STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315520	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Woods Rehabilitation & Nursing Center	780 Old New Brunswick Road Somerset, NJ 08873

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Complaint #: NJ 168006 Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) implement their abuse policy and ensure residents were protected from sexual abuse after a cognitively intact resident (Resident #155) made an allegation of rape on 9/30/23, and was sent to the hospital for evaluation. This deficient practice was identified for 1 of 2 residents reviewed for abuse (Resident #155). A review of a Nursing Note dated 9/30/23, revealed that Resident #155 was in bed with their Resident Representative (RR #1) at bedside, when the resident reported to the Registered Nurse (RN #1) that they were raped. The note further indicated that the resident, without RR #1 or RN #1's knowledge, had called the local police to report the rape. RN #1 documented that they spoke to the physician who ordered the resident to be transferred to the hospital for evaluation. Interviews on 1/24/25, with the Director of Nursing (DON) and on 1/28/25, with RN #1 confirmed the allegation of rape was made. The DON acknowledged that all allegations of abuse were to be immediately investigated and reported to the New Jersey Department of Health (NJDOH), and the DON confirmed Resident #155's allegation of sexual abuse was not investigated or reported to the NJDOH. The facility's failure to implement their abuse policy including investigating and reporting all allegations of abuse including sexual abuse placed all residents at risk for abuse which posed the likelihood of serious physical and emotional harm, or impairment resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 9/30/23, after Resident #155 made an allegation of rape to RN #1. The facility was notified of the IJ on 1/28/25 at 5:59 PM. The facility submitted an acceptable Removal Plan (RP) on 1/29/25 at 2:56 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 1/29/25. The facility further failed to ensure b.) an allegation of neglect and intimidation was investigated and reported in a timely manner when a cognitively intact resident made an allegation of not receiving a respiratory treatment as it was requested and was spoken to by staff in an intimidating manner. This deficient practice was identified for 1 of 2 residents reviewed for abuse (Resident #73). The evidence was as follows: (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Part A A review of the facility's Abuse, Neglect, Misappropriation Prevention Policy and Procedure dated reviewed 6/2024, included: Policy: Every resident as the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary isolation .Purpose: To ensure timely and thorough investigation of abuse, neglect and/or mistreatment of residents .Sexual abuse: Includes but is not limited to humiliation, harassment, sexual coercion, unwanted sexual touching, or sexual assault Investigation & Protection: Procedure: 1. When an incident or suspected incident of abuse is reported, the Administrator will appoint a facility representative to initiate an investigation and follow through to completion. 2. The investigation will proceed as follows: a. Interview/obtain statement of person(s) reporting incident, b. Interview/obtain statement from involved resident, c. Interview/obtain statement of any witnesses to incident, d. As necessary interview/obtain statements from staff members having contact with the resident during the previous shift prior to the shift of the alleged incident, e. If relevant, interview/obtain statements from resident's roommate, family, and visitors, f. Review the medical record .5. The Administrator or investigative designee will provide the resident or responsible party with timely progress reports in addition to all corrective actions taken. 6. All investigative information will be documented on the Resident Abuse Investigation form 7. In the event of allegation of abuse or neglect of any kind, the Administrator or designee will report the findings immediately to the Office of Ombudsman and the New Jersey Department of Health and Senior Services. Additional notification to the [name redacted] Police Department as circumstances warrant, 8. Inquiries concerning abuse reporting and investigation should be referred to the Administrator of designee .Abuse, Neglect, Exploitation Incident Investigation Checklist .Checklist to be initiated by Administrator, Assistant Administrator, Director of Nursing or Director of Social Services .Obtain Incident report. Be thorough. Obtain verbal or written statement form Resident, if possible. A verbal statement may be transcribed and signed by the resident .Obtain written statements from all staff involved in Resident's care .Place information in investigative file that is available for survey process. The Director of Nursing/designee is designated as the individual who conducts the investigation. 3. The DON/Designee: a. Reviews the accident/incident report. b. Obtains written statements of staff assigned to the Resident for: i. the shift during the allegation is noted; ii. A minimum of 16 hours prior to the incident if indicated or appropriate, c. interviews witnesses, if any, d. Reviews the Resident's record. E. Reviews staff assignments and staff performance .h. Reports finding to the Administrator. The surveyor reviewed the electronic medical record (EMR) for Resident #155. A review of the Admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; acute posthemorrhagic anemia (low blood count), heart failure (a condition in which the hear does not pump blood as well as it should), hypertension (high blood pressure), and depression (a mental illness that can cause severe symptoms that affect a person's mood, thoughts, and daily activities.) A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 9/16/23, revealed the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating the resident was cognitively intact. Further review of the MDS, revealed the resident required extensive assistance with activities of daily living and mobility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the Progress Notes included a Nursing Note written by the RN #1 dated 9/30/23 at 9:58 PM, which revealed that the resident was received in their room with RR #1 by their bedside. The resident was alert, awake, and oriented to person and place, but not time. The resident reported, I was raped by some people; some people spoke to me but in real sense they did not, I want to talk to the [doctor], when is the doctor coming? RR #1 at the bedside reported that the resident's mental status was never like that before the resident was taken to the hospital and brought to the facility for rehabilitation. The resident, without RR #1's and RN #1's knowledge, used their landline phone and called the police who then showed up at the facility and conversed with the resident. RN #1 assured RR #1 that the change would be communicated to the resident's physician. The physician was notified who then recommended that the resident be sent to [hospital name redacted] for evaluation. The resident was picked up at around 7:15 PM. A review of the individual comprehensive care plan (ICCP) included a focus of area for the use antidepressant medication related to depression, dated 9/10/23. The goals included; will show decreased episodes of the behaviors of depression through the review date, revised on 9/21/23. Interventions included to monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal, dated initiated 9/10/23. On 1/24/25 at 9:28 AM, the surveyor requested any accidents, incidents, grievances, or reportable events for Resident #155. On 1/24/25 at 10:04 AM, the DON informed the surveyor that she did not have any reports for Resident #155. On 1/24/25 at 2:44 PM, the surveyor interviewed the DON in the presence of the survey team, regarding an allegation of rape. At that time, the DON stated the Licensed Nursing Home Administrator (LNHA) had already left for the day. The DON stated if this is [name redacted-Resident #155], I had spoken with the Social Worker (HSW) from the hospital who stated they (the hospital) would work [Resident #155] up (tests and assessments conducted to collect evidence of sexual assault). The DON stated she spoke with the facility's nursing staff who stated RR #1 was in the room that whole day with the resident. The DON stated the police were called to the facility by the resident, and she notified the LNHA the police were here. At that time, the DON stated she was not sure it (the allegation of rape) was a reportable event (to the NJDOH) as the resident did not return to the facility. The DON stated the allegation happened on a Saturday, and on Monday when she came in, the resident was not back. I spoke to the HSW who said Resident #155 was not sexually assaulted. The DON stated the HSW gave no timeframe or no specifics to the allegation, at that time. The DON stated the resident said the rape occurred while they were still here (in the facility.) The DON stated the resident was sent to the hospital due to saying they were raped and had a change in their mental status. On 1/28/25 at 12:34 PM, the surveyor conducted a telephone interview with RN #1, who documented the resident's allegation of rape on 9/30/23. RN #1 did not remember the incident at first, but when the surveyor read RN #1's note from 9/30/23, RN #1 stated, Now I remember, that evening I was the RN working. RN #1 further explained that the resident stated they were raped by some people, only RR #1 was in room with the resident. RN #1 stated the police just showed up and said the resident called and said they were raped. RN #1 confirmed the supervisor was aware and was on the floor. RN#1 was unsure if the DON was notified, and she was unsure if she should have been. RN #1 remembered talking to the police, but was not sure if Resident #155 remained in the facility or went to the hospital. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/28/25 at 1:16 PM, the surveyor conducted a telephone interview with the RN Nursing Supervisor (RNS #1), who verified they were the supervisor on 9/30/23. RNS #1 stated he thought he vaguely remembered that case, but he could not recall the nurse on the unit. RNS #1 stated that the nurse called me that the resident was confused; RR #1 was always at the bedside; and I don't think that anyone would do that while [RR #1] was there. RNS #1 stated he and RN #1 called the physician, who ordered to send the resident to the emergency room . He further stated that we (the facility) called the police because of the allegation of rape. RNS #1 stated the resident told the police they were being raped or something like that. RNS #1 stated the DON was notified. The surveyor asked RNS #1 what should be done if a resident made an allegation of rape, he stated, let the doctor know, call the police, let the family know and notify the DON. On 1/28/25 at 2:19 PM, the surveyor interviewed the Infection Prevention Nurse (IPN), who stated if a resident told you a concern, you told the Unit Manager and informed the DON or LNHA and an investigation would occur. The IPN stated a grievance should be made available to the resident. The IPN stated it (the concern) would follow the chain of events, and then I would give a statement, and all parties involved would also need to give one, including the resident. The IPN added that he would go straight to the DON or LNHA, if the concern was mistreatment, he stated that was a serious situation because I believe they would have to report it to the state and start an official investigation. On 1/28/25 at 2:39 PM, the survey team interviewed the Activities Director (AD), who stated examples of abuse were physical, sexual, financial, emotional, restraining, withholding things and should be reported to the DON. On 1/28/25 at 5:55 PM, the survey team met with the DON and LNHA. The LNHA stated the types of abuse were physical, sexual, and verbal. The LNHA stated that an allegation of sexual abuse was a reason to suspect something happened, and he should be notified as soon as possible. The LNHA stated it would be reported, then investigated. The LNHA stated that typically an allegation of rape was reported to the NJDOH unless the staff was 100% certain it did not happen. The LNHA further stated that if a resident was cognitively impaired, it was sometimes their behavior so determination to report was made on a case-by-case basis. The LNHA stated that the DON had a soft file for Resident #155's allegation. The survey team informed him the soft file was not provided to the survey team on 1/24/25, when the accidents, incidents, grievances, or reportable events were requested for Resident #155. The survey team also stated that a soft file was not mentioned during the interview with the DON on 1/24/25. On 1/30/25 at 9:07 AM, the surveyor interviewed the Assistant Administrator (AA), who stated any type of abuse: verbal, physical, or sexual should be discussed with the LNHA and the DON. The AA stated an investigation included: checking on the resident; interviewing the resident and staff; reaching out to the family; doing a body assessment; and calling the police if warranted. The AA stated that the facility reported any allegation of abuse to the NJDOH as soon as we found out an incident occurred. The AA stated, if a resident made a statement of rape, they should be assessed; the LNHA should be called; and an investigation started. The