFM) who was responsible for maintenance, housekeeping and security. The surveyor asked when was the garbage and recycling pick up scheduled. He stated that garbage was picked up throughout the building three times per day and it would be brought out and it would be in the receptacles that were kept in the garage which would include garbage and recycling from the health care unit also. When asked about the garbage accumulated in the kitchen, he stated, The kitchen is separate from us. When asked about concerns related to any recently missed garbage pick- ups, he stated that there were a couple of pick-ups missed due to trucks blocking the ability for the garbage trucks to access the dumpsters. The DFM stated that the garbage was picked up three days per week and two days per week for recycling and included Monday, Wednesday and Friday. When asked about the garbage that was observed piled up outside the building, the dumpsters that were overflowing with garbage and the boxes that were piled up inside of the building, the DFM stated the facility has the ability to call for additional garbage pick up it that was needed and the kitchen staff should have informed the DFM if there had been a concern. When asked if there were any garbage pick-ups missed due to the holiday, the DFM stated, there were no pick ups missed, they (garbage truck) was supposed to come on Tuesday and there was a delivery truck blocking access and the garbage truck left. When asked what should have happened, the DFM stated the garbage truck could have been called to come back to the facility.On 02/19/26 at 10:06 AM, the surveyor showed the DFM the pictures of the garbage outside and boxes piled up inside and asked if that was okay? The DFM stated, it is not okay they were a separate company (kitchen contractor) and the boxes should be tied and put in bundles and then put in the recycling bin, you could get mice, and there is a fire risk. The DFM stated there was another area in the garbage that could have been utilized if he had been made aware. The DFM stated he was not responsible for the kitchen since it was run by a contractor and he does not go into to the kitchen, but they could report concerns to him.NJAC 8:39-19.3(a)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observations, interview and document review it was determined that the facility failed identify and include the staff competencies and skill sets that were necessary to provide the level and types of care needed for the resident population which included the contracted food service department. The deficient practice affected all residents who resided at the facility and was identified by the following: On 2/18/26, the facility provided the survey team with a copy of the Facility Assessment (FA). A review of the document revealed the following: Staff training/education and competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, training competency instruction and testing policies. The [facility name] utilizes [name of computer training as well as live training, conduct competencies and review policies and procedures. See competency binder. There were no specific competencies listed and Consider the following training topics (this is not an inclusive list): The FA appeared to be a template that was not specific to the facility. On 2/20/26 at 12:55 PM, the surveyor interviewed the Director of Nursing (DON) regarding staff education. The DON stated that she was overall responsible for staff education and stated we do all of our education on [computer education program name].On 2/20/26 at 1:07 PM, the DON provided the education book utilized by the Infection Preventionist. The surveyor asked if the Dietary department was included in any training, or competencies and she stated they were not. When asked to list all the competencies completed for the staff, the DON stated, Wound Competencies were completed by a Registered Nurse and had respiratory training competencies, and no other competencies were completed by the facility. On 2/25/26 at 8:41 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) about what the purpose of the FA was. The LNHA stated to make sure resources were available to take care of residents. The surveyor asked the LNHA if the FA included any competencies or education required by the contracted Dietary Department and she stated, no the Dietary Department was not included in the FA. NJAC 8:39-33.4

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, interview and document review it was determined that the facility failed to self-identify areas of concerns and develop comprehensive data driven Quality Assurance Performance Improvement plans to address sanitation, pest management, garbage disposal, appropriate meal preparation and meal service, and also failed to self-identify concerns related to timely implementation of wound care recommendations and clarification of wound care orders. The deficient practice affected all residents who resided in the facility and was evidenced by the following: Refer to : F550, F686, F802, F804, F805, F812, F925 On 02/25/26 at 8:48 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) about the Quality Assurance Performance Improvement (QAPI) process and what the current active QAPI plans included. The LNHA stated the most recent QAPI was the 4th Quarter QAPI meeting that was held on 1/15/26. The LNHA stated that if the QAPI team thought a process had improved, that it would not be included. The LNHA stated the current QAPIs included the following: Pharmacy report; Nursing online education completion and nursing competencies were not reviewed or identified as a concern by the QAPI team. The LNHA stated pressure ulcer averages. When asked if there was anything related to the ensuring wound recommendations were clarified, she stated that there were no QAPIs related to wound recommendations or wound orders. The LNHA stated accidents and incidents were reviewed, and infection prevention related to enhanced barrier precautions, vaccines and antibiotic stewardship. The LNHA stated social services had a QAPI related to reporting. The LNHA stated the maintenance department reviewed responses to work orders as their QAPI. The surveyor asked the LNHA if the concerns regarding the kitchen sanitation, the failure of the kitchen to use recipes for modified foods, the lack of hand hygiene during meals, the overflowing garbage or flies that were also observed in the kitchen have been brought to QAPI? The surveyor also asked there was anything related to staff education for the Dietary staff identified by the QAPI team. The LNHA stated there was nothing related to QAPIs from the Dietary Department other than the Registered Dietitian's review of weight changes. The LNHA confirmed that there were QAPI plans related to garbage disposal concerns or pest concerns identified during the survey. The Facility QAPI Plan 2025 revealed the facility delivered care across the continuum, impacting both clinical outcomes and quality of life for all residents. All departments and services will participate in Quality Assessment and Assurance (QAA) activities to promote ongoing performance improvement. A review of the Assistance with Meals Policy, last reviewed 1/15/26 revealed Procedure: . 6. All employees who provide residents assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. NJAC 8:39-33.1

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and review of pertinent facility provided documentation, it was determined that the facility failed to ensure that the Infection Preventionist (IP) had completed specialized training in infection prevention and control per Centers for Medicare & Medicaid Services (CMS) guidance for one (1) of one (1) employee reviewed for IP.Refer to: F882: An IP must have obtained specialized IPC training beyond initial professional training or education prior to assuming the role. Training can occur through more than one course, but the IP must provide evidence of training through a certificate(s) of completion or equivalent documentation. CMS recommends specialized training include the following topics: Infection prevention and control program overview, The infection preventionist's role, Infection surveillance, Outbreaks, Principles of standard precautions (e.g., content on hand hygiene, personal protective equipment, injection safety, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing reusable resident care equipment), Principles of transmission-based precautions, Resident care activities (e.g., use and care of indwelling urinary and central venous catheters, wound management, and point-of-care blood testing), Water management, Linen management, Preventing respiratory infections (e.g., influenza, pneumonia), Tuberculosis prevention, Occupational health considerations (e.g., employee vaccinations, exposure control plan, and work exclusions), Quality assurance and performance improvement, Antibiotic stewardship, and Care transitions. This deficient practice was evidenced by the following:On 2/24/26 at 9:14 AM, upon entrance the facility, the surveyor was provided with a Certificate of Attendance for a Basic Course for Infection Prevention and Control. The course was not designed to meet federal, state, and specialized industry requirements for infection preventionists. On 2/24/26 at 10:27 AM, the surveyor interviewed the Regional Corporate Nurse (RCN) and the Director of Nursing (DON). The RCN stated that he was covering for the IP Nurse who was out on leave. The surveyor requested to review the IP's specialized training in infection prevention and control per CMS. The DON stated she would obtain a copy of the training certificate and provide it to the surveyor. On 2/25/26 at 12:25 PM, RCN provided the surveyor with the same document that was provided during the entrance conference, as referenced above. The RCN confirmed and stated, that was all they had.On 2/25/26 at 2:31 PM, during the exit conference held with the [NAME] President of Health Services Registered Nurse (VPHS), Regional Corporate Nurse (RCN), Regional Director of Operations (RDO), Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The VPHS stated that Certificate of Attendance that was previously provided for the IP Nurse was acceptable specialized training because the IP Nurse had 5 years of infection control experience and that was the information that was included in the IP job description. No further information was provided. A review of the IP job description provided, dated 11/30/2023, included the following, and was not reflective of the current regulation (Implemented by CMS on 08-08-24)Qualifications:has primary professional training in medicine, nursing, medical technology, microbiology, epidemiology, or a related field;is qualified by education, training, and at least (5) years of infection control experience or by certification in infection control by the Certification Board of Infection Control and Epidemiology;is employed by the facility consistent with the requirements.has completed specialized training in infection prevention and control. N.J.A.C. 8:39-19.1(b)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and review of pertinent documents it was determined that the facility failed to ensure an effective pest management program was in effect to control flies in the kitchen. The deficient practice affected all residents who resided in the facility and was evidenced by the following: On 2/18/26 during a kitchen tour conducted by the surveyor that began on 8:24 AM, with the Executive Chef (EC),and the Director of Dining Services (DDS), the surveyor observed small black flies sporadically in the kitchen, and observed black flies were on the front and side of the white microware oven in the area where the ice cream freezer was located. The EC stated the flies were due to a leak in a pipe that had a crack. On 02/19/26 at 9:53 AM, the surveyor interviewed the Director of Facility Management (DFM) who was responsible for maintenance, housekeeping and security. The surveyor inquired if there was a pest log for the kitchen and if there were any concerns reported regarding an issue with a leak due to a cracked pipe. The DFM stated there was no pest log and he had not been made aware of a cracked pipe. When asked about the flies that were observed in the kitchen and the relationship with a cracked pipe, he stated they were aware that there were flies in the kitchen and the kitchen was supposed to flush the drains for the flies when the kitchen was cleaned. The DFM stated the used environmentally safe fly traps in the kitchen and the kitchen was supposed to notify him if the flies were still present. The DFM confirmed he was not notified of the continued presence of the flies. The surveyor requested any policies or information related to the flies. On 2/19/25 at 10:25 AM, the DFM provided the surveyor with the Pest Service Record for the facility from 1/12/24 through 2/11/26 which revealed: an entry on 6/13/25 inspected and treated for flies in kitchen; an entry dated 12/12/25 flies in kitchen area Recommend all pails to be washed out with bleach and drain traps to be degreased/cleaned to Head Chef; an entry 2/11/26 fly vinegar traps replaced in soda fountain area inspected treated food preparation area kitchen for flies . to the kitchen manager to have drains checked for break with camera . On 02/24/26 at 2:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations (RDO), [NAME] President of Health Services (VPHS), and Regional Corporate Nurse (RCN) to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with the DON, RCN, LNHA and RDO and the facility had no additional information to provide. NJAC 8:39-31.5(a)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, it was determined that the facility failed to consistently treat residents in a dignified manner. This deficient practice was identified during the meal observation for three 4 of eight 8 residents (Resident #5, Resident #18, Resident #22, Resident #24) observed during breakfast and lunch on 2 of 2 resident units and was evidenced by the following. 1. On 02/18/26 at 8:30 AM, the surveyor toured the 300 Unit and observed the meal delivery system. Some residents were observed eating in their rooms while other residents were at the nursing station waiting for assistance with the breakfast meal. The surveyor observed Resident #24 in bed with the breakfast tray positioned on the bedside table. The surveyor observed that Resident #24 was eating with their bare hands. The surveyor observed that Resident #24 had tremors on both hands and had difficulty holding the pancake and bringing the pancake to their mouth at the same time.On 02/20/26 at 8:40AM, the surveyor observed the residents eating breakfast in the dayroom, there was no staff in attendance. The surveyor observed the Director of Nursing (DON) in the hallway and inquired who was responsible for monitoring the residents during meals. The DON stated that residents should be monitored while eating in the dining room. While interviewing the DON in the hallway, a resident started coughing and the DON exited the interview and went to the dining room to assist the resident. On 02/20/26 the surveyor reviewed Resident #24's medical record. A review of the resident's admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; Alzheimer's Disease, Dysphagia and Parkinson's disease.A review of the Physician Order Sheet reflected an order dated 1/15/26 for a mechanical soft diet and thin liquids. The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate management of care, reflected that Resident #24 had severe cognitive impairment. Resident #24 scored 02 out of 15 on the Brief Interview for Mental Status (BIMS). Section GG0130 of the MDS which addressed Self-Care Resident #24 was coded as 05 reflected that Resident #24 needs setup or clean-up assistance. Helper assists only prior to or following the activity. A review of Resident #24's Comprehensive Care Plan revealed a problem for altered nutrition related to history of weight loss, risk of dehydration, and modified consistency diet. The goals were for staff to anticipate the residents' needs. Interventions included: Assist me with meals and encourage oral intake of foods and fluids. Please encourage me to go back to dining room if I leave before meals service was completed. On 02/19/26 at 12:35 PM, the surveyor interviewed the Dietitian regarding the above observation on 02/18/2026 during breakfast. The Dietitian stated the Resident #24 needed help with all meals, and the pancake should have been cut up. The Dietitian added if the kitchen failed to cut the pancake, the staff who delivered the meal should have cut the pancake and assisted Resident #24.2. On 02/18/2026 at 12:21 PM, the surveyor went to the dayroom to observe the lunch meal on the 3rd floor. The surveyor observed 8 residents in the dayroom. Some residents were being assisted while others were being cued to eat their meals. The surveyor observed Resident #22 seated in a recliner chair in the dayroom. Their lunch tray was placed uncovered on the bedside table next to the resident. The resident was looking at other residents eating their meals while waiting to be assisted. Most of the residents had completed their meals, Resident # 22 was still waiting. At 12:56 PM, the surveyor observed a Certified Nursing Aide (CNA) entered the dayroom, proceeded to wash her hands, then sat next to Resident #22 to assist with the lunch tray that had been sitting uncovered on the table for more than 30 minutes. The surveyor then inquired about how long the meal had been sitting on the table. The CNA stated that she was busy in the room providing care as all residents had to be out of bed by 12:00 PM, and she was not aware that the lunch tray had been sitting on the table. The Licensed Practical Nurse (LPN) who was in the dayroom and assisted also with the meal delivery, prompted the CNA to reheat the meal at that time. The CNA took the tray in the kitchen and reheated the lunch at 1:06 PM. On 02/18/26 at 1:30 PM, the surveyor interviewed the Certified Nursing (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant who was also in the dayroom regarding the meal delivery and the above observation. The CNA stated that the lunch tray should not have been placed on the table in front of the resident if there was no staff available to assist with the meal. The tray should have been left in the kitchen. On 02/18/26 at 1:40 PM, the surveyor interviewed the nurse who was present in the dining room and observed Resident # 22 not being assisted with the lunch tray. The nurse stated that the resident should have been removed from the dayroom, and the tray should have been left in the kitchen until the resident could be assisted. On 02/20/26 the surveyor reviewed the medical record for Resident # 22.A review of the resident's admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, Alzheimer's Disease, contracture of muscles, personal history of traumatic brain injury and dysphagia (swallowing difficulty).The quarterly Minimum Data Set (MDS), an assessment tool used by the facility to prioritize care dated 10/01/25, reflected that Resident #22 had a BIMS Score of 03 out of 15, indicative of severe cognitive impairment. Resident #18 was totally dependent on staff for all activities of daily living.Section GG of the MDS which addressed Activities of daily living (ADLs) reflected that the resident was coded as88 for eating indicating that the activity was not attempted due to medical condition or safety concerns. The resident was assessed as being dependent on staff for all activities of daily living including being assisted with meals. The surveyor attempted to interview the resident but the resident could not procced with the interview. 3. On 12/19/26 at 12:15 PM, the surveyor entered the dayroom to observe lunch. The surveyor observed a CNA seated in the back of the room who assisted Resident #18 with the lunch meal and proceeded to also converse with another CNA while assisting Resident #18. The surveyor also observed 7 other residents in the room. The surveyor exited the dayroom to inquire regarding if the CNA could wear gloves on while assisting the resident and then interviewed the Dietitian who was in the hallway. The surveyor escorted the Dietitian to the dayroom, and we both observed the CNA with her gloves on while assisting the resident with the lunch meal. The Dietitian went to the back of the room and informed the CNA that she could not have gloves on in the dayroom while assisting with meals. On 02/19/26 at 12:30 PM, the surveyor returned to the room and observed the same CNA, again assisted the resident using her gloved hands. The CNA also continued to have a conversation with the other CNA while assisting Resident #18. The CNA then during the observation, removed one of the gloves off of her hand while in the presence of the surveyor.On 02/19/26 at 12:40 PM, the surveyor interviewed the CNA regarding having gloves on while assisting the resident in the dining room. When inquired regarding the rationale for having gloves on while in the dining room, the CNA stated, I was told that Resident #18 drooled and spat during mealtime, I put the gloves on to protect myself. The CNA showed to the surveyor her hand with a pinpoint redness. The surveyor then asked the CNA what should have been done if she had a wound. The CNA replied, I should cover it with a band aid. When inquired if it was the facility policy to use gloves while assisting residents in the dining room, she stated, No. When asked for the rationale, she stated, it is a dignity issue.The surveyor then reviewed the medical record for Resident #18 which revealed, the resident was admitted to the facility with diagnoses which included but were not limited to; Parkinson's disease, unspecified dementia, dysphagia and encounter for palliative care.The Quarterly Minimum Data Set (MDS) an assessment tool dated 10/01/2025 reflected that Resident #18 scored 02 out of 15 on the Brief Interview for Mental Status (BIMS) indicative of severe cognitive impairment.Section GG of the MDS, which addressed Activities of Daily Living reflected that Resident #18 was totally dependent on staff for all activities of daily living. A review of the Comprehensive Care Plan (undated) provided by the facility identified a problem of self-care deficit related to dementia and Parkinson's. The goals were for staff will anticipate my needs throughout the next review. The interventions were to assist with grooming, bathing, dressing, transfers, bed mobility, toileting. 