AA stated she could not recall Resident #155's allegation of sexual abuse. On 1/30/25 at 9:37 AM, the surveyor interviewed the Medical Director (MD), who stated if staff called him regarding an allegation of abuse with a resident, he would have the resident sent to the hospital for evaluation and tell the staff to follow the facility's protocol for investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/30/25 at 9:58 AM, the surveyor interviewed the LNHA and asked who was ultimately responsible for the building, and he stated, I am as the administrator. I am expected to be notified everyday of anything going on in the building. My staff are instructed to make me aware of everything. I understand it to be my responsibility. The LNHA stated typically we would be notified right away but if he was unavailable, the AA should field that call. The LNHA stated if staff left him a voicemail, it went to his email. The LNHA stated ultimately the DON knew what to do when he was not at the facility, and she knew what should be reported. The LNHA stated, Monday morning anything that happened over the weekend, I expect my staff to tell me and make me aware. The LNHA stated he instructed his staff to keep soft files in case there was ever a question about an event, and he could not explain the purpose of keeping a soft file. On 1/30/25 at 10:15 AM, the surveyor interviewed the DON regarding Resident #155's allegation of rape. The DON stated, I knew right away who (which resident) they (the survey team) were asking about. The DON stated she received a phone call from RNS #1, who stated that the police came to the building and he notified the physician. The DON stated she could not recall if she reported the event to the LNHA. The DON stated she kept a soft file on the event in case there was a question, and she added it was not part of the medical record. The surveyor asked was that not the purpose of an investigation, and the DON stated yes. The DON could not explain why she did not offer the soft file to the survey team during the interview on 1/24/25. The DON stated she normally discussed any significant events that happened over the weekend at the Monday morning meeting, which included all the department heads: the DON, the Assistant Director of Nursing (ADON), the LNHA, and the AA. When asked if an allegation of rape or if the police came to the building was a significant event, the DON stated yes. The DON stated, I cannot remember if I discussed it (the allegation of abuse and the police coming to the building) in morning meeting. An acceptable removal plan was received on 1/29/25 at 2:56 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: investigation immediately started with conclusion completed; NJDOH and the Ombudsman's office were notified of the allegation; employee files of staff scheduled during the incident were reviewed to ensure appropriate background checks; the Quality Assurance committee reviewed the facility's abuse policy with no revisions; the LNHA inserviced the DON on the facility's abuse policy, reporting allegations to the LNHA and appropriate authorities; the DON or designee inserviced all staff in the building on the facility's abuse policy and all staff would be inserviced before their next shift; the DON interviewed cognitively intact residents for any concerns on abuse; and the DON interviewed designated staff to determine if any residents had made allegations of abuse. The survey team verified the implementation of the removal plan during the continuation of the on-site survey on 1/29/25. 40042 Part B (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/23/25 at 10:31 AM, the surveyor observed Resident #73 dressed and groomed seated in a wheelchair in the doorway of their room. The resident stated they used continuous oxygen, which was observed by the surveyor. At that time, the resident had not expressed any concerns related to abuse. The surveyor observed an oxygen concentrator (a medical device that delivers oxygen to those with breathing related disorders) in the room set at 2 liters per minute (lpm), and an oxygen tank secured to the back of the resident's wheelchair. On 1/24/25 at 10:30 AM, the surveyor conducted a Resident Council Meeting where Resident #73 was in attendance. At that time, Resident #73 stated that one night they had difficulty breathing around 4:00 AM, and requested a nebulizer (a device used to administer medication in a form of a mist inhaled into the lungs) treatment to the Certified Nurse Aide (CNA #1). The resident stated they waited two hours until the nurse came in. At that time, the nurse stated she did not know anything about the resident's above mentioned request. The resident stated the nurse left the room, and it took another 45 minutes to receive the treatment. The resident further stated that they reported this to the Activities Director (AD); however, they (the AD) did not acknowledge the issue, and no one came back to follow up. A review of the Resident Council Minutes which was conducted on 1/14/25 at 2:00 PM, reflected that Resident #73 and the AD were in attendance. The minutes included that Resident #73 stated they were in respiratory distress at approximately 3:00 AM and told CNA #1. The resident further stated that they did not receive a nebulizer treatment until 7:15 AM. The resident also stated they spoke with the Licensed Practical Nurse/Unit Manager (LPN/UM #1) about the issue and the staff member (CNA#1). The resident further stated that CNA #1 stood in front of the resident in an intimidating manner because the resident told on her. On 1/24/25 at 2:02 PM, the surveyor requested any accidents, incidents, grievances, or investigations for Resident #73, and the DON stated she did not have anything for that resident. The surveyor reviewed the EMR for Resident #73. A review of the Admission Record face sheet revealed the resident had diagnoses which included but were not limited to; asthma, acute and chronic respiratory failure (a condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in the body tissues), alcohol abuse and depression (a mental illness that can cause severe symptoms that affect a person's mood, thoughts, and daily activities). A review of the comprehensive MDS, dated [DATE], reflected the resident had a BIMS score of 15 out of 15, which indicated an intact cognition. It also reflected the above diagnoses and was coded for oxygen therapy. A review of the ICCP reflected a focus dated 11/29/23, that the resident had noncompliance with respiratory therapy. In addition, there was a care plan dated 10/30/23, with a focus that the resident had oxygen therapy due to respiratory illness. The goal was that the resident would not have poor oxygen absorption and interventions included but were not limited to; oxygen settings at 2 lpm, administer medications as ordered by the physician and monitor/document side effects and effectiveness. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the Order Summary Report reflected a physician's order (PO) dated 3/20/24, for oxygen set at 2 lpm; a PO dated 4/3/24, to check oxygen level every shift for shortness of breath (SOB); and a PO dated 1/5/24, for a nebulizer treatment every six hours as needed for SOB. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for December 2024 and January 2025, revealed the resident's oxygen levels were 90% or above from 12/1/24 through 12/31/24, for all three shifts and 95% or above from 1/1/25 through 1/29/25, for all three shifts. A further review revealed the resident had not used a nebulizer treatment for either month. A review of the Progress Notes from 12/2/24 through 1/30/25, revealed no documented evidence that the resident had SOB, was in respiratory distress, or received a nebulizer treatment. In addition, there was no documented evidence of the resident's alleged incident prior to surveyor inquiry. On 1/24/25 at 2:04 PM, the surveyor interviewed the DON, who stated that she was unaware of the resident's alleged incident on 1/14/25, until now. The DON stated Resident #73 had not approached her with this concern, which she was surprised since she felt they had a good rapport and saw the resident often. The DON stated that now that she was aware, she would initiate an immediate investigation. She acknowledged that she had no formal way to follow up Resident Council Minutes content. On 1/24/25 at 2:48 PM, the surveyor interviewed the AD, who stated if there were nursing concerns brought up during Resident Council, he sent the DON an email and waited for a response. The AD stated that he could not remember concerns that were brought up at the last Resident Council Meeting, and at that time, he reviewed the minutes from the meeting on 1/14/25. The AD stated that if a resident expressed a concern at council, he spoke to them on the side and encouraged the resident to speak to the department head and could not recall if he did that with Resident #73. The AD stated the resident was very cognitively intact and could express themselves, but he still sent an email to the DON. He acknowledged he did not send the email to the LNHA as well. The AD stated he was taught to communicate via email and could not speak to why he did not report the resident's concern/allegation verbally as well. The AD stated he did not recall a response from the DON and stated he knew she was very busy. The AD stated if he had not received a response, he would reapproach the email recipient and acknowledged he did not do that and that 10 days was too long to wait. The AD stated, I should have followed up. The AD provided a copy of the email he sent to the survey team. On 1/24/25 at 3:56 PM, the surveyor interviewed the DON, who acknowledged that the AD sent an email but used the previous director's email account. The DON acknowledged the subject indicated 1/14 Resident Council, and stated, I just didn't get a chance to see that. The DON also stated LPN/UM #1 denied awareness of the incident, and the DON was able to identify the CNA and LPN that were allegedly involved and relayed that information to the survey team. The DON could not speak to why Resident #73 had not reported this to her and that the resident stated the incident occurred a few weeks before that Resident Council Meeting on the overnight shift. The DON stated that the resident had no history of making accusatory or inaccurate statements. The DON stated the AD should have brought this to her attention immediately, and further stated that the AD attended morning meeting daily as well. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/28/25 at 2:00 PM, the surveyor conducted a follow up interview with the resident in their room. The resident stated that they spoke to the AD the morning of the Resident Council Meeting on 1/14/25, about their concerns. The resident stated the AD stated to hold off and to mention the incident without details during the Resident Council Meeting so he can include it in an official report. The resident further described the incident to the surveyor. The resident stated that morning, while trying to sleep they felt they needed a nebulizer treatment. The resident stated they rang the call bell around 4:00 AM, and CNA #1 responded, Don't be like your friend [name redacted], which the resident stated was a resident who complained often. The resident acknowledged that they had not used the call bell again after. The resident stated at 6:30 AM, LPN #2 came to the room to administer medications. At that time, the resident asked if CNA #1 told her about the request for a nebulizer treatment. LPN #2 stated no and the resident stated that LPN #2 administered a nebulizer treatment at 7:15 AM. During that same interview, the resident stated they felt fine and that there was no negative outcome. The resident then stated that at approximately 9:30 AM, they went outside to the smoking area to speak with LPN/UM #1 (who they knew smoked after morning meeting) about the incident. The resident further stated the IPN was also present. The resident also stated later that morning, CNA #1 approached the resident in an intimidating manner, and stated the resident never told her about needing a nebulizer treatment and that the resident reported her and got her in trouble. The resident stated that later that morning they reported the incident to the AD, who told the resident to hold off and bring it up at the Resident Council Meeting so he could put it in an official report. The resident stated they did speak of the incident at the 2:00 PM Resident Council Meeting that day. The resident stated that they were disappointed this was not addressed in a timely manner since they went through the chain of command. The resident stated that on Friday (1/24/25) as soon as the DON was aware of the incident, she took care of it right away. The resident further stated that if the DON had known sooner, she would have acted rapidly. The resident stated that at no time did they feel unsafe or threatened to live on the 3rd floor. On 1/28/25 at 2:19 PM, the surveyor interviewed the IPN, who stated if he was made aware a resident reported they did not receive a requested treatment or care, he went straight to the unit manager and then reported it to the DON and LNHA. The IPN stated an investigation should have been done. The IPN stated that if he became aware that a resident reported that they were spoken to inappropriately by staff, he would go straight to the DON and LNHA, that's a serious situation, and it's a dignity issue. The IPN further stated it would have to be reported to the state and an official investigation should then be started. He did not recall being in the presence of the resident and LPN/UM #1 outside in the smoking area during a conversation regarding the resident's allegation. The IPN also stated that the resident had not reported anything to him. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/28/25 at 2:39 PM, the surveyor interviewed the AD, who stated he could not recall if the resident reported the allegation to him prior to the Resident Council Meeting. The AD stated, I think I would have remembered that. The AD stated that he did not think the resident was an accurate historian and was an emotional person who used extreme words. The AD stated he reported what the resident stated via an email sent rapidly. He did acknowledge and stated, I should have acted sooner. The AD stated, I don't want to diminish what [gender redacted] says but I know [gender redacted] does exaggerate. He further stated, I should have followed up sooner. He also stated I don't remember if the email or concern was discussed in morning meeting or if he checked with the DON to ensure she received the email and had followed up. He stated he assumed the DON read the email and followed up. The AD stated he received abuse education and named emotional abuse. The AD stated if a resident reported any type of abuse to him, he would have reported this to the DON. The AD stated, like I said, I should have possibly followed through a little more maybe I dropped the ball a little. On 1/28/25 at 3:32 PM, the surveyor interviewed LPN/UM #1, who stated that if a resident stated they rang the call bell for help and did not receive it, that she would interview the staff identified and report this to the DON and LNHA. LPN/UM #1 stated that if staff denied the allegation, she reassured the resident and still reported it to the LNHA. LPN/UM #1 stated, she reported all incidents to the DON, and the DON asked her for a statement related to an allegation by Resident #73. LPN/UM #1 stated she had no recollection of such incident, and had not been outside in the smoking area at the same time as the resident since the summer. LPN/UM #1 had no recollection of Resident #73 alleging any complaints about staff. UM/LPN #1 stated that had she been aware, she would have reported it to the DON. The LPN/UM #1 further stated the resident requested nebulizer treatments very infrequently. On 1/28/25 at 3:50 PM, the surveyor interviewed CNA #1, who stated that if a resident rang the call bell and needed treatment from a nurse, she reported this to the nurse immediately, especially if the resident was having trouble breathing. CNA #1 stated she had not experienced any incidents with a resident on the 3rd floor since she has worked there full time since 2020. CNA #1 stated that she answered call bells even if they were not on her assignment, and if a nurse did not do their job, she would have reported it to the unit manager, especially if it had to do with difficulty breathing. CNA #1 stated that Resident #73 was not on her assignment, but recalled that she answered her call bell one night or early morning. CNA #1 stated the resident stated they could not sleep, and that the resident was watching a scary movie at a loud volume. CNA #1 stated that it was sometime after 3:00 AM, and she encouraged the resident to turn off the television, that it may help them sleep. The CNA stated that the resident did not ring the call bell again, I guess [they] slept. CNA #1 stated she could not recall the exact date and stated it was sometime last year. On 1/29/25 at 10:33 AM, the surveyor conducted a phone interview with LPN #2, who stated that she was the resident's regular nurse and could not recall any incident with the resident. LPN #2 stated she could not recall the last time she provided the resident with a nebulizer treatment; that it was infrequent. LPN #2 stated that if she had, it would have been accounted for in the MAR/TAR. LPN #2 further stated the resident received continuous oxygen on 2 lpm and the resident's oxygen level was typically 95% or above. On 1/30/25 at 12:22 PM, the surveyor interviewed the Director of Social Work (DSW), who stated the LNHA was the abuse officer. The DSW further stated that if she was aware of any type of abuse allegation, she would have addressed it in morning meeting and that the DON and LNHA would follow up immediately. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/30/25 at 3:49 PM, the surveyor interviewed the DON and LNHA, in the presence of the survey team. The LNHA stated he would have expected the AD to go directly (physically) to the DON with Resident #73's allegation brought up at Resident Council and that email communication was not the typical procedure. The LNHA stated that he addressed this with the AD. The LNHA stated the AD did not feel it was abuse. The DON stated that in the past, the AD report[TRUNCATED]

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Complaint #: NJ 168006 Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to report within two hours to the New Jersey Department of Health (NJDOH) a.) an allegation of sexual abuse for a cognitively intact resident (Resident #155) who reported being raped. This deficient practice was identified for 1 of 2 residents reviewed for abuse. A review of a Nursing Note dated 9/30/23, revealed that Resident #155 was in bed with their Resident Representative (RR #1) at bedside, when the resident reported to the Registered Nurse (RN #1) that they were raped. The note further indicated that the resident, without RR #1 or RN #1's knowledge, had called the local police to report the rape. RN #1 documented that they spoke to the physician who ordered the resident to be transferred to the hospital for evaluation. Interviews on 1/24/25, with the Director of Nursing (DON) and on 1/28/25, with RN #1 confirmed the allegation of rape was made. The DON acknowledged that all allegations of abuse were to be reported immediately to the NJDOH, and the DON confirmed Resident #155's allegation of sexual abuse was not reported to the NJDOH. The facility's failure to implement their abuse policy including investigating and reporting all allegations of abuse including sexual abuse placed all residents at risk for abuse which posed the likelihood of serious physical and emotional harm, or impairment resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 9/30/23, after Resident #155 made an allegation of rape to RN #1. The facility was notified of the IJ on 1/28/25 at 5:59 PM. The facility submitted an acceptable Removal Plan (RP) on 1/29/25 at 2:56 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 1/29/25. The facility further failed to ensure b.) an allegation of neglect and intimidation was reported to the NJDOH in a timely manner when a cognitively intact resident made an allegation of not receiving a respiratory treatment as it was requested and was spoken to by staff in an intimidating manner. This deficient practice was identified for 1 of 2 residents (Resident #73) reviewed for abuse. The evidence was as follows: Refer F 600 Part A (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility's Abuse, Neglect, Misappropriation Prevention Policy and Procedure dated reviewed 6/2024, included: Policy: Every resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary isolation .Sexual abuse: Includes but is not limited to humiliation, harassment, sexual coercion, unwanted sexual touching, or sexual assault .Investigation & Protection: Procedure: 1. When an incident or suspected incident of abuse is reported, the Administrator will appoint a facility representative to initiate an investigation and follow through to completion .7. In the event of allegation of abuse or neglect of any kind, the Administrator or designee will report the findings immediately to the Office of Ombudsman and the New Jersey Department of Health and Senior Services. Additional notification to the [name redacted] Police Department as circumstances warrant .Reporting, 1. The Director of Nursing/Administrator/designee will report the incident to the Department of Health and Ombudsman program according to regulatory requirements if there is reason to suspect abuse, neglect or mistreatment .7. All appropriate regulatory agencies will be notified of any allegations of abuse or neglect according to required timeframe's. The surveyor reviewed the electronic medical record (EMR) for Resident #155. A review of the Admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; acute posthemorrhagic anemia (low blood count), heart failure (a condition in which the hear does not pump blood as well as it should), hypertension (high blood pressure), and depression (a mental illness that can cause severe symptoms that affect a person's mood, thoughts, and daily activities.) A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 9/16/23, revealed the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating the resident was cognitively intact. Further review of the MDS, revealed the resident required extensive assistance with activities of daily living (ADLs) and mobility. A review of the Progress Notes included a Nursing Note written by the RN #1 dated 9/30/23 at 9:58 PM, which revealed that the resident was received in their room with RR #1 by their bedside. The resident was alert, awake, and oriented to person and place, but not time. The resident reported, I was raped by some people; some people spoke to me but in real sense they did not, I want to talk to the [doctor], when is the doctor coming? RR #1 at the bedside reported that the resident's mental status was never like that before the resident was taken to the hospital and brought to the facility for rehabilitation. The resident, without RR #1's and RN #1's knowledge, used their landline phone and called the police who then showed up at the facility and conversed with the resident. RN #1 assured RR #1 that the change would be communicated to the resident's physician. The physician was notified who then recommended that the resident be sent to [hospital name redacted] for evaluation. The resident was picked up at around 7:15 PM. On 1/24/25 at 9:28 AM, the surveyor requested any accidents, incidents, grievances, or reportable events for Resident #155. On 1/24/25 at 10:04 AM, the DON informed the surveyor that she did not have any reports for Resident #155. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/24/25 at 2:44 PM, the survey team interviewed the DON, who stated that she and the Licensed Nursing Home Administrator (LNHA) were responsible for reportable events (reporting to the NJDOH) and that they should be reported as soon as possible. In Resident #155's case, the DON stated that she had spoken with the staff, and they informed her that RR #1 had been in the room with Resident #155 that whole day. The police were called to the facility by the resident, and the DON notified the LNHA that the police were at the facility. The DON further stated that at that time she was not sure it (the allegation of rape) was reportable event as the resident did not return to the facility. The DON stated the allegation was made on a Saturday, and when she came in on Monday, the hospital's Social Worker (HSW) called her. The DON reported that the HSW stated the hospital would work [Resident #155] up. (Tests and assessments conducted to collect evidence of sexual assault) The surveyor was unable to interview the LNHA as the DON stated he had left the facility already. On 1/28/25 at 12:34 PM, the surveyor conducted a telephone interview with RN #1, who documented the resident's allegation of rape on 9/30/23. RN #1 did not remember the incident at first, but when the surveyor read RN #1's note from 9/30/23, RN #1 stated, Now I remember, that evening I was the RN working. RN #1 further explained that the resident stated they were raped by some people, only RR #1 was in room with the resident. RN #1 stated the police just showed up and said the resident called and said they were raped. RN #1 confirmed the supervisor was aware and was on the floor. RN#1 was unsure if the DON was notified, and she was unsure if she should have been. On 1/28/25 at 1:16 PM, the surveyor conducted a telephone interview with the RN Nursing Supervisor (RNS #1), who verified they were the supervisor on 9/30/23. RNS #1 stated he thought he vaguely remembered that case, but he could not recall the nurse on the unit. RNS #1 stated that the nurse called me that the resident was confused; RR #1 was always at the bedside; and I don't think that anyone would do that while [RR #1] was there. RNS #1 stated he and RN #1 called the physician, who ordered to send the resident to the emergency room . He further stated that we (the facility) called the police because of the allegation of rape. RNS #1 stated the resident told the police they were being raped or something like that. RNS #1 stated the DON was notified. The surveyor asked RNS #1 what should be done if a resident made an allegation of rape, he stated, let the doctor know, call the police, let the family know and notify the DON. On 1/28/25 at 5:55 PM, the survey team met with the DON and LNHA. The LNHA stated the types of abuse were physical, sexual, and verbal. The LNHA stated that an allegation of sexual abuse was a reason to suspect something happened, and he should be notified as soon as possible. The LNHA stated it would be reported, then investigated. The LNHA stated that typically an allegation of rape was reported to the NJDOH unless the staff was 100% certain it did not happen. The LNHA further stated that if a resident was cognitively impaired, it was sometimes their behavior so determination to report was made on a case-by-case basis. The LNHA stated that the DON had a soft file for Resident #155's allegation. The survey team informed him the soft file was not provided to the survey team on 1/24/25, when the accidents/incidents, grievances, or reportable events were requested for Resident #155. The survey team also stated that a soft file was not mentioned during the interview with the DON on 1/24/25. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/30/25 at 9:07 AM, the surveyor interviewed the Assistant Administrator (AA), who stated any type of abuse: verbal, physical, or sexual should be discussed with the LNHA and the DON. The AA stated that the facility reported any allegation of abuse to the NJDOH as soon as we found out an incident occurred. The AA stated, if a resident made a statement of rape, they should be assessed; the LNHA should be called; and an investigation started. The AA stated she could not recall Resident #155's allegation of sexual abuse. On 1/30/25 at 9:58 AM, the surveyor interviewed the LNHA, who stated ultimately the DON knew what should be reported to the NJDOH when there was an allegation of abuse. On 1/30/25 at 10:15 AM, the surveyor interviewed the DON, who stated that she normally discussed any significant events that happened over the weekend at the Monday morning meeting, which included all the Department Heads: the DON, the Assistant Director of Nursing (ADON), the LNHA, and the AA. When asked if an allegation of rape or if the police came to the building was a significant event, she stated yes. The DON stated, I cannot remember if I discussed it (the allegation of abuse and the police coming to the building) in morning meeting. An acceptable removal plan was received on 1/29/25 at 2:56 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: the allegation was reported to the NJDOH on 1/28/25, and the Ombudsman on 1/29/25; an investigation and conclusion was completed immediately for Resident #155 on 1/28/25; as of 1/28/25, the LNHA ensures that within two hours, all allegations will be reported to the appropriate authorities (NJDOH, Ombudsman, and local police department); the DON was re-educated by the LNHA regarding the requirement to report any allegation of abuse or neglect immediately to the LNHA, NJDOH. Ombudsman, and local police department; the DON or designee has inserviced all staff currently available in the building regarding reporting allegations of abuse and completion of incident report and investigations within two hours; and any staff member who has not received the inservice in person or over the phone on 1/29/25, will not be allowed to work their next scheduled shift until receiving re-education regarding reporting of abuse allegations. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 1/29/25. 40042 Part B On 1/23/25 at 10:31 AM, the surveyor observed Resident #73 dressed and groomed seated in a wheelchair in the doorway of their room. The resident stated they used continuous oxygen, which was observed by the surveyor. At this time, the resident had not expressed any concerns related to abuse. The surveyor observed an oxygen concentrator (a medical device that delivers oxygen to those with breathing related disorders) in the room set at 2 liters per minute (lpm), and an oxygen tank secured to the back of the resident's wheelchair. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/24/25 at 10:30 AM, the surveyor conducted a Resident Council Meeting where Resident #73 was in attendance. At that time, Resident #73 stated that one night they had difficulty breathing around 4:00 AM, and requested a nebulizer (a device used to administer medication in a form of a mist inhaled into the lungs) treatment to Certified Nurse Aide (CNA #1). The resident stated they waited two hours until the nurse came in. At that time, the nurse stated she did not know anything about the resident's above mentioned request. The resident stated the nurse left the room, and it took another 45 minutes to receive the treatment. The resident further stated that they reported this to the Activities Director (AD); however, they (the AD) did not acknowledge the issue, and no one came back to follow up. A review of the Resident Council Minutes which was conducted on 1/14/25 at 2:00 PM, reflected that Resident #73 and the AD were in attendance. The minutes included that Resident #73 stated they were in respiratory distress at approximately 3:00 AM and told CNA #1. The resident further stated that they did not receive a nebulizer treatment until 7:15 AM. The resident also stated they spoke with the Licensed Practical Nurse/Unit Manager (LPN/UM #1) about the issue and the staff member (CNA#1). The resident further stated that CNA #1 stood in front of the resident in an intimidating manner because the resident told on her. On 1/24/25 at 2:02 PM, the surveyor requested any accidents/incidents/grievances or investigations for Resident #73, and the DON stated she did not have anything for that resident. On 1/28/25 at 11:10 AM, the DON provided the survey team with a copy of an email which verified she reported the allegation of abuse for Resident #73 to the NJDOH on 1/24/25 at 4:41 PM. The surveyor reviewed the EMR for Resident #73. A review of the Admission Record face sheet revealed the resident had diagnoses which included but were not limited to; asthma, acute and chronic respiratory failure (a condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in the body tissues), alcohol abuse and depression. A review of the annual MDS dated [DATE], reflected the resident had a BIMS score of 15 out of 15 which indicated an intact cognition. It also reflected the above diagnoses and was coded for oxygen therapy. On 1/24/25 at 2:04 PM, the surveyor interviewed the DON in the presence of the survey team. The DON stated that she was unaware of the resident's alleged incident on 1/14/25 until now. On 1/24/25 at 2:48 PM, the surveyor interviewed the AD in the presence of the survey team. At that time, he reviewed the minutes from the last resident council meeting dated 1/14/25. He stated he sent an email to the DON regarding Resident #73's allegation during the resident council meeting. He acknowledged he did not send the email to the LNHA as well. He stated he could not speak to why he did not report the resident's concern/allegation verbally. He did not recall a response from the DON and stated he knew she was very busy. The AD stated, I should have followed up and that 10 days was too long to wait. He provided a copy of the email he sent to the survey team. On 1/24/25 at 3:56 PM, the surveyor interviewed the DON in the presence of the survey team. The DON stated the AD should have brought this to her attention immediately. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/28/25 at 3:32 PM, the surveyor interviewed LPN/UM #1, in the presence of a second surveyor. LPN/UM #1 stated, she reported all incidents to the DON. She stated that Resident #73 did not report any allegations of neglect or intimidation to her. She stated had she been aware, she would have reported it to the DON. On 1/28/25 at 3:50 PM, the surveyor interviewed CNA #1, in the presence of a second surveyor. She stated that if a resident rang the call bell and needed treatment from a nurse, she would report this to the nurse immediately, especially if the resident was having trouble breathing. CNA #1 stated that if a nurse did not do their job, she would have reported it to the unit manager, especially if it had to do with difficulty breathing. On 1/30/25 at 3:49 PM, the surveyor interviewed the DON and LNHA, in the presence of the survey team. The LNHA stated he would have expected the AD to go directly (physically) to the DON with Resident #73's allegation brought up at resident council and that email communication was not the typical procedure. He stated that he addressed this with the AD. The LNHA stated the AD did not feel it was abuse. The DON stated that in the past, the AD reported concerns to her verbally. In addition, she stated she was the only department the AD emailed, and not the LNHA as well. The LNHA stated that he was shocked. On 1/31/25 at 10:31 AM, the surveyor interviewed the LNHA, in the presence of the survey team. He acknowledged he was the abuse officer and was responsible to ensure allegations of abuse were reported and fully investigated. The LNHA stated he was responsible to oversee this process and that it was done in accordance to their facility abuse policy. A review of the AD's employee file reflected the resident had training on Abuse and Neglect of 1/10/24. He answered 10 of 10 questions correctly, which included If you suspect that a resident has been abused or neglected, it is your duty to report it to your supervisor; he correctly answered True. NJAC 8:39-9.4(f)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858 Complaint #: NJ 168006 Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) implement their abuse policy and investigate an allegation of sexual abuse for a cognitively intact resident (Resident #155) who reported being raped. This deficient practice was identified for 1 of 2 residents reviewed for abuse (Resident #155). A review of a Nursing Note dated 9/30/23, revealed that Resident #155 was in bed with their Resident Representative (RR #1) at bedside, when the resident reported to the Registered Nurse (RN #1) that they were raped. The note further indicated that the resident, without RR #1 or RN #1's knowledge, had called the local police to report the rape. RN #1 documented that they spoke to the physician who ordered the resident to be transferred to the hospital for evaluation. Interviews on 1/24/25, with the Director of Nursing (DON) and on 1/28/25, with RN #1 confirmed the allegation of rape was made. The DON acknowledged that all allegations of abuse were investigated, and the DON confirmed Resident #155's allegation of sexual abuse was not investigated. The facility's failure to implement their abuse policy including investigating all allegations of abuse including sexual abuse placed all residents at risk for abuse which posed the likelihood of serious physical and emotional harm, or impairment resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 9/30/23, after Resident #155 made an allegation of rape to RN #1. The facility was notified of the IJ on 1/28/25 at 5:59 PM. The facility submitted an acceptable Removal Plan (RP) on 1/29/25 at 2:56 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 1/29/25. The facility further failed to ensure b.) an allegation of neglect and intimidation was investigated when a cognitively intact resident made an allegation of not receiving a respiratory treatment as it was requested and was spoken to by staff in an intimidating manner. This deficient practice was identified for 1 of 2 residents (Resident #73) reviewed for abuse. The evidence was as follows: Refer to F 600 Part A (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility's Abuse, Neglect, Misappropriation Prevention Policy and Procedure dated reviewed 6/2024, included: Policy: Every resident as the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary isolation .Purpose: To ensure timely and thorough investigation of abuse, neglect and/or mistreatment of residents .Sexual abuse: Includes but is not limited to humiliation, harassment, sexual coercion, unwanted sexual touching, or sexual assault Investigation & Protection: Procedure: 1. When an incident or suspected incident of abuse is reported, the Administrator will appoint a facility representative to initiate an investigation and follow through to completion. 2. The investigation will proceed as follows: a. Interview/obtain statement of person(s) reporting incident, b. Interview/obtain statement from involved resident, c. Interview/obtain statement of any witnesses to incident, d. As necessary interview/obtain statements from staff members having contact with the resident during the previous shift prior to the shift of the alleged incident, e. If relevant interview/obtain statements from resident's roommate, family, and visitors, f. Review the medical record .5. The Administrator or investigative designee will provide the resident or responsible party with timely progress reports in addition to all corrective actions taken. 6. All investigative information will be documented on the Resident Abuse Investigation form .8. Inquiries concerning abuse reporting and investigation should be referred to the Administrator of designee .Abuse, Neglect, Exploitation Incident Investigation Checklist .Checklist to be initiated by Administrator, Assistant Administrator, Director of Nursing or Director of Social Services .Obtain Incident report. Be thorough. Obtain verbal or written statement form Resident, if possible. A verbal statement may be transcribed and signed by the resident .Obtain written statements from all staff involved in Resident's care .Place information in investigative file that is available for survey process. The Director of Nursing/designee is designated as the individual who conducts the investigation. 