4. On 02/20/26 at 8:29 AM, the surveyor observed Resident #5's breakfast meal in their room, and a CNA entered Resident #5's room, put the meal tray in front of the resident, did not open the milk, and did not finish setting up the resident's meal tray at that time. The surveyor asked (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the CNA about the resident and the CNA stated that she was assigned to the roommate who was the only feeder that she had, but that the resident was feeding themself and she was not assigned to Resident #5 but knew they needed help. When asked the CNA about what a feeder was and should that be used to describe the residents? The CNA asked the surveyor what should I use? and stated she was not told to use any term besides feeder. On 2/24/26 at 2:54 PM, during a meeting with the survey team, the above concerns were discussed with the Regional Director of Operations, [NAME] President of Health Services, Regional Nurse, the Licensed Nursing Home Administrator, and the Director of Nursing (DON). The DON informed the surveyor that the dietitian reported the concerns to the administrative staff. No additional information was provided during the exit conference held on 2/25/26. A review of the facility's policy titled, Dignity dated and last revised 1/8/26. reflected the following: Residents shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Procedure. 2. Treated with dignity means the resident will be assisted in maintaining, and enhancing his or her self-esteem and self worth. 3. Residents shall be groomed as they with to be groomed (hair styles, nails, facial hair, etc.), 7 Staff shall always speak respectfully to residents, including addressing the resident by his or her name of choice, and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. A review of the Assistance with Meals Policy, last reviewed 1/15/26 revealed Procedure: B. Nursing staff will perform hand hygiene before serving residents. D. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, by nursing staff: for example: a. Not standing over residents while assisting them with meals, , b. Keeping interactions with other staff to a minimum while assisting residents with meals, c. avoiding the use of labels when referring to residents (e.g., feeders), a. Nursing staff will feed those residents needing full assistance within 15 minutes of the delivery of food trays. 4. For all resident, hot foods shall be held at a temperature of 135 degrees or above until served. Cold foods shall be held at 41 degrees or below until served. Nursing and Dietary Services will establish procedures such that delivery of food to serving areas accommodate this requirement. 6. All employees who provide residents assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and document review, it was determined that the facility failed to have a system in place to ensure a) prior to hire, all employees were pre-screened to ensure that they had not been found guilty in a court of law of abuse, neglect, or misappropriation, or had findings entered into the state nurse aide registry or against a professional license, and b) a process was in place to maintain documentation to confirm an appropriate pre-screening had occurred for all contracted facility employees which included dietary. The deficient practice was identified for 3 of 56 employee files reviewed that were provided by the facility. The evidence was as follows:A review of facility policy Hiring Policy: Employment Application & Pre-Employment Checks, revised April 2025 included:Policy: [Facility Name], Inc. (SSL) is an equal opportunity employer and believes in the fair treatment of all applicants. It is SSL's policy to hire only those individuals who successfully complete the pre-employment assessment criteria, mandatory drug screen, fitness for duty exam, criminal background check, satisfactory references, and regulatory health testing when applicable.On 2/18/2026 at 9:40 AM, the surveyor requested a list of all employees, including contracted employees, that had been hired since 9/19/24 (last recertification survey date) and included employee name, date of hire, title, and date of separation (if applicable) from the Human Resources Director (HRD). A review of employee files revealed the following:Employee # 8 was hired on 2/17/25, and there was no criminal background report in the file. Employee # 22 was hired on 2/4/25, and there was no criminal background report in the file. Employee # 44 was hired on 2/24/25, and a criminal background search was completed and dated 11/15/25 (264 days after employee #44 began working).Employee # 56 was hired on 10/08/25, and there was no criminal background report in the file. On 2/20/26 at 2:00 PM, the LNHA provided a copy of the Dining Service Agreement (Contractor) effective on 6/01/22, which revealed: the Contractor would provide the services identified on 1.3 Purchasing. (a) Employee pre-employment background screening for {name redacted} personnel. On 2/25/26 at 2:31 PM, during an exit conference held with the Regional Corporate Nurse (RCN), Regional Director of Operations (RDO), Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), no further information was provided.NJAC 8:39-9.3(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure dependent residents were provided with routine and appropriate nail care in a timely manner. This deficient practice was identified for 1 of 2 resident reviewed for Activities of Daily Living Care (Residents #18) and was evidenced by the following: On 02/18/2026 at 8:25 AM, the surveyor observed Resident #18, seated in a recliner chair adjacent to the nursing, their breakfast tray was on the bedside table. The surveyor observed the resident's nails long, jagged and discolored with a black substance underneath the fingernails. The resident was unable to answer the surveyor's inquiries when asked if they would like their nails to be trimmed and cleaned.On 02/19/2026 at 12:50 AM, the surveyor observed Resident #18 being assisted with the lunch meal by a Certified Nursing Aide (CNA), the resident's fingernails were long, jagged and the black substance was still present underneath the fingernails.On 02/20/2026 the surveyor reviewed Resident #18's electronic medical record (EMR). The admission face sheet (an admission summary) reflected that Resident #18 had diagnoses which included but were not limited to: Parkinson's disease, unspecified dementia, dysphagia and encounter for palliative care. The Quarterly Minimum Data Set (MDS), an assessment tool dated 10/01/2025, reflected that Resident #18 scored 02 out of 15 on the Brief Interview for Mental Status (BIMS) indicative of severe cognitive impairment.Section GG of the MDS, which addressed Activities of Daily Living reflected that Resident #18 was totally dependent on staff for all activities of daily living (ADLs). A review of the Comprehensive Care Plan (undated) provided by the facility identified a problem of self-care deficit related to dementia and Parkinson's. The goals were for staff will anticipate my needs throughout the next review. The interventions were to assist with grooming, bathing, dressing, transfers, bed mobility, toileting. The surveyor reviewed the Treatment Administration Record (TAR) and noted that Resident #18 was scheduled to have their shower on Monday and Thursday during the 3:00 PM-11:00 PM shift. A review of the TAR failed to indicate that Resident #18 received a shower on 02/23/2026 during the 3:00 PM-11:00 PM shift. The TAR was left blank. On 02/24/2026 at 10:30 AM (6 days after the initial observation), the surveyor observed Resident #18 seated in the dayroom. Resident #18's nails were observed in the same condition as observed on 02/18/25. During an interview with the CNA, she stated that the resident's nails needed to be trimmed and cleaned. The CNA proceeded to open Resident #18's hand and a strong odor was observed. The CNA then informed the surveyor that the 11:00 PM-7:00 AM shift was responsible to provide AM care to the resident and placed the resident in the recliner chair. The surveyor then asked the CNA who was responsible for providing nail care to all the residents, the CNA stated that the nurses were responsible for providing nail care.On 02/24/26 at 11:40 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) and inquired who was responsible for providing nails care. The LPN informed the surveyor if during medication administration, she observed a resident's nails needed to be trimmed, she stated she could but then stated that the CNAs should be providing nail care during the morning care.On 02/24/2026 the surveyor interviewed the Director of Nursing (DON) and requested the policy for ADLs care. The DON then informed the surveyor that the CNAs were responsible for providing nails care.A review of the facility's policy titled, Activities of Daily Living (ADL) last revised 1/16/25, provide on 02/24/26 at 1:37 PM, revealed the following: The Skilled Nursing Facility will assess each resident's ability to perform ADLs upon admission, quarterly, and with any significant change in condition. ADLs included bathing, dressing, grooming, toileting, transferring, ambulation, eating, nail care and incontinence care. All care provided, including the level of assistance and any refusals, will be documented accurately.On 2/24/26 at 2:54 PM, during a meeting with the survey team, the Regional Director of Operations, [NAME] President of Health Services, Regional Nurse, the Licensed Nursing Home Administrator, and the Director of Nursing (DON) could not provide documentation that nail care were offered and refused by the resident and no additional information was provided. On 02/25/26 at 2:31 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	PM, the survey team met with DON, RCN, LNHA and RDO and the facility had no additional information to provide. NJAC 8:39-27.2(g)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium at Navesink Harbor, The	40 Riverside Avenue Red Bank, NJ 07701

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a system was in place to ensure wound treatment recommendations were clarified and implemented in a timely manner. This deficient practice was identified for one (1) of three (3) residents reviewed for pressure ulcers (Resident #1), who had a wound treatment recommended by the Wound Consultant (WC) on 1/13/26, which was implemented on 1/21/26 (7 days later) and the dose was not clarified by the physician until 2/19/26 (38 days later). The deficient practice was evidenced by the following:On 2/18/26 at 12:16 PM, the surveyor observed Resident #1 in the seated in a recliner in the dining room and was being assisted with the meal by facility staff. On 2/19/26 at 8:57 AM, the surveyor observed Resident #1 sleeping in bed. At that time, the surveyor then reviewed the medical record for Resident #1which revealed the following: The admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; Parkinson's Disease (a movement disorder of the nervous system that worsens over time), pressure ulcer of the sacral region (bottom of the spine). The comprehensive Minimum Data Set (MDS), an assessment tool dated 12/21/25, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 14 out of 15, which indicated Resident #1 was cognitively intact. A review of Section M, Skin Conditions, reflected that the resident had one (1) unhealed pressure ulcer that was unstageable due to coverage of wound bed by slough (dead tissue) /or eschar (scab) upon admission to the facility . The Nursing Evaluation assessment dated [DATE], indicated that the resident had a sacral wound with a measurement of 5.0 centimeters long (cm) by 4.5 cm wide by 0.0 cm deep with slough present. The individualized comprehensive Care Plan with an effective date of 12/17/25, had a Focus area for skin breakdown related to deconditioning (physical decline), weakness, fragile skin, pressure wound, to gluteal/sacral region. The 1/6/26 skilled nursing documentation reflected the resident was readmitted on [DATE] from the hospital after a wound debridement of the left sacral wound. A review of WC #1's notes included the following: On 12/29/25 at 1:19 PM, WC # 1 who provided wound care services at the facility, documented an initial encounter regarding a sacral wound with measurements of: 7cm x 8.5cm x 0.5cm, was a Stage 3 pressure ulcer, had moderate exudate (fluid seepage), 26 - 50 % of slough, fat exposed .After the procedure the wound measured at 7cm x 8.5cm x 1 cm. On 1/8/26 [untimed], WC#2 a WC /surgeon who also provided care to Resident #1, while in the hospital, documented sacral wound measurements of: 12.5cm x 8cm x 2cm, stage 3 full thickness, sharp debridement (medical procedure, removal of dead, damaged, or infected tissue, foreign debris to promote faster healing) a at bedside. The plan was to follow up in one (1) week, daily wet to dry with saline, Santyl (a medication, sterile debriding ointment for chronic skin ulcers and burned areas), to wound bed daily, 4x4 abdominal pads (ABD) and to cleanse wound with hydrogen peroxide. On 1/12/26 at 9:44 AM, WC#1 then documented sacral wound measurements of 7cm x 10cm x 2.4cm for pre and post debridement, used a curette (small handheld surgical instrument with a scoop, ring or hook-shaped design for scraping and removal of dead skin).The plan included: to cleanse wound with Vashe (a cleanser used to irrigate and debride wounds), pack the wound with Vashe soaked self-clinging gauze, apply collagen sheets and change the dressing daily or as needed. On 1/13/26 [untimed], WC #2's documented, on a Consultation form, New Findings and Recommended Treatment: measurements 13.5 [cm] x 8.5[cm] x 2[cm]; and wound was debrided. the wound was debrided; Cleanse wound with Vashe, apply Santyl to slough, pack with Dakin's (sodium hypochlorite; modified bleach used as an antiseptic to clean and treat infected wounds or ulcers; dosing available in full strength equivalent to 0.5%, half strength equivalent to 0.25% and quarter strengths equivalent to 0.125%) soaked gauze [twice daily] and cover with foam dressing. The Attending Physician and Consulting Physician name was left blank. A handwritten initial noted [Registered Nurse initials] dated 1/21/26 was reflected on the side of the document. There was no (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	signature on the document from the either the attending or consultant Physician. There was no specific dose documented for the Dakins solution on the form by WC #2, or upon being noted by staff. The resident was administered the 0.5% Dakin's solution on 1/21/26, without clarification by WC #2 for the Recommendation. A review of all Physician Orders from 1/10/26 through 2/23/26 did not reflect a clarification of WC #2's recommendation. A review of a type-written wound note dated 1/22/26, for a Visit on 1/22/26 at 9:30 AM, was signed by the Advanced Practice Nurse (APN) that worked under WC# 2. The note revealed Current Medications and Dosages included H-Chlor 12 [generic Dakin's solution] .125% solution (1/4 strength of the 0.5% solution that was administered beginning on 1/21/26). A review of a type-written wound note dated 1/27/26, for a Visit on 1/27/26 at 1:45 PM, was signed by the APN that worked under WC# 2. The note revealed Current Medications and Dosages included H-Chlor12 [Generic Dakin's solution] .125% solution (1/4 strength of the 0.5% solution that was administered beginning on 1/21/26).A review of a type-written wound note dated 2/4/26, for a Visit on 2/4/26 at 3:50 PM, was signed by the APN that worked under WC# 2. The note revealed Current Medications and Dosages included H-Chlor 12 [generic Dakin's solution] .125% solution (1/4 strength of the 0.5% solution that was administered beginning on 1/21/26). A review of a type-written wound note dated 2/11/26, for a Visit on 2/11/26 at 7:00 AM, was signed by the APN that worked under WC# 2. The note revealed Current Medications and Dosages included H-Chlor 12 [generic Dakin's solution] .125% solution (1/4 strength of the 0.5% solution that was administered beginning on 1/21/26).A review of a type-written wound note dated 2/17/26, for a Visit on 2/17/26 at 10:0 AM, was signed by the APN that worked under WC# 2. The note revealed Current Medications and Dosages included H-Chlor 12 [generic Dakin's solution] .125% solution (1/4 strength of the 0.5% solution that was administered beginning on 1/21/26). On 2/19/26 at 9:07 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN #1) stated that both WC's provided wound treatment to Resident #1 once per week and also measured the resident's wound. and would provide new wound treatment orders as needed? On 2/19/26 at 9:11 AM, the surveyor and LPN #2 reviewed the active February 2026 Treatment Administration Record (TAR) together and observed the order for Dakin's solution was implemented on 1/21/26 for 0.5%. The surveyor requested the corresponding physician order for the Dakin's solution at that time. LPN #2 was unable to provide the surveyor with the physician order, or any documentation to show that a physician was contacted to clarify the strength of the Dakin's solution that was recommended by WC #2 on 1/13/26. At that time, the surveyor observed the wound treatment cart with LPN #1. A Dakin's 0.5% solution bottle that was labeled with Resident #1's name and dated 1/22/26. There were no other strengths of Dakin's solution for Resident #1 observed and LPN #1 confirmed that the 0.5% solution was what was used for Resident #1.At that time, LPN #1 and LPN #2 (the off-going shift 11:00 PM to 7:00 AM) both confirmed that neither of them had entered the Dakin's 0.5% order. Both LPNs then confirmed and acknowledged that the strength should have been clarified with WC #2 who documented the recommendation for the Dakin's and was also providing the wound treatments for Resident #1. LPN #2 then stated she would inform the Director of Nursing (DON) of the identified concerns.On 2/19/26 at 10:04 AM, after surveyor inquiry, LPN #2 then provided the surveyor with two documents: an additional Electronically Signed by the DON note dated 2/19/25 at 9:26 AM [15 minutes after both LPNs confirmed they were unable to locate an order for the strength of the Dakin's] the note reflected an Order Date for Dakins strength of 0.5 % was dated 2/19/26. [38 days after the initial recommendation was made on 1/13/26] A second document Amendment for Resident #1 revealed on 2/19/26 at 9:50 AM, the WC #2 provided Verbal taken today for the following clarification: Dakins strength-1/2 [percent], and dressing may be changed.On 2/19/26 at 10:39 AM, two surveyors observed Resident #1 in bed turned to their right-hand side. Resident #1 stated they received wound treatments daily, and during wound treatments experienced that when the liquid was placed the liquid it burns and stated they informed staff.On 2/19/26 at 11:32 AM, during an interview with the survey team, the primary Medical Doctor (MD) for Resident #1 stated that she deferred to the WCs recommendations.On 2/19/26 at 11:51 AM, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	the surveyor and the DON reviewed Resident #1's electronic medical record (eMR) together. At that time, the DON stated that the strength for Dakins 0.5% was ordered on 1/13/26 and was not clarified until surveyor inquiry she clarified it on the morning of 2/19/26. The DON stated we don't know that the strength was clarified prior to 2/19/26. The DON stated when she was made aware that she clarified the strength with the APN for WC #2 on 2/19/26 and they ordered 0.5% Dakin's.At that time, the DON also stated that the Dakins 0.5% solution was not implemented until 1/21/26 and acknowledged the order should have been clarified and implemented the same day the recommendations/order from the WC #2 was obtained. The DON stated that prior to 1/21/26 Resident #1's wound was cleansed with hydrogen peroxide from 1/8/26 to 1/13/26. When asked why WC 2's recommendation was not clarified and implemented on the day it was written, 1/13/26, the DON stated she would have to speak with the Registered Nurse/ Supervisor (RN/S) who received the order as she did not know what occurred. The DON did not respond as to why the WC#2's consultation notes included a current medication for Dakin's (hypochlorite) 0.125% solution and not 0.5%. On 2/19/26 at 12:59 PM, during a telephone interview with the surveyor, WC #2/surgeon stated he did not speak with his APN in that day. The WC #2/surgeon also stated that typically in his practice Dakin's 0.125% was used as a debriding agent, and wound cleanser. When asked about potential side effects for using a higher concentration, the WC #2/surgeon stated burning could be a side effect if the 0.5% was utilized. The WC #2/surgeon had not been made aware that Resident #1 had an order for Dakin's 0.5%. When asked about the consultation form dated 1/13/26 that did not have the % of the Dakin's solution indicated. The WC #2/surveyor stated he should have been contacted to clarify his recommendation. On 2/19/26 at 1:16 PM, during an interview with the surveyor, the Consultant Pharmacist stated that if an order did not have a strength or dose, the order should be clarified by nursing or that pharmacy whomever received the order from the prescriber.On 2/19/26 at 1:54 PM, during an interview with the survey team, the Registered Nurse (RN) regarding the consultation process for a resident. The RN stated, the Consultation form would be documented with the physician and/or consultant physician's name. When a resident returned from a consultation visit from a provider, the facility's MD was informed of the order, we don't take orders from the consultant and we look to see if there were new recommendations the MD would either agree or disagree with the recommendations. The RN stated that this process would be completed within one hour or no more than two. The RN stated that Consultation forms were vague and would say continue or change. The RN stated the order would be clarified from the attending physician first. At that time the RN stated that the facility's physician ordered Dakin's 0.5% and confirmed she failed to document the conversation that she stated occurred with the physician regarding the order clarification. The RN also stated that after a note would be written that the orders would be sent to the pharmacy. When asked if there would be any reason why this process would not be followed, she stated no. The RN was unresponsive when asked why the recommendations documented on the Consultation note dated 1/13/26 were not implemented until 1/21/26 [8 days later].On 2/24/26 at 2:54 PM, during a meeting with the survey team, the Regional Director of Operations, [NAME] President of Health Services, Regional Nurse, the Licensed Nursing Home Administrator, and the DON, the surveyor discussed the concern with delayed clarification, order and the resident's complaints of pain during wound care. At that time, the DON confirmed the order was not clarified and not implemented at the time the treatment recommendation was received on 1/13/26. The DON also confirmed and acknowledged that the RN's documentation of the Dakin's order was vague.On 02/25/26 at 2:31 PM, the survey team met with DON, RCN, LNHA and RDO and the facility had no additional information to provide. According to the provided facility policy titled, General