3. The DON/Designee: a. Reviews the accident/incident report. b. Obtains written statements of staff assigned to the Resident for: i. the shift during the allegation is noted; ii. A minimum of 16 hours prior to the incident if indicated or appropriate, c. interviews witnesses, if any, d. Reviews the Resident's record. E. Reviews staff assignments and staff performance .h. Reports finding to the Administrator. The surveyor reviewed Resident #155's electronic medical record (EMR). A review of the Admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; depression (a mental illness that can cause severe symptoms that affect a person's mood, thoughts, and daily activities) and heart failure (a condition in which the hear does not pump blood as well as it should). A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 9/16/23, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Further review of the MDS, revealed the resident required extensive assistance with activities of daily living and mobility. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the Progress Notes included a Nursing Note written by the RN #1 dated 9/30/23 at 9:58 PM, which revealed that the resident was received in their room with RR #1 by their bedside. The resident was alert, awake, and oriented to person and place, but not time. The resident reported, I was raped by some people; some people spoke to me but in real sense they did not, I want to talk to the [doctor], when is the doctor coming? RR #1 at the bedside reported that the resident's mental status was never like that before the resident was taken to the hospital and brought to the facility for rehabilitation. The resident, without RR #1's and RN #1's knowledge, used their landline phone and called the police who then showed up at the facility and conversed with the resident. RN #1 assured RR #1 that the change would be communicated to the resident's physician. The physician was notified who then recommended that the resident be sent to [hospital name redacted] for evaluation. The resident was picked up at around 7:15 PM. A review of the individual comprehensive care plan (ICCP) included a focus of area for the use antidepressant medication related to depression, dated 9/10/23. The goals included; will show decreased episodes of the behaviors of depression through the review date, revised on 9/21/23. Interventions included to monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal, dated initiated 9/10/23. On 1/24/25 at 9:28 AM, the surveyor requested any accidents, incidents, grievances, or reportable events for Resident #155. On 1/24/25 at 10:04 AM, the DON informed the surveyor that she did not have any reports for Resident #155. On 1/24/25 at 2:44 PM, the surveyor interviewed the DON in the presence of the survey team, regarding an allegation of rape. At that time, the DON stated the Licensed Nursing Home Administrator (LNHA) had already left for the day. The DON stated if this is [name redacted-Resident #155], I had spoken with the Social Worker (HSW) from the hospital who stated they (the hospital) would work [Resident #155] up (tests and assessments conducted to collect evidence of sexual assault). The DON stated she spoke with the facility's nursing staff who stated RR #1 was in the room that whole day with the resident. The DON stated the police were called to the facility by the resident, and she notified the LNHA the police were here. At that time, the DON stated she was not sure it (the allegation of rape) was a reportable event (to the New Jersey Department of Health (NJDOH)) as the resident did not return to the facility. The DON stated the allegation happened on a Saturday, and on Monday when she came in, the resident was not back. I spoke to the HSW who said Resident #155 was not sexually assaulted. The DON stated the HSW gave no timeframe or no specifics to the allegation, at that time. The DON stated the resident said the rape occurred while they were still here (in the facility.) The DON stated the resident was sent to the hospital due to saying they were raped and had a change in their mental status. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/28/25 at 12:34 PM, the surveyor conducted a telephone interview with RN #1, who did not remember the incident at first. When the surveyor read RN #1's note from 9/30/23, she stated, Now I remember that evening, I was the RN working, I think the [resident] had just come from the hospital, [RR #1] was at the bedside. RN #1 stated that the resident was oriented to maybe only person and place, not time, and the resident stated raped by some people, only their [RR #1] was in room with [resident]. RN #1 stated the police just showed up and said the resident called and said they were raped, and RR #1 was in the room; there were no other people around. RN #1 stated she notified the supervisor who was on the floor, and she was not sure if the DON or the physician were notified. RN #1 remembered talking to the police, but she was not sure if the resident went to the hospital or remained in facility. She stated, the police told her the [resident] told them they were raped. On 1/28/25 at 1:16 PM, the surveyor conducted a telephone interview with the RN Nursing Supervisor (RNS #1), who verified he was the supervisor on 9/30/23. RNS #1 stated he thought he vaguely remembered that case; that he was the supervisor, but he was unsure of the nurse on the unit. RNS #1 stated that the nurse called him that the resident was confused, and RR #1 was always at the bedside and I don't think that anyone would do that while [RR #1] was there. RNS #1 stated that he and RN #1 called the physician, who ordered to send the resident to the emergency room . He further stated that we (the facility) called the police because of the allegation of rape; that the resident told the police they were being raped or something like that. RNS #1 stated that the DON was notified as we notified the DON, whenever we sent a resident out regardless of the reason being sent out. The surveyor asked RNS #1 what should be done if a resident made an allegation of rape, he stated, let the doctor know, call the police, let the family know and notify the DON. On 1/28/25 at 2:19 PM, the surveyor interviewed the Infection Prevention Nurse (IPN), who stated if a resident told you a concern, you tell the Unit Manager and inform the DON or LNHA and an investigation would occur. The IPN stated a grievance should be made available to the resident. The IPN stated it (the concern) would follow the chain of events, and then I would give a statement, and all parties involved would also need to give one, including the resident. The IPN added that he would go straight to the DON or LNHA, if the concern was mistreatment, he stated that was a serious situation because I believe they would have to report it to the state and start an official investigation. On 1/28/25 at 5:55 PM, the survey team met with the LNHA and the DON. The LNHA stated types of abuse were physical, sexual, and verbal. The LNHA stated an allegation of sexual abuse was a reason to suspect something happened, and he should be notified as soon as possible. The LNHA stated, I would typically report before and do an investigation after. The LNHA added the DON had a soft file for the above mentioned event, and he could not speak to why the facility did not follow their policy and use the forms in their policy. No evidence of an investigation was provided to the surveyors regarding the allegation of rape. The soft file was not provided to surveyors when previously asked for any investigation, grievance, or reportable events. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/30/25 at 9:07 AM, the surveyor interviewed the Assistant Administrator (AA), who stated any type of abuse: verbal, physical, or sexual should be discussed with the LNHA and the DON, and it was discussed as a team. The AA stated an investigation included to check on the resident, interview them and staff, reach out to the families, do a body assessment and call the police if warranted. The AA stated, if a resident made a statement of rape, they should be assessed. The LNHA should be called and an investigation started. The AA stated she could not recall Resident #155's allegation of rape. On 1/30/25 at 9:37 AM, the surveyor interviewed the Medical Director (MD), who stated if staff called him regarding an allegation of abuse with a resident, he would have the resident sent to the hospital for evaluation and tell the staff to follow the facility's protocol for investigation. On 1/30/25 at 10:15 AM, the surveyor interviewed the DON, who stated she kept a soft file on the event in case there was a question, she added it was not part of the medical record. The surveyor asked was that not the purpose of an investigation, she stated yes. The DON could not explain why she did not offer the soft file to the survey team. An acceptable Removal Plan was received on 1/29/25 at 2:56 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: the LNHA or designee initiated immediately an investigation and conclusion was completed; the allegation was reported to the NJDOH; the DON was reeducated on Investigations/Prevention/Correct Alleged Violations; and all staff were educated on the facility's abuse policies and procedures. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 1/29/25. 40042 Part B On 1/23/25 at 10:31 AM, the surveyor observed Resident #73 dressed and groomed seated in a wheelchair in the doorway of their room. The resident stated they used continuous oxygen, which was observed by the surveyor. At that time, the resident had not expressed any concerns related to abuse. The surveyor observed an oxygen concentrator (a medical device that delivers oxygen to those with breathing related disorders) in the room set at 2 liters per minute, and an oxygen tank secured to the back of the resident's wheelchair. On 1/24/25 at 10:30 AM, the surveyor conducted a Resident Council Meeting where Resident #73 was in attendance. At that time, Resident #73 stated that one night they had difficulty breathing around 4:00 AM, and they requested a nebulizer (a device used to administer medication in a form of a mist inhaled into the lungs) treatment to the Certified Nurse Aide (CNA #1). The resident stated they waited two hours until the nurse came in. At that time, the nurse stated she did not know anything about the resident's above mentioned request. The resident stated the nurse left the room, and it took another 45 minutes to receive the treatment. The resident further stated that they reported this to the Activities Director (AD); however, they (the AD) did not acknowledge the issue, and no one came back to follow up. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the Resident Council Minutes which was conducted on 1/14/25 at 2:00 PM, reflected that Resident #73 and the AD were in attendance. The minutes included that Resident #73 stated they were in respiratory distress at approximately 3:00 AM and told CNA #1. The resident further stated that they did not receive a nebulizer treatment until 7:15 AM. The resident also stated they spoke with the Licensed Practical Nurse/Unit Manager (LPN/UM #1) about the issue and the staff member (CNA #1). The resident further stated that CNA #1 stood in front of the resident in an intimidating manner because the resident told on her. On 1/24/25 at 2:02 PM, the surveyor requested any accidents/incidents/grievances or investigations for Resident #73, and the DON stated she did not have anything for that resident. On 1/24/25 at 2:04 PM, the surveyor interviewed the DON, who stated that she was unaware of the resident's alleged incident on 1/14/25, until now. She stated Resident #73 had not approached her with this concern, which she was surprised since she felt they had a good rapport and saw the resident often. The DON stated that now that she was aware, she would initiate an immediate investigation. She acknowledged that she had no formal way to follow up resident council minutes content. The surveyor reviewed the EMR for Resident #73. A review of the Admission Record face sheet revealed the resident had diagnoses which included but were not limited to; asthma, acute and chronic respiratory failure (a condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in the body tissues), alcohol abuse and depression (a mental illness that can cause severe symptoms that affect a person's mood, thoughts, and daily activities). A review of the comprehensive MDS, dated [DATE], reflected the resident had a BIMS score of 15 out of 15 which indicated an intact cognition. It also reflected the above diagnoses and was coded for oxygen therapy. On 1/24/25 at 2:48 PM, the surveyor interviewed the AD in the presence of the survey team. At that time, he reviewed the minutes from the last Resident Council Meeting dated 1/14/25. The AD stated he sent an email to the DON regarding Resident #73's allegation during the Resident Council Meeting, and he acknowledged that he did not send the email to the LNHA as well. The AD stated he could not speak to why he did not report the resident's concern/allegation verbally, and he did not recall a response from the DON, but he stated he knew the DON was very busy. The AD stated, I should have followed up and that 10 days was too long to wait. The AD provided a copy of the email he sent to the survey team. On 1/24/25 at 3:56 PM, the surveyor interviewed the DON, in the presence of the survey team. The DON stated the AD should have brought this to her attention immediately. On 1/30/25 at 3:49 PM, the surveyor interviewed the DON and LNHA, in the presence of the survey team. The LNHA stated he would have expected the AD to go directly (physically) to the DON with Resident #73's allegation brought up at Resident Council and that email communication was not the typical procedure. The LNHA stated that he addressed this with the AD. The LNHA stated the AD did not feel it was abuse. The DON stated that in the past, the AD reported concerns to her verbally. In addition, she stated she was the only department the AD emailed, and not the LNHA as well. The LNHA stated that he was shocked. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/31/25 at 10:31 AM, the surveyor interviewed the LNHA in the presence of the survey team. He acknowledged he was the abuse officer and was responsible to ensure allegations of abuse were reported and fully investigated. The LNHA stated he was responsible to oversee this process and that it was done in accordance to their facility abuse policy. NJAC 8:39-4.1 (a) (5); 8:39-33.2 (c) (12)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assess the resident when there is a significant change in condition 48964 Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) using the Resident Assessment Instrument (RAI) process on a resident who elected hospice benefits. This deficient practice was identified for 1 of 1 residents reviewed for hospice (Resident # 4). This deficient practice was evidenced by the following: On 1/23/25 at 10:36 AM, the surveyor observed Resident #4 lying in bed. The resident denied any complaints or issues. A fall mat was noted on right side of bed. A review of Resident #4's admission record revealed that the resident had diagnoses which included but not limited; unspecified dementia (loss of cognitive functioning), bipolar disorder (a mental health condition characterized by extreme mood swings), and hypertension (high blood pressure). A review of Resident #4's order summary revealed an order to admit to [Name redacted] Hospice on 4/7/24. A review of the resident's Minimum Data Set (MDS) 3.0 Assessment History, an assessment tool contained within the resident's Electronic Health Record (EHR) dated 4/20/24, revealed that a SCSA was not completed for the resident within 14 calendar days from the resident's hospice election as required. It was completed 4/26/24, which was twenty days after admission to hospice services. On 1/29/25 at 1:27 PM, the surveyor interviewed the MDS Coordinator who stated that she completed the significant change MDS as she's been taught. The surveyor requested the facility's policy. On 1/29/25 at 01:40 PM, the MDS Coordinator brought the surveyor from the RAI manual (page 2-17). A review revealed Significant Change in Status (SCSA) - MDS Completion Date no later than 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days). A review of the facility's untitled policy reviewed 06/2024, provided by facility revealed: Policy: It is our policy to complete the RAI process according to the Requirements and Standards of the latest published RAI manual. Procedure: 10. Should a Significant Change in Status in a resident's condition be noticed, the Nurse Assessment Coordinator will open a Significant Change Assessment within 14 days as required and will be completed as stated above according to the RAI manual. NJAC 8:39-11.2(i)

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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. 40042 COMPLAINT #: NJ 169737, NJ 171801 Based on observations, interviews, record review and review of pertinent facility documents it was determined that the facility failed to ensure timely care to resident's dependent on staff for care. This was a.) observed for 1 of 3 residents reviewed for activities of daily living (ADLs) Resident #22 who required incontinence care and b.) revealed during a resident council meeting for 7 of 8 residents (Resident's #9, #13, #15, #44, #61, ##73 and 80) in attendance. This deficient practice was evidenced by the following: 1. On 1/23/25 at 11:12 AM, Surveyor #1 observed Resident #22 in bed. Upon entering the room, there was a strong foul odor. The resident stated they rang the call bell for staff to change their brief as the resident stated they soiled themselves. The resident stated a nurse responded to the call bell and stated she would get an aide to assist. The call bell was not on when the surveyor entered the room. On 1/23/25 at 11:23 AM, Surveyor #2 interviewed the resident. Upon entering the room, there was a strong foul odor. The resident stated they had been waiting for assistance for a change of their brief and had activated the call bell some time ago. The resident stated a nurse had responded initially and informed the resident that an aide would be coming. The resident was unable to identify the name of the nurse who responded to the call bell. At this point, the resident activated the call bell again, upon the surveyor's exit. On 1/23/25 11:25 AM, Surveyors #1 and #2 observed the Licensed Practical Nurse / Unit Manager (LPN/UM) #1, who wore a surgical mask, enter the resident's room for a brief period, during which the call bell was deactivated. She then exited the room, proceeded to the nursing station desk, and seated herself. However, she made no visible attempt to offer further assistance to the resident. On 1/23/25 at 11:43 AM, Surveyors #1 and #2 remained on the unit and observed LPN/UM #1 leave the unit via the elevator across from the nurse's station. On 1/23/25 at 11:45 AM, Surveyor #2 re-entered the resident's room and conducted a follow-up interview. The resident confirmed that the nurse who responded to the initial call bell was the same nurse who responded again later (LPN/UM #1). The resident stated they had informed the nurse they were still waiting to be changed. The resident activated the call bell once more as the surveyor exited the room. On 1/23/25 at 11:47 AM, Surveyors #1 and #2 observed Certified Nurse Aide (CNA) #1 promptly respond to the activated call bell. She exited the room and proceeded to seek assistance. (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.	On 1/23/25 at 11:50 AM, Surveyor #1 interviewed CNA #1 in the presence of Surveyor #2. She stated Resident #22 was not her assigned resident however she answered the call bell. She stated that the resident's assigned CNA was assisting another resident, and therefore she sought the assistance from CNA #2. CNA #1 further stated the resident required two staff members for assistance and they needed to use a lift or mechanical device designed to assist care givers to safely lift or transfer the resident. On 1/23/25 at 11:54 AM, LPN/UM #1 returned to the unit. Surveyor # 1 interviewed her in the presence of Surveyor #2. She stated that Resident #22 was alert and able to respond appropriately. She also stated the resident was unable to walk and required two staff members and a lift to assist them. LPN/UM #1 confirmed the presence of a strong foul odor in the resident's room. She acknowledged that the resident needed assistance to change their brief and that the assigned CNA was on break at that time. LPN/UM #1 stated that staff should prioritize residents who required incontinence care. In addition, she stated wait time for assistance should be approximately 10-15 minutes. When Surveyor #1 informed LPN/UM #1, the resident had been soiled during the initial tour of the unit at approximately 11:15 AM and that the resident's needs were not attended to until approximately 11:50 AM, LPN/UM #1 stated this represented a wait time of about 35 minutes, which she considered extreme. She further stated that prolonged wait times while soiled could lead to complications such as skin breakdown, infections, and urinary tract infections (UTIs). On 1/23/25 at 12:05 PM, Surveyors #1 and #2 observed CNA's #1 and #2 exit Resident #22's room. The surveyor reviewed the electronic medical record for Resident #22. A review of the Admission Record (an admission summary) reflected the resident had diagnoses that included but were not limited to; hypertension and a cerebral infarction (stroke). A review of the quarterly Minimum Data Set (a tool that facilitates the management of care) dated 11/20/24, reflected the resident had a Brief Interview for Mental Status score of 14 out of 15, which indicated the resident had an intact cognition. It also reflected that the resident was frequently incontinent of bowel and bladder. It further reflected that the resident was coded as dependent for the functional ability required for toileting hygiene. This is defined as Helper does all the effort. Resident 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. A review of the resident's individualized comprehensie care plan reflected a focus area dated 8/24/23, which the resident had an ADL, self-care performance deficit related to impaired balance and limited mobility. It also included interventions of the resident required two staff assistance as well as mechanical lift for transfer's and to encourage the resident to use the call bell for assistance. The ICCP also included a focus area for both bowel and bladder incontinence, dated 8/14/23, which reflected the resident required peri care (cleaning the private areas after an incontinent occurrence) after each incontinent episode. A review of the Bladder Elimination task for 30 days (1/1/25-1/30/25) reflected the resident experienced 69 episodes of bladder incontinence. A review of the Bowel Elimination task for 30 days (1/1/25-1/30/25) reflected the resident experienced 46 episodes of bowel incontinence. (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.	On 1/24/25 at 2:19 PM, Surveyor #1 interviewed the Director of Nursing (DON), in the presence of the survey team. She stated any licensed staff (CNA, LPN or Registered Nurse [RN]) was able to assist to change a resident's brief after an incontinent episode. The DON further stated if the person who answered a call bell was unable to assist the resident, they should not turn off the call bell until the resident's needs were resolved and that staff member should seek assistance. The DON stated that if a resident needed incontinence care, she would expect staff to provide assistance as soon as possible if not immediately. If after 30 minutes, if staff were still unable to provide care, she would expect that staff member to seek help from another nurse. On 1/29/25 at 3:36 PM, the Surveyor #1 interviewed LPN/UM #1, who was wearing a surgical mask, in the presence of survey team. She stated that she responded to Resident #22's call bell and that the resident stated they did not need anything and further stated she did not smell any odor in the resident's room. LPN/UM #1 stated if the resident needed a brief change due to an incontinence episode she would have informed the CNA. On 1/30/25 at 3:49 PM, the survey team met with the DON and the Licensed Nursing Home Administrator (LNHA). The DON stated her expectation was that the UM (LPN/UM) should have gotten another CNA to assist the resident after waiting 5-10 minutes, if that residents CNA was still busy. Additionally, the DON stated that the UM herself could have assisted the resident herself with another staff member (CNA, LPN or RN). The DON stated her expectation was staff to meet the residents needs within 15 minutes and after 30 minutes to seek other assistance if needed. She again stated that she encouraged the staff not to turn the call bell off until the residents' needs were met. 2. On 1/24/25 at approximately 11 AM, Surveyor #2 conducted a resident council meeting with eight residents. Seven out of eight residents stated they were not provided with the care they need in a timely manner. A review of the facility policy Activities of Daily Living (ADLs) dated 5/17, included a resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. A review of the facility policy Incontinence Care dated 7/2024, included outlined a procedure for cleansing the perineum and buttocks after an incontinence episode with daily care to prevent infection from fecal matter and urine. A review of an undated facility list of UM responsibilities provided by the DON included Address incontinence. NJAC 8:39-27.1 (a); 8:39-27.2 (h)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Woods Rehabilitation & Nursing Center	780 Old New Brunswick Road Somerset, NJ 08873