Guidelines Wound and Skin Care, dated 6/23/25 included that the suggested protocols may be instituted by a physician order . According to the provided facility policy titled; Wound and Skin Care, At Risk Residents included ongoing documentation by licensed nurses in the medical record to describe the effectiveness of interventions and the resident's response to therapy. NJAC 8:39-27.1(e)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observations, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to have a system in place to ensure a) weights were consistently and accurately monitored and verified a weight loss and implemented interventions in response to a significant weight loss, and b) staff implemented identified nutritional interventions appropriately and consistently. The deficient practice was identified for 2 of 2 residents reviewed for nutrition, who sustained significant unplanned weight loss (Resident #1 lost 9.53% in 10 days (from 12/17/25 to 12/27/25) and Resident #5 who had a 14 % weight loss x 6 months). The deficient practice was evidenced by the following: Refer to F804, F805 a) On 2/18/26 at 12:16 PM, the surveyor observed Resident #1 in the dining room seated in a recliner with legs elevated and was being assisted with the meal by a facility staff. The meal appeared pureed, and the cold tea nectar thickened On 2/19/26 at 8:57 AM, the surveyor observed Resident #1 was asleep in bed and the surveyor then reviewed the medical record for Resident #1 which revealed the following: The admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; Parkinson's Disease (a movement disorder of the nervous system that worsens over time), pressure ulcer of the sacral region (bottom of the spine) and dysphagia (swallowing disorder) The comprehensive Minimum Data Set (MDS), an assessment tool dated 12/21/25, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 14 out of 15, which indicated Resident #1 was cognitively intact. Section K0100-Swallowing Disorder indicated the resident held food in food in mouth/cheeks or residual food in mouth after meals. On admission required mechanically altered food and while a resident received parenteral/intravenous feeding. The Nursing admission Evaluation, dated 12/17/25, reflected the resident required assistance with eating, liked all foods and required a pureed consistency diet. The individualized Care Plan, effective from 12/17/25 included a Focus of altered nutrition due to weight loss, decreased intake, and increased need for assistance with meals. The resident received a modified texture and thickened liquid diet and was at risk for dehydration. The Goals included [intake by mouth] greater than or equal to 75%, no significant weight loss, no signs and symptoms of dehydration. The interventions required the staff to monitor Resident #1's intake, labs and weights. Resident #1's Vital Sign Report, under Weights revealed the following: On 12/17/25, the residents documented weight was 128.0 pounds (#). On 12/27/25, the residents documented weight was 115.8 #'s. The Notes and Alert column next to the weight, indicated # an alert for 5% in 30 days, and 7.5% value change in 90 days This indicated an approximate 9.53% significant weight loss in 10 days]. On 1/6/25, a weight was documented by the Director of Nursing which indicated the resident weighed 115.0 # and an Alert Note: for 5% and 7.5% value change in 30 days was present [This indicated an approximate 10.16% significant weight loss in one (1) month]. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the 12/16/25 Nutritional Assessment reflected Resident #1 received a regular, pureed [consistency] diet, nectar thickened liquids, and received nutritional supplements. On admission the resident received with mechanically altered diet, did well with meals in the past and required set-up help. The resident's meal intake varied and was not underweight at that time. The Registered Dietitian (RD) documented that the resident was observed not eating well and required assistance with meals. The RD recommended the following nutritional interventions in response to the observation: Staff to encourage fluid intake, one (1) health milk shake once a day, a frozen nutritional cup to be given with lunch and dinner and 30 milliliters of protein supplement [brand redacted] twice a day in between meals and for staff to monitor weights and food intake. At that time, the resident had no documented weight loss. A review of the 12/17/25, Mini Nutritional Assessment (MNA), documented by the RD reflected the resident had a moderate decrease in food intake, had no weight loss, was able to get out of bed, had no psychological stress, no neuro-psychological problems and had a body mass index of less than 21 which indicated an optimal range (healthy weight), but was at risk for malnutrition A review of the medical record did not reveal that the significant weight loss that occurred on 12/27/25, was verified with a reweight, and addressed by the interdisciplinary team. There was no documented evidence that the physician or RD had been notified of the weight loss. A review of the following Nutritional Progress Note dated 1/9/26, reflected the resident was and was out of the facility beginning 12/30/25 for a procedure. On 2/24/26 at 1:36 PM, the surveyor interviewed the RD stated that Resident #1 experienced an unplanned significant weight loss on 12/27/25, during their 10-day period stay. The RD also stated that the resident had not been reweighed and she could confirm the accuracy of the admission weight recorded. as their was no reweight obtained. At that time, the RD stated that she was included as part of the Interdisciplinary Team. The RD stated that any staff should have alerted her of the significant weight loss when it was recorded and stated usually the nurses informed me when there was a weight discrepancy. The RD also stated that she was available via telephone and if she had been informed of the unplanned significant weight loss she would have made additional dietary recommendations depending on results of the nutritional assessments for the unplanned significant weight loss. On 2/24/26 at 2:54 PM, during a meeting with the survey team, the Regional Director of Operations, [NAME] President of Health Services, Regional Nurse, the Licensed Nursing Home Administrator, and the Director of Nursing (DON), the surveyor discussed the above concerns At that time, the surveyor inquired as what the process was regarding weights upon admission. The DON stated that there was one weight obtained upon admission, and then weekly weights for 4 weeks. b. On 2/19/26 at 8:48 AM, the surveyor interviewed the RD about Resident #5's weight loss. The RD stated the resident had become more confused, enjoyed sweets and in response to weight loss, the RD had implemented different types of supplements with, and between meals. On 02/19/26 at 12:38 PM, the surveyor observed Resident #5's breakfast meal tray was still in room and appeared only small amount of food was consumed and observed a broken muffin was observed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the plate. On 02/19/26 at 12:41 PM, Resident #5 was observed in the main dining room with a meal plate that included ground meat and puree carrots. Resident #5 did not initiate self-feeding and there were no staff in attendance encouraging the resident. The surveyor attempted to interview the resident and the resident appeared confused. The observation continued and on 01/19/26 at 12:49 PM (8 minutes after the surveyor observed the resident sitting in front of the uneaten meal), a staff member appropriated the resident and tied a napkin around the resident, and then brought over two 4-ounce supplements, poured the supplements in a cup, and provided to the resident. The staff did not remain with the resident or encourage to eat the meal or provide an alternate option. On 2/19/26 at 2:30 PM, the surveyor reviewed the electronic medical record for Resident #5 which revealed the following: The Face Sheet (an admission summary) revealed the resident had diagnoses which included, but were not limited to Alzheimer's disease, Dysphagia, oropharyngeal phase (difficulty initiating a swallow, causing food to stick in the throat), Myasthenia Gravis (a chronic autoimmune disorder causing fluctuating weakness in voluntary muscles). The Annual Minimum Data (an assessment tool) dated 1/25/26, revealed the staff assessment for Mental Status was completed and the resident had moderately impaired cognitively skills for decision making (poor decisions; cues/supervision required). The behavior exhibited was wandering coded 4 to 6 days. Section GG for functional Abilities revealed the resident was coded as 01 which indicated the resident was Dependent for Eating (Helper does ALL the effort. Residents does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). Section K. Swallowing/Nutritional Status revealed the resident was 95 pounds and was coded as had a weight loss of 5% or more in the last month or loss of 10 % or more in the last 6 month and was not on a physician prescribed weight loss regimen. The resident was coded as being on a Mechanically altered diet (require change in texture of food or liquids (e.g., pureed food, thickened liquids) Resident #5's individualized Care Plan, Effective 2/27/24 revealed the revealed the following: Problem: I have a self-care deficit and require assist with my ADLs (Activities of Daily Living) .Goals: I want to participate in my care as long as I am able with the assist from staff . Interventions included staff will anticipate my needs; Problem: I have altered Nutrition r/t weight loss, poor intake, modified consistency diet/ dysphagia (swallowing difficulty) diagnosis, risk of dehydration. Goals: Intake greater than or equal to 75 %, maintain skin integrity, no signs or symptoms of dehydration. Interventions: Staff will monitor weights; laboratory values as ordered; Provide me my prescribed diet, Provide me my nutritional supplements as ordered; Please provide me with increased encouragement or assistance at meals, please try to feed me if I am receptive; I like chocolate; Recommend weekly weights x 4 weeks (2/19/26); Recommend fortified cereal at breakfast. A review of the documented weights and RD Nutritional Progress Notes revealed: 8/4/25- 106.3 pounds (#); 10/1/25 - 110 #; 11/3/25 -104.9; 11/4/25- 100 #, 11/10/25 -100.9 #; 12/2/25- 101.2 #, 1/5/26- 97.2 #, 2/2/26 -94.1 # (15.9 #s -14% weight loss over 6 months). A Nutritional Progress Note documented by the RD, dated 11/12/25 revealed resident with 8.2% weight loss in one month, pushes away from food, refusing to eat, staff makes attempts to feed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident, refuses /resists, on mechanical soft diet, receives frozen nutritional cup with lunch and /dinner (290 calories and 9 grams of protein each), recommended chocolate health shake (200 calories and 6 grams of protein each), and offered if refuses meal, continues on house 2 calorie supplement given by nursing in between meals (approximately 240 -260 calories and 9-11 grams of protein, continue to monitor weekly weights, staff to encourage fluids and continue to assist at meals, monitor weights and intake. A Nutritional Progress note completed by the RD and dated 1/27/26, revealed that refuses to eat most foods at mealtime and continues on multiple supplements, most recent weight shows 12.6 % weight loss over six months. A Nutritional Progress note completed by the RD and dated 2/20/26, revealed rarely takes any food at meals, decline noticed by staff- most recent weight 94.5 #, shows 5.7 % significant loss over 30 days .drinks supplements and recommend increasing to three times per day between meals . resident needs assistance/encouragement at meals . On 02/20/26 at 8:29 AM, the surveyor observed Resident #5 was in bed with the meal tray in front of them and a Certified Nurse Aide (CNA #1) entered the room, assisted the room mate with the meal, then opened and moved the meal tray in front of Resident #5, and the surveyor observed a plate of cut up sausage circles, with 3 pieces of French toast, syrup was opened but not poured on the French toast, milk was unopened, watery, in appearance hot cereal was also on the tray, with a beige colored beverage next to the tray in a small cup and the silverware was wrapped in a blue napkin and not accessible to the resident. CNA #1 stated she was not assigned to Resident #5 and did not further assist or encourage the resident. The Meal Ticket had 4 ounces orange juice, 6 ounces cream of wheat and super cereal handwritten on the ticket, 8 ounces of 2 % milk, 2 ounces of GR Canadian Bacon (not on tray), and 4 ounces chilled crushed pineapple (not on tray). On 2/20/26 at 8:44 AM (15 minutes after the surveyor first observed the resident in the room without the meal tray being set up), a Certified Nurse Aide (CNA #2) entered the room, and stated to Resident #5, you're not hungry?, and stood next to Resident #5 and began setting up the meal tray by cutting the French toast and put the utensil in the resident's hand. The surveyor then interviewed the CNA about the meal ticket and asked what did the GR. Canadian Bacon mean and the CNA stated she was not sure but the resident had sausage not Canadian bacon. The surveyor asked if the resident required assistance with meals and CNA #2 stated it didn't look like [they] touched it and [they] need encouragement. When asked what the usual waiting time should be for a resident to be assisted with the meal, CNA #2 stated, I don't know. When asked were you trained on that, she stated, no, we don't have trainings on that. On 2/20/26 at 9:33, the surveyor interviewed the Executive Chef (EC), Director of Dining Services (DDS) and the [NAME] regarding the watery in appearance cereal on Resident #5's meal tray and asked the [NAME] if he used a recipe for the super cereal. The [NAME] stated he would add butter and milk and did not use a recipe for the super cereal, and at that time the EC was looking for a recipe. The surveyor asked the EC what the purpose of the super cereal was and he stated, for someone to gain weight. On 02/20/26 at 10:28 AM, the surveyor interviewed the RD regarding the purpose super cereal. The RD stated it was of recent addition as an intervention due to the continued weight loss and poor intake. When asked if it was important to follow a recipe, the RD sated, yes, it was important, to ensure that the appropriate calories and protein were provided and the surveyor asked for the recipe. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/20/26 at 10:47 AM, the RD provided a copy of the HiCal Cream Wheat (Fortified) recipe which revealed the recipe required Nonfat Dry Milk, Dark [NAME] Sugar, Whole Milk, Granulated Sugar, Butter in addition to the cream of wheat and water and if the recipe is followed a 3/ 4 cup serving would equal 360 calories and 7 grams of protein. On 2/20/20 at 12:03 PM, the surveyor conducted a telephone interview with the Speech Therapist (ST) in the presence of the RD. The ST confirmed the resident was on a Mechanical Soft consistency diet and had a cognitive decline. The ST stated Resident #5 needed cueing at meals. When asked if leaving a resident for 15 minutes by themselves without setting them up would that be considered queueing? The surveyor then shared the observations from the meal with the ST, and the ST stated, no, they should assist [Resident #5] and set them up. On 2/20/26 at 12:10 PM, the surveyor reviewed the nursing assignment sheet for Resident #5 which indicated Resident #5 required feeding assistance. On 02/24/26 at 2:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations (RDO), [NAME] President of Health Services (VPHS), and Regional Corporate Nurse (RCN) to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with DON, RCN, LNHA and RDO and the facility had no additional information to provide. A review of the Assistance with Meals policy Revised 1/15/26 revealed Policy: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Procedure: Resident's Room: Nursing staff will feed those residents within 15 minutes of the delivery of food trays. A review of the provided facility policy, titled Resident Weights and Weight Changes revealed; Policy: Regular monitoring of weights is necessary in order to screen resident for significant weight changes, which may may indicate a resident is at nutritional risk. Residents' weights will be obtained at least monthly and recorded in the electronic medical record. Significant weight changes will be reviewed by the dietitian and physician if indicated. Procedure: a weight must be obtained within 48 hours if a weight change meets the following criteria: Interval: 1 month 5% weight change. The DON did not indicate why a reweight was not obtained after the significant weight loss was identified for Resident #1 on 12/27/25. NJAC 8:39-27.1(a),27.2(a)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observations, interviews and record review the facility failed to assure the nursing staff had the competency and skills sets to provide nursing care to two sampled residents to provide appropriate wound care and ensure nursing staff were competent in a process to verify physician recommendations and clarify orders for wound care. The deficient practice was evidenced for 2 of 3 residents reviewed for wound care (Resident #1 and Resident #3) and was evidenced by the following: a. On 1/13/26 [untimed], WC #2's documented, on a Consultation form, New Findings and Recommended Treatment: measurements 13.5 [cm] x 8.5[cm] x 2[cm]; and wound was debrided. the wound was debrided; Cleanse wound with Vashe, apply Santyl to slough, pack with Dakin's (sodium hypochlorite; modified bleach used as an antiseptic to clean and treat infected wounds or ulcers; dosing available in full strength equivalent to 0.5%, half strength equivalent to 0.25% and quarter strengths equivalent to 0.125%) soaked gauze [twice daily] and cover with foam dressing. The Attending Physician and Consulting Physician name was left blank. A handwritten initial noted [Registered Nurse initials] dated 1/21/26 was reflected on the side of the document. There was no signature on the document from the either the attending or consultant Physician. There was no specific dose documented for the Dakins solution on the form by WC #2, or upon being noted by staff. The resident was administered the 0.5% Dakin's solution on 1/21/26, without clarification by WC #2 for the Recommendation. A review of all Physician Orders from 1/10/26 through 2/23/26 did not reflect a clarification of WC #2's recommendation. On 2/19/26 at 9:11 AM, the surveyor and LPN #2 reviewed the active February 2026 Treatment Administration Record (TAR) together and observed the order for Dakin's solution was implemented on 1/21/26 for 0.5%. The surveyor requested the corresponding physician order for the Dakin's solution at that time. LPN #2 was unable to provide the surveyor with the physician order, or any documentation to show that a physician was contacted to clarify the strength of the Dakin's solution that was recommended by WC #2 on 1/13/26. At that time, the surveyor observed the wound treatment cart with LPN #1. A Dakin's 0.5% solution bottle that was labeled with Resident #1's name and dated 1/22/26. There were no other strengths of Dakin's solution for Resident #1 observed and LPN #1 confirmed that the 0.5% solution was what was used for Resident #1. At that time, the DON also stated that the Dakins 0.5% solution was not implemented until 1/21/26 and acknowledged the order should have been clarified and implemented the same day the recommendations/order from the WC #2 was obtained. The DON stated that prior to 1/21/26 Resident #1's wound was cleansed with hydrogen peroxide from 1/8/26 to 1/13/26. When asked why WC 2's recommendation was not clarified and implemented on the day it was written, 1/13/26, the DON stated she would have to speak with the Registered Nurse/ Supervisor (RN/S) who received the order as she did not know what occurred. The DON did not respond as to why the WC#2's consultation notes included a current medication for Dakin's (hypochlorite) 0.125% solution and not 0.5%. On 2/19/26 at 11:51 AM, the surveyor reviewed Resident #1's electronic medical record (eMR) with the DON. At that time, the DON confirmed that the strength for Dakins 0.5% ordered on 1/13/26, was not clarified until that morning 2/19/26 by her, we don't know the strength was clarified prior to that day. The DON stated she clarified the strength with the Wound Care Nurse after the surveyor's inquiries. On 2/19/26 at 12:59 PM, during a telephone interview with the surveyor, WC #2/surgeon stated he did not speak with his APN in that day. The WC #2/surgeon also stated that typically in his practice Dakin's 0.125% was used as a debriding agent, and wound cleanser. When asked about potential side effects for using a higher concentration, the WC #2/surgeon stated burning could be a side effect if the 0.5% was utilized. The WC #2/surgeon had not been made aware that Resident #1 had an order for Dakin's 0.5%. When asked about the consultation form dated 1/13/26 that did not have the % of the Dakin's solution indicated. The WC #2/surveyor stated he should have been contacted to clarify his recommendation. b. On 2/20/2026 at 11:47 AM, a surveyor observed a Licensed Practical Nurse (LPN (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#2) perform wound care to Resident #3's wound and observed the following:The LPN washed her hands under running water for six seconds. (CDC recommendations 20 seconds away from the stream of water).Prior to performing the wound care, the LPN failed to cleanse the bedside table and use a barrier for the supplies needed for the wound treatment. The LPN used her lap to set up the field. On 2/20/26 at 1:07 PM, the DON provided the education book utilized by the Infection Preventionist. The surveyor asked if the Dietary department was included in any training, or competencies and she stated they were not. When asked to list all the competencies completed for the staff, the DON stated, Wound Competencies were completed by a Registered Nurse. Upon review, the competencies did not include all staff, or were related to order clarification. NJAC 27.1(a)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, record review and document review it was determined that the facility failed to ensure a system was in place to ensure that a resident who required a mechanically altered diet, received appropriate meal items. The deficient practice was identified for 1 of 3 Residents reviewed for nutrition (Resident #5) and who required a mechanical soft diet and had the potential to affect all residents who required a mechanical soft diet. The deficient practice was evidenced by the following: On 2/19/26 at 8:48 AM, the surveyor interviewed the Registered Dietitian (RD) about Resident #5's weight