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40042 COMPLAINT #: NJ 169737, NJ 171801 Based on observations, interviews, record review and review of pertinent facility documents it was determined that the facility failed to provide adequate staff to answer call bells and ensure residents were provided with timely care. This included a.) incontinence care for 1 of 3 residents reviewed for activities of daily living (ADLs) (Resident #22), and b.) 7 of 8 residents who attended a resident council meeting with a state surveyor (Resident's #9, #13, #15, #44, #61, #73 and #80). This deficient practice was evidenced by the following: Refer to F 677 Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor reviewed staffing for the following dates which revealed that the facility was deficient in Certified Nursing Assistant (CNA) staffing as follows: For the 2 weeks of staffing from 10/29/2023 to 11/11/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -10/29/23 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -11/03/23 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -11/04/23 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -11/05/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -11/11/23 had 12 CNAs for 113 residents on the day shift, required at least 14 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	For the 5 weeks of staffing from 01/07/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 17 of 35 day shifts as follows: -01/07/24 had 7 CNAs for 100 residents on the day shift, required at least 12 CNAs. -01/13/24 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -01/17/24 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/19/24 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/20/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -01/21/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -01/26/24 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/27/24 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/28/24 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/01/24 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -02/03/24 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -02/04/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -02/06/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -02/07/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -02/08/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -02/09/24 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -02/10/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. For the 2 weeks of staffing prior to survey from 01/05/2025 to 01/18/2025, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -01/05/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/06/25 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/09/25 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/13/25 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	-01/18/25 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. 1.) On 1/23/25 at 9:21 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1. She stated the unit census was 34 residents and there were four CNAs, and two LPNs on medication carts in addition to herself. The surveyor verified the staff and LPN/UM #1 provided the surveyor with a CNA assignment sheet. On 1/23/25 at 11:12 AM, Surveyor #1 observed Resident #22 in bed. Upon entering the room there was a strong foul odor. The resident stated they rang the call bell for staff to change their brief as the resident stated they soiled themselves. The resident stated a nurse responded to the call bell stated she would get an aide to assist. The call bell was not on when the surveyor entered the room. On 1/23/25 at 11:23 AM, Surveyor #2 interviewed the resident. Upon entering the room there was a strong foul odor. The resident stated they had been waiting for assistance for a change of their brief and had activated the call bell some time ago. The resident stated a nurse had responded initially and informed the resident that an aide would be coming. The resident was unable to identify the name of the nurse who responded to the call bell. At this point, the resident activated the call bell again upon the surveyor's exit. On 1/23/25 11:25 AM, Surveyors #1 and #2 observed the Licensed Practical Nurse / Unit Manager (LPN/UM) #1, who wore a surgical mask enter the resident's room for a brief period, during which the call bell was deactivated. She then exited the room, proceeded to the nursing station desk, and seated herself. However, she made no visible attempt to offer further assistance to the resident. On 1/23/25 at 11:43 AM, Surveyors #1 and # 2 observed LPN/UM #1 leave the unit via the elevator across from the nurse's station. On 1/23/25 at 11:45 AM, Surveyor #2 re-entered the resident's room and conducted a follow-up interview. The resident confirmed that the nurse who responded to the initial call bell was the same nurse who responded again later (LPN/UM #1). The resident stated they had informed the nurse they were still waiting to be changed. The resident activated the call bell once more as the surveyor exited the room. On 1/23/25 at 11:47 AM, Surveyors #1 and #2 observed Certified Nurse Aide (CNA) #1 promptly responded to the activated call bell. She exited the room and proceeded to seek assistance. On 1/23/25 at 11:50 AM, Surveyor #1 interviewed CNA #1 in the presence of Surveyor #2. She stated Resident #22 was not her assigned resident however she answered the call bell. She stated that the resident's assigned CNA was assisting another resident, and therefore she sought the assistance from CNA #2. CNA #1 further stated the resident required two staff members for assistance and they needed to use a lift or mechanical device designed to assist care givers to safely lift or transfer the resident. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 1/23/25 at 11:54 AM, LPN/UM #1 returned to the unit. Surveyor # 1 interviewed her in the presence of Surveyor #2. She stated that Resident #22 was alert, and able to respond appropriately. She also stated the resident was unable to walk and required two staff and a lift to assist them. LPN/UM #1 confirmed the presence of a strong foul odor in the resident's room. She acknowledged that the resident needed assistance to change their brief and that the resident's assigned CNA was on break at that time. LPN/UM #1 stated that staff should prioritize residents who required incontinence care. In addition, she stated wait time for assistance should be approximately 10-15 minutes. When Surveyor #1 informed LPN/UM #1, the resident had been soiled during the initial tour of the unit at approximately 11:15 AM and that the resident's needs were not attended to until approximately 11:50 AM, LPN/UM #1 stated this represented a wait time of about 35 minutes, which she considered extreme. She further stated that prolonged wait times while soiled could lead to complications such as skin breakdown, infections, and urinary tract infections (UTIs). On 1/23/25 at 12:05 PM, Surveyors #1 and #2 observed CNA #1 and 2 exit Resident #22 room. The surveyor reviewed the electronic medical record (EMR) for Resident #22. A review of the Admission Record (an admission summary) reflected the resident had diagnoses that included but were not limited to; hypertension and a cerebral infarction (stroke). A review of the quarterly Minimum Data Set (a tool that facilitates the management of care) dated 11/20/24, reflected the resident had a Brief Interview for Mental Status score of 14 out of 15 which indicated the resident had an intact cognition. A review of the resident's individualized comprehensive care plan (ICCP), included a focus area dated 8/24/23, which reflected the resident had an ADL, self-care performance deficit related to impaired balance and limited mobility. It also included an intervention to encourage the resident to use the call bell for assistance. A review of the Bladder Elimination task for 30 days (1/1/25-1/30/25) reflected the resident experienced 69 episodes of bladder incontinence. A review of the Bowel Elimination task for 30 days (1/1/25-1/30/25) reflected the resident experienced 46 episodes of bowel incontinence. 2.) On 1/24/25 at approximately 11 AM, the surveyor conducted a resident council meeting with eight residents. Seven out of eight residents stated that staff did not answer call bells in a timely manner. The following were some specific complaints: -Resident #9 stated, I happen to wait an hour or more when I call for help. -Resident #13 stated, It takes them forever to respond to the residents here. You wait anywhere from 45 minutes to an hour. -Resident #15 stated, delays during shift changes are frustrating; shift change is at 3 PM, but sometimes you don't see them until 5 PM; it really affects the care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	-Resident #44 stated, I wait a long time between 3 PM and 7 AM. Two weeks ago . I hit the bell about 2 AM and didn't get a response until 2:40 AM. -Resident #61 stated, I waited a long time today when I hit my call bell; they respond to the call bell but don't address your concern right away. -Resident #73 stated, I feel like we are not being provided with the care we need timely; one night around 4 AM . I hit my call bell . The resident stated a CNA answered the call bell but then waited 2 hours plus for assistance. -Resident #80 stated, When I hit the call bell, it takes 45 minutes to an hour for someone to answer, but they don't take care of the concern. They just say someone will be there, and then I wait another 30-45 minutes. On 1/24/25 at 2:19 PM, the survey team met with the DON. She stated that anyone could answer call bells; however, the light should not be turned off until the resident's needs were met. The DON further stated if the person who answered the call bell was not the one who resolved the resident's needs, they cannot turn off the call bell. She further stated she had come across that problem. The DON stated she conducted call bell audits on her rounds but did not have documentation. She stated she has rung call bells to see how long it took for staff to respond but did not have anything in writing. In addition, the DON stated that anyone can answer a call bell (except for dietary) and if it the need was something small (i.e. passing a remote) it should be resolved right away. On 1/28/25 at 3:32 PM, the surveyor interviewed LPN/UM #1, in the presence of a second surveyor. She stated she conducted call bell audits on her unit unofficially. She could not provide any documentation of audits. On 1/30/25 at 3:49 PM, the survey team met with the DON and the Licensed Nursing Home Administrator (LNHA). The DON stated her expectation was staff to meet the residents needs within 15 minutes and after 30 minutes to seek other assistance if needed. She again stated she encouraged the staff not to turn the call bell off until the residents' needs were met. On 1/31/25 at 12:26 PM, the DON acknowledged she could not provide any call bell audits in the presence of the survey team. A review of the facility policy Call Bells dated 6/2024, included that it was everybody's job to help out and respond to call bells. The policy delineated what was appropriate for non-nursing associates verse nurses to do for residents. The facility policy did not address expected or goals for response times or audits. A review of the facility policy Staffing Policy and Procedure dated 6/2024, included the facility's goal was to provide adequate staffing to meet needed care and services for the resident population, In addition, the goal was for nursing staff to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual care plans. The policy also included the following: 1) One Certified Nurse Aide (CNA) to every eight residents for the day shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	2) One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 3) One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. NJAC 8:39-5.1(a); 8:39-25.2 (a)(b); 8:39-27.1(a);8:39-27.2(d); 27.2(h)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40042 Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) provide lunch menu items in accordance to resident preferences, meal tickets and physician orders (PO) for 2 of 3 residents (Resident #31 and #62), and b.) provide fortified mashed potatoes (super mashed) at lunch for 1 of 3 residents (Resident #62) reviewed for food. This deficient practice was evidenced by the following: On 1/24/25 at 12:15 PM, the surveyor observed Resident #62 in their room, groomed and seated in a wheelchair with an overbed table over their lap area. There was yogurt in a plastic cup, a liquid supplement and a six-ounce (oz) [name redacted] juice on the table. The resident's representative was present, and the surveyor interviewed them in the presence of a second surveyor. The resident's representative stated the resident had a PO for a puree diet and that she filled out menus in order to select food items and beverages they know [the resident] would prefer. The resident's representative stated even though they checked off preferred items on the meal tickets, they (the kitchen) often make mistakes, especially yogurt with all meals. The resident's representative stated the resident liked yogurt and often did not receive it and that was why they brought it from home daily. On 1/24/25 at approximately 1 PM, the surveyor observed Resident #62's lunch tray, in the presence of a second surveyor and the Registered Nurse / Unit Manager (RN/UM) #1. The resident's meal ticket indicated the resident was on a pureed diet. Fruit yogurt was checked; however, it was not on the tray. The meal ticket also indicated the resident should have received extra gravy/sauce on the side with meals, however it also was not on the tray. Additionally, the meal ticket indicated the resident should have received super mashed, the surveyor observed what appeared to be regular mashed potatoes. The RN/UM #1 acknowledged the surveyors' observations. On 1/28/25 at 9:39 AM, the surveyor observed Resident #62's regular Certified Nurse Aide (CNA) #1, feeding the resident breakfast. The meal ticket indicated the resident was on a puree diet. The surveyor observed a small plate of cut strawberries and sliced orange wedges which was wrapped with clear cellophane (untouched). CNA #1stated, I know [gender redacted] is on pureed, and stated he would not have given the fruit to the resident. He further stated staff need to read the meal tickets before assisting the residents at meals. The surveyor reviewed the electronic medical record (EMR) for Resident #62. A review of the Admission Record (an admission summary) which included diagnoses but were not limited to; dementia and oral phase dysphagia (difficulty swallowing). A review of a quarterly Minimum Data Set (MDS), a tool to facilitate the management of care dated 12/26/24, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated severely impaired cognition. The resident was also coded for dementia and oral phase dysphagia as well as receiving a mechanically altered diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the individualized comprehensive care plan (ICCP), reflected a nutrition care plan initiated 11/1/22. It included a goal for the resident to tolerate the diet consistency without difficulty swallowing and an intervention for a PO puree diet. Interventions further included to identify resident food preference, and provide fortified foods three times per day. A review of the Order Summary Report, reflected a PO for a pureed texture diet dated 11/28/24. It also reflected a PO dated 1/3/25, Nursing - please check breakfast, lunch, and dinner tray to ensure texture is puree prior to feeding. Thank you before meals. A review of the electronic medication administration record for January 2025 reflected the above PO's. A review of the Registered Dietitian (RD) progress note dated 1/15/25, reflected the resident received a puree diet and experienced a planned weight gain. It also reflected to honor and update resident food preferences regularly as well as to provide fortified mashed potatoes twice a day. On 1/29/25 at 1:44 PM, the surveyor observed Resident #31 in bed with their eyes closed, who did not rouse for surveyor. The resident's lunch tray was on the overbed table. The surveyor observed the contents of the lunch tray verse what was indicated on the meal ticket in the presence of the RD, Food Service Director (FSD) and the Division Director of Food and Nutrition Operations. The main menu item (protein) pork was checked off on the selected menu. The only item on the resident's plate was diced potatoes. In addition, the meal ticket indicated the resident should have received 8 oz of whole milk (also on the menu), instead a 4 oz milk container was observed on the tray. At that time, all three staff members acknowledged these mistakes and could not speak to how this occurred. The FSD stated that he was in the kitchen monitoring the tray line for accuracy; however, when the food truck for this unit was prepared, he was on a resident unit and not in the kitchen. He stated in his absence the 3rd position on the tray line should have checked the tray for accuracy. He stated that position was also responsible for putting the correct cold items on the trays. The FSD acknowledged that the position that should have been checking the trays for accuracy made a mistake themselves for putting the wrong size milk on the tray for Resident #31. The surveyor reviewed the EMR for Resident #31. A review of the Admission Record reflected the resident had diagnoses which were not limited to; alcohol dependence (in remission), chronic pancreatitis (inflammation of the pancreas), and history of peptic ulcer disease (open sores on the stomach lining and/or small intestine). A review of a quarterly (MDS) dated [DATE], reflected a BIMS score of 15 out of 15, which indicated the resident has an intact cognition. A review of the ICCP included a nutrition care plan dated 4/10/23, which reflected interventions cater to food preferences, and the resident had a PO for a No Added Salt (NAS) diet. A review of the Order Summary Report reflected the resident had a PO for a NAS diet, dated 2/14/24. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/24/25 at approximately 1:15 PM, the surveyor went to kitchen with a second surveyor. The surveyor observed [NAME] #1 cleaning up food from the steam tables on the tray line. The surveyor observed whole potatoes individually wrapped in tin foil and a deep pan of mashed potatoes in the steel table on the tray line. [NAME] #1 stated the potato was the main starch and the mashed potatoes were served to mechanically altered diets. He stated he had not made fortified mashed potatoes for lunch because no residents get that. [NAME] #1 stated he did not see that indicated on any meal tickets and could not speak to a recipe for fortified mashed potatoes. The FSD and the interim Regional FSD joined the surveyors and [NAME] #1. The FSD stated that he prepared the pureed food for lunch the night before and that [NAME] #1 heated it up. The FSD stated there were residents who received fortified mashed potatoes, and he asked [NAME] #1 if he prepared it, [NAME] #1 responded no. The FSD could not speak to a recipe for fortified mashed potatoes and there was no recipe posted or readily available. The FSD stated that the purpose of fortified foods was to help residents gain weight or avoid losing weight. The FSD showed the surveyor that they had fruit yogurt available and could not speak to why Resident #62 did not receive it at lunch. At that time, the FSD stated he would have been the one to check the meal trays for accuracy prior to delivery; however, today he was delivering food trucks to the resident units. He could not speak to if another staff member was instructed to do so in his absence. He acknowledged it was important for the meal trays to be accurate and stated the purpose was for customer satisfaction and overall health. The interim Regional FSD stated he was not at the lunch tray line to check the meal trays for accuracy and acknowledged that fortified food recipes should have been readily available. On 1/24/25 at 3:27 PM, the FSD was unable to provide a recipe for fortified mashed potatoes. On 1/29/25 at 11:50 AM, the surveyor interviewed the RD. She acknowledged that Resident #62 had a PO for a puree diet. She stated the kitchen prepared fortified foods (cereal, mashed potatoes and pudding). The RD stated she believed the kitchen had recipes and they should be readily available. She further stated that fortified foods were nutritional interventions, and the purpose was to promote weight gain and/or prevent loss. The RD also stated she updated resident food preferences frequently for resident satisfaction and maximum meal intake. She stated there were residents who received selective menus which were provided in advance to be filled out by the resident or family member. Her expectation would be that whatever was checked off, would be received at that meal. The RD stated she was unaware of meal tray inaccuracies. In addition, the RD stated that she was frequently in contact with the resident representative of Resident #62. She acknowledged that the resident enjoyed yogurt, and that the resident's representative brought it daily. On 1/29/25 at 12:18 PM, the surveyor interviewed the Speech Language Pathologist (SLP). She stated that if a resident received an incorrect diet consistency it could be harmful. She stated that if the puree diet was not prepared properly, it could be unsafe. The SLP stated when she conducted evaluations or provided therapy at the resident's bedside during meals, she had noticed what the resident received did not match what was checked off on their meal ticket. She stated the residents get very upset. The SLP stated that when she noticed that she notified the nurse who notified the kitchen to correct it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Woods Rehabilitation & Nursing Center	780 Old New Brunswick Road Somerset, NJ 08873

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/29/25 at 3:02 PM, the survey team met with the dietary team: RD, FSD and the interim Regional FSD. The dietary team could not speak to the tray accuracy errors observed by surveyors. The interim Regional FSD stated that there was a tray accuracy audit done on 1/15/24 and that an audit for Quality Assurance & Improvement Plan (QAPI) will be started again tonight. He stated that staff need to be more diligent on the tray line and they need to pay attention. He further stated a tray accuracy audit started in 2023 but ceased on 1/15/24 because they thought the problem resolved. He acknowledged that the new QAPI for tray accuracy was started after surveyor inquiry. The FSD acknowledged that during his food committee meeting with residents in December 2024, tray accuracy and ticket accuracy were concerns brought up by residents. He could not speak to what he did about these concerns. He further stated, It was more of a conversation. The RD acknowledged Resident #62 was supposed to receive fortified mashed potatoes twice a day. On 1/30/25 at 10:10 AM, the surveyor interviewed the SLP, in presence of survey team. She stated that Resident #62's representative had told her that they check off items on the selective menus, yet the kitchen provided something else. The SLP stated the resident enjoyed yogurt and that it was a staple for [gender redacted]. She stated she taught the resident's representative a feeding technique which was to alternate spoons of pureed food and yogurt because the resident had an affinity to sweet foods (yogurt, ice cream and juice) which encouraged greater consumption. The SLP stated that she provided therapy to Resident #62 for three weeks in December 2024 and acknowledged there were times items would be missing from the meal trays such as yogurt, ice cream and extra juice. The SLP stated when she noticed missing items she notified the nurse who notified the kitchen to correct it. On 1/30/25 at 1:55 PM, the surveyor interviewed the FSD and the interim Regional FSD, in the presence of the survey team. When discussing tray inaccuracy for Resident #31 which included the portion size of milk, the FSD stated that some resident's meal tickets indicated a four oz milk. The interim FSD acknowledged that the menus indicated eight oz milk and so did the resident's meal ticket and therefore it was a mistake, and the resident should have received an eight oz portion of milk. On 1/30/25 at 3:08 PM, the surveyor interviewed the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) about the QAPI committee meetings and topics. They stated there had been a prior QAPI due to tray line and meal ticket inaccuracies. The LNHA acknowledged that if the FSD identified any issue during last months menu committee meeting he should have implemented a plan of correction right away. On 1/30/25 at 4:19 PM, after reviewing tray accuracy concerns for Resident #31 and #62 with the DON and LNHA, in the presence of the survey team. The LNHA acknowledged, tray accuracy needs work. On 1/31/25 at 11:29 AM, the surveyor interviewed the the DON and LNHA, they acknowledged that the tray accuracy QAPI had been completed and was not currently ongoing. A review of the facility policy Food Preferences Policy dated 1/2025, included the policy of the facility was to provide food preferences and also allow residents to make point of service choices that reflect individualized, day to day meal preferences as able. It also included the FSD will provide food preferences. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of an undated policy provided by [name redacted] a contracted company for Fortified Foods, included residents food preferences should be considered when planning a residents to improve their food intake. It also reflected the RD would determine if a resident required fortified foods which are calorically dense to improve a resident's nutritional status. A review of policy provided by [name redacted] a contracted company, Tray Line Process Policy dated 11/2024, reflected the purpose was to ensure accurate delivery of meal trays to residents while maintaining compliance with dietary orders, and resident preferences. It also included that Each completed tray must be checked for accuracy before being sent out for delivery. A review of the facility's undated FSD Job Description, included the FSD oversees all aspects of food service operations to ensure high standards of culinary excellence, and nutritional and regulatory compliance. In addition, it included the FSD should collaborate with other departments and services to plan and implement patient care as necessary in meeting the nutritional needs of the patients. A review of the undated Clinical Dietitian Job Description, provided by the contracted company [name redacted] included to Monitor food service operations to ensure adherence to nutritional standards . and quality requirements in accordance with all applicable state and federal regulations. NJAC 8:39-17.4 (a)(1) (2)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40042 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of hot and cold foods served to the residents. This deficient practice was identified for 7 of 8 residents (need Resident #s?) interviewed during the Resident Council meeting and confirmed during the lunchtime meal service on 1/30/25 for 1 of 3 nursing units tested for food temperatures by two surveyors and was evidenced by the following: On 1/24/25 at approximately 11:00 AM, the surveyor met with eight residents for a resident council meeting. Seven out of eight residents stated that hot food temperatures were unacceptable. On 1/30/25 at 12:39 PM, the surveyor calibrated a state issued digital thermometer via the ice bath method to 32 degrees Fahrenheit (F) in the presence of the survey team. On 1/30/25 at 1:14 PM, the closed food truck arrived with lunch trays to the 3rd floor (2 surveyors present). The surveyor marked a regular consistency food tray as a test tray in the presence of staff and requested another tray be delivered to the unit for that resident (the dietary aide did so promptly). On 1/30/25 at 1:23 PM, the last tray was taken out of the food truck. At that same time, the surveyor took the temperature of the tray items in the presence of a second surveyor and the Licensed Practical Nurse / Unit Manager (LPN/UM) #1, who verified the temperature on the calibrated digital thermometer. The temperatures were recorded as follows: Milk 4 ounces (oz): 50.5 degrees F Canned peaches 