loss. The RD stated that the resident has had weight loss, has become increasingly confused, and she has added interventions in response to the weight loss. On 2/19/26 at 2:30 PM, the surveyor reviewed the electronic medical record for Resident #5 which revealed the following: The Face Sheet (an admission summary) revealed the resident had diagnoses which included, but were not limited to Alzheimer's disease, Dysphagia, oropharyngeal phase (difficulty initiating a swallow, causing food to stick in the throat), Myasthenia Gravis (a chronic autoimmune disorder causing fluctuating weakness in voluntary muscles). A Change in Condition Note, dated 8/10/25 at 10:31 AM, revealed resident was observed spitting out food during breakfast .masticating eggs and sausage, but unable to swallow it, able to eat a muffin and pudding. Downgraded to mechanical soft diet . On 02/20/26 at 8:29 AM, the surveyor observed Resident #5 was in bed with the meal tray in front of them a Certified Nurse Aide (CNA #1) entered the room, assisted the room mate with the meal, then moved the meal tray in front of Resident #5, and the surveyor observed a plate of cut up sausage circles, with 3 pieces of French toast, syrup was opened but not poured on the French toast, milk was unopened, watery, in appearance hot cereal was also on the tray, with a beige colored beverage next to the tray in a small cup and the silverware was wrapped in a blue napkin. CNA #1 stated she was not assigned to Resident #5 and did not further assist or encourage the resident. On 02/20/26 at 8:43 AM, the surveyor continued the observation, as the resident did did not self initiate feeding. The meal ticket was documented Texture: Mechanical Soft and GR Canadian Bacon listed (not sausage). On 2/20/26 at 8:44 AM, a Certified Nurse Aide (CNA) entered the room, and began cutting the French toast and put the spoon in the resident's hand. The surveyor then interviewed the CNA about the meal ticket and asked what does GR. Canadian Bacon meant and the CNA stated she was not sure but the resident had sausage not Canadian bacon. On 02/20/26 at 8:53 AM, the surveyor interviewed Resident #5's Licensed Practical Nurse, regarding the diet and what GR. Canadian Bacon was. The LPN stated she doesn't know what that means and asked the surveyor if she could contact dietary to assist. The LPN stated Resident #5's texture was mechanical soft, and it meant that they could not have cookies. Surveyor asked the LPN how she would know if the resident had received the appropriate diet, she stated that dietary checked the tray before they sent it and the CNA's checked the tray before they gave it to the resident. The surveyor requested to speak with Dietary Staff at that time. On 2/20/26 at 9:06 AM, the surveyor handed Resident #5's meal ticket to the Director of Dining Services (DDS) who came to Resident #5's room and observed the cut-up sausage circles on Resident #5's tray. The surveyor asked what the GR meant? The DDS stated he needed to confirm before he answered and the surveyor then asked to see the facility diet manual.On 2/20/26 at 9:13 AM, the DDS provided the surveyor with the diet manual and stated everything was in the manual. The DDS stated he was still unsure of what the GR meant but Resident #5 should have had Canadian bacon instead of sausage and he would discuss with the RD the meaning of GR.On 02/20/26 at 10:28 AM, the surveyor interviewed the RD regarding what GR meant. The RD stated the meat should have been ground and that the diet had be downgraded to mechanical soft by the speech therapist. A review of the Mechanical Soft Diet signed by the Speech Therapist (ST) on 6/2/25 revealed that meat or meat substitutes included ground meat and the sample menu included ground chicken salad as an entree. On 2/20/20 at 12:03 PM, the surveyor (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted a telephone interview with the ST in the presence of the RD. The ST stated that the GR meant ground and that Resident #5 should have had ground meat. The ST stated that the diet was downgraded due to cognitive issues and stated when asked about the sausage circles that were provided I do not think [they] would choke on that.On 02/24/26 at 2:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations (RDO), [NAME] President of Health Services (VPHS), and Regional Corporate Nurse (RCN) to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with the DON, RCN, LNHA and RDO and the facility had no additional information to provide. 8:39-17.4 (a)(1)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain proper infection control practices for a) hand hygiene and establishing a clean field during a wound treatment b) hand hygiene during resident meal service one (1) of two (2) nurses who administered medications to one (1) of four (4) residents during the medication administration observation, to limit the potential of spreading infection. The deficient practice was evidenced by the following: Reference: According to Centers for Disease Control and Prevention, Guideline for Disinfection and Sterilization in Healthcare Facilities, dated 11/28/23, included that: Semicritical items contact mucous membranes or non-intact skin. This category included respiratory therapy. These medical devices should be free from all microorganisms. a. On 2/20/2026 at 11:47 AM, the surveyor observed Licensed Practical Nurse (LPN #2) perform a treatment for Resident #3 in the resident's bathroom. Prior to performing the treatment LPN #2 was observed performing hand hygiene. LPN#2 turned on the faucet, wet her hands, applied soap and lathered for six seconds. LPN #2 then placed her hands under the running water and then removed her hands from the running water and lathered for 10 more seconds and rinsed hands. LPN #2 turned off facet with wet hands. LPN #2 then dried her hands with paper towel and applied gloves. LPN #2 observed Resident #3's sacrum and then assisted Resident #3 with toileting. LPN#2 performed hand hygiene. She turned on the faucet, wet her hands, applied soap and lathered for 10 seconds. LPN #2 placed her hands under the running water and then removed her hands from the running water and lathered for 7 more seconds and rinsed hands. LPN #2 turned off facet with wet hands. LPN #2 then dried her hands with paper towel and applied gloves. LPN#2 kneeled her right knee down on the bathroom floor and kept her left knee bent. She opened the packages of gauze and placed the gauze on her left thigh scrub pants. There was no clean barrier observed. LPN#2 applied saline to the gauze and cleansed the left heel, then applied skin prep to the left heel. The LPN #2 did not perform hand hygiene and proceeded to perform the same treatment on the right heel using the same gloves. After completing the treatment, LPN#1 performed hand hygiene. She turned on the faucet, wet her hands, applied soap and lathered for 8 seconds. LPN #1 placed her hands under the running water and then removed her hands from the running water and lathered for 7 more seconds and rinsed hands. LPN #1 turned off facet with wet hands. LPN #1 then dried her hands with paper towel and applied gloves. On 2/20/26 at 11:58 AM, the surveyor discussed the concerns with LPN #1. LPN #1 stated that she should have washed her hands for the length of singing the happy birthday song 2 times or 20 seconds. Stated that she placed her hands under the running water to make them more wet. She acknowledged that she should have rinsed her hands and dried them with a clean paper towel and then turned off the faucet with a clean paper towel. In addition, she acknowledged that the opened gauze should not have been placed on her scrubs. She stated, I should have left them in the packet. She stated, I didn't perform hand hygiene and change my gloves between treatments because I was under the impression it was one treatment. On 02/24/2026 11:14 AM Interview with the Regional Corporate Nurse (RCN) and Director of Nursing (DON), the surveyor discussed the concerns regarding hand hygiene and treatment observation for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN#2. RCN and DON acknowledged that hand washing should be done for 20 seconds, and the faucet should have been shut off using a clean paper towel. The RCN stated, the Nurse should have shut off the faucet using a paper towel if not she would have contaminated her hands. The RCN and DON acknowledged that the Nurse should have performed hand hygiene in between the two treatments and that LPN #2 should not have placed the opened gauze on her left thigh scrub pants and that should not have been used for the clean field because it is contaminated. The surveyor reviewed facility provided policy, Infection Control Policies and Procedures Handwashing/Hand Hygiene, revised 3/12/25 which included: Purpose: The facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: Washing Hands 3. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) away from the stream of water. 5. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. The surveyor reviewed facility provided competency, Dressing a Wound, undated which included: Title- Supplies Description- Assemble supplies on a protective barrier on the bedside table. Rationale- Allows for efficiency and prevents disruption of the procedure. On 2/18/26 at 12:27 PM, the surveyor observed lunch in the second-floor dining room. A Certified Nurse Aide (CNA #1) was observed wearing gloves and with gloved hands assisted a resident to perform hand hygiene with a hand towelette. CNA #1was observed to remove her gloves, put on a clean pair of gloves, without performing hand hygiene and with gloved hands poured soup for another resident. CNA #1 then removed her gloves, did not perform hand hygiene, assisted a third resident with a can of soda with her bare hands, and then put on a clean pair of gloves without performing hand hygiene. With gloved hands, she then assisted a fourth resident to perform hand hygiene using a hand towelette. She then removed her gloves and without performing hand hygiene she assisted a fifth resident with a can of soda with her bare hands. CNA #1 then put on a clean pair of gloves without performing hand hygiene. The surveyor asked CNA #1 if hand hygiene was needed before and/or after gloving and she stated she did not need to perform hand hygiene if she assisted residents with hand towelettes, she then stated, I probably should have performed hand hygiene. On 2/24/2026 at 2:53 PM, the survey team met with the Director of Nursing (DON), along with the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Health Services, the Regional Corporate Nurse, and the Regional Director of Operations and discussed the above concerns. On 02/25/2026 at 10:18 AM, the DON confirmed that hand hygiene was needed between different pairs of gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed facility provided policy, Infection Control Policies and Procedures Handwashing/Hand Hygiene, revised 3/12/25 which included: Purpose: The facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents. and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: f. Before donning (putting on) gloves; m. After removing gloves; p. Before and after assisting a resident with meals Apply and Removing Gloves Perform hand hygiene before applying gloves When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove Perform hand hygiene NJAC 8:39-19.4(a) b. On 2/20/26 at 8:41 AM, the surveyor observed Licensed Practical Nurse (LPN #1) prepare medications (meds) for Resident #25 on the surface of the medication cart. The meds included a physician's order dated 1/20/26, for Trelegy Ellipta 200 microgram (mcg) -62.5 mcg powder for inhalation, 1 application [puff] with inhalation device one time a day for asthma/chronic obstructive pulmonary disease. On 2/20/26 at 8:46 AM, LPN #1 entered the resident's room, followed by the surveyor and observed the administration of the meds to the resident. At 8:50 AM, LPN #1 explained to the resident that they had to rinse and spit the water after using their Trelegy inhaler. At 8:51 AM, the surveyor observed the resident self-administer their inhaler [semicritical item] and placed it on their tray table [a high touch surface; frequently touched area], LPN #1 handed the glass of water to the resident, to rinse and spit. At that time, LPN #1 removed the inhalation device from the tray table, returned to the medication cart, placed the inhaler on the medication cart, unlocked the medication cart, grabbed the carton, was going to place the medication device into the carton, which was stored in the medication (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cart. On 2/20/26 at 8:54 AM, the surveyor discussed the concern that the inhalation device was placed on the resident's tray table, a high touch surface, was placed on the medication cart, where medications were prepared for other residents and was to be returned into the medication cart without any cleaning of the top of the medication cart or medication device. At that time, LPN #1 acknowledged and confirmed that she should have cleaned the device and should not have placed the inhaler on the medication cart. On 2/24/26 at 2:54 PM, during a meeting with the survey team, the Regional Director of Operations, [NAME] President of Health Services, the Regional Nurse, the Licensed Nursing Home Administrator, and the DON, the surveyor discussed the concern with the inhalation device, a semicritical item was placed on the tray table, a high touch surface, without a barrier, and disinfection in between, then placed on top of the medication cart where other resident's medications for administration were prepared, and placed into the boxed manufacturer's container which was to be stored in the medication cart with other resident's medications. On 2/25/26 at 10:19 AM, during a meeting with the survey team, the Regional Director of Operations, the Licensed Nursing Home Administrator, and the Director of Nursing, the Regional Nurse stated he had spoken with the Consultant Pharmacist (CP) and was advised that the manufacturer's recommendation does not require storage of the inhaler in a plastic bag and the inhalers cover was sufficient. On 2/25/26 at 2:18 PM, during an interview with the surveyor, the Director of Facilities Management (DFM) stated that a tray table was a high touch area and required cleaning 3 to 4 times a day to prevent spread of disease, germs, bacteria and overall infection control. The DFM stated that med carts were cleaned by the nurses. A review of the provided facility's communication with the CP, dated 2/24/26, included: Medication carts/med prep areas should be clean and free from contaminated equipment . No further information was provided. A review of the provided facility policy for Cleaning and Disinfection of Resident-Care Items and Equipment, dated 3/1/17, included that Resident-Care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendation for disinfection and the OSHA Bloodborne Pathogens Standards. Under, Procedure for semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin. Such devices should be free from all microorganisms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium at Navesink Harbor, The	40 Riverside Avenue Red Bank, NJ 07701

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview, record review, and document review, it was determined that the facility failed to issue the required Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN) and Notice of Medicare Non-Coverage (NOMNC) in the proper time frame for 2 of 3 residents (Resident #12, and Resident #46) reviewed for Beneficiary Protection Notification. This deficient practice was evidenced by the following:On 2/18/26 at 1:36 PM, the surveyor reviewed the facility provided list of residents who were discharged from Medicare covered Part A in the last six months and randomly chose three residents and requested the Beneficiary Notices from the Licensed Nursing Home Administrator (LNHA). On 2/21/26 at 1:55 PM, the surveyor reviewed the Beneficiary Notices provided which revealed the following: Resident #12 had a Medicare Part A episode that began on 8/28/25 and a last covered day of 9/26/25. An email provided by the facility revealed the SNF ABN and the NOMNC were both sent to the Resident #12's responsible party (RP) on 9/25/25 at 4:06 PM. Resident #46 had a Medicare Part A episode that began on 9/25/25 and a last covered day of 10/5/26. The SNF ABN and NOMNC provided by the facility were both signed by Resident #46's RP and dated 10/6/25. On 2/24/2026 at 2:53 PM, the survey team met with the LNHA, along with the Director of Nursing, the [NAME] President of Health Services, the Regional Nurse, and the Regional Director of Operations. The surveyor notified the facility management of the above concerns regarding the Beneficiary Notices. On 2/25/26 at 10:18 AM, the LNHA stated that she had no further information to provide. NJAC 8:39 - 5.1(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview, record review, and review of facility documents, it was determined that the facility failed to identify medication irregularity from 1/13/26 to 2/19/26, during the monthly Medication Record Review (MRR) of the Consultant Pharmacist (CP) for one (1) of three (3) residents (Resident #1) reviewed for pressure ulcers. The deficient practice was evidenced by the following: On 2/18/26 at 12:16 PM, the surveyor observed Resident #1 in the dining room seated in a recliner with legs elevated and was fed by a facility staff.On 2/19/26 at 8:57 AM, the surveyor observed Resident #1 asleep on their back, unaroused by the surveyor's voice, head of the bed was elevated, and legs were covered with a blanket. The surveyor reviewed the medical record for Resident #1. A review of the admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; Parkinson's Disease (a movement disorder of the nervous system that worsens over time), pressure ulcer of the sacral region (bottom of the spine). A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 12/21/25, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 14 out of 15, which indicated Resident #1 was cognitively intact. A review of Section M, Skin Conditions, reflected that the resident had one (1) unhealed pressure ulcer that was unstageable due to coverage of wound bed by slough (dead tissue) /or eschar (scab) upon admission to the facility and used a pressure relieving device on the chair, and bed. A review of the 1/13/26 [time note included] Wound Consultant note included wound care treatment: wash the wound with Vashe, apply Santyl to slough, pack with Dakin's (sodium hypochlorite; modified bleach used as an antiseptic to clean and treat infected wounds or ulcers; dosing available in full strength equivalent to 0.5%, half strength equivalent to 0.25% and quarter strengths equivalent to 0.125%) soaked gauze twice a day with foam dressing. A small handwritten initial dated 1/21/26, was reflected on the side. A review of the 1/13/26 order entry made by the Registered Nurse included to pack wound with Dakin's-soaked gauze. The strength was not documented on the new wound order. On 2/19/26 at 9:11 AM, the surveyor and LPN #2 reviewed the active February 2026 Treatment Administration Record (TAR) together and observed the order for Dakin's solution was started on 1/21/26 for 0.5%. At that time, LPN #2 could not show that the physician was contacted to clarify the strength of Dakin's solution, a recommendation made by WC #2 on 1/13/26. A review of the CP's MRR from 1/1/26 to 1/25/26 included that Resident #1's chart was reviewed sometime during the specified period and did not require any recommendations. On 2/19/26 at 1:16 PM, during an interview with the surveyors, the CP stated that he reviewed the Treatment Administration Record (TAR) every 6 to 12 months. On 2/24/26 at 2:54 PM, during a meeting with the survey team, the Regional Director of Operations, [NAME] President of Health Services, the Regional Nurse, the Licensed Nursing Home Administrator, and the Director of Nursing, the surveyor discussed the concern that missing strength for the Dakin's solution was not identified during the CP's MRR. At that time, the [NAME] President of Health Services stated that the expectation was that all medication be reviewed monthly. A review of the provided facility policy, titled Medication Regimen Review (MRR), dated 3/5/35 included that MRR or Drug Regiment review is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. NJAC 8:39- 29.1(b), 29.3 (a)(1)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview, record review, and document review, it was determined that the facility failed to have a current written agreement between the Medicare-certified hospice and the facility for 1 of 1 resident (Resident #28) reviewed for hospice/end of life care. The deficient practice was evidenced by the following:On 2/20/2026 at 9:23 AM, the surveyor observed and interviewed Resident #28 who was in their room. On 2/24/26 at 10:20 AM, the surveyor reviewed the resident's hard chart (paper chart) which revealed the following: The Face Sheet revealed the resident had diagnoses including but not limited to; arteriosclerotic heart disease (thickening and hardening of the arteries of the heart). The physician's orders included an order dated 10/27/25 for [name redacted #1] Hospice (H #1). A review of Resident #28's electronic medical record (EMR) revealed the following: The quarterly Minimum Data Set (MDS), an assessment tool, dated 2/25/26 included a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. A review of the individual comprehensive care plan (ICCP) included a focus area that the resident was receiving hospice services with H #1 for overall decline and per my wishes for diagnosis of heart disease. A review of the hospice communication book, kept behind the nursing station, revealed Resident #28 was admitted to H #1 in August 2025 for a diagnosis of arteriosclerotic heart disease.On 2/24/26 at 2:06 PM, the surveyor reviewed the facility provided hospice contract, with an effective date of July 8, 2020, between the facility and [name redacted #2] Hospice (H #2). The surveyor then asked the Licensed Nursing Home Administrator (LNHA) for the contract with H #1 as identified in Resident #28's medical record and she stated the hospice changed names.On 2/24/2026 at 2:53 PM, the survey team met with the LNHA, along with the Director of Nursing, the [NAME] President of Health Services, the Regional Nurse, and the Regional Director of Operations. The surveyor notified the facility management of the above concerns regarding the hospice contract. On 2/25/26 at 10:18 AM, the LNHA provided the surveyor with a social service note dated 10/7/25 which indicated the social worker met with Resident #28's responsible party (RP), who had given permission to make a hospice referral to H #1. On 2/25/26 at 2:00 PM, the facility administration had no further information to provide. NJAC 8:39-27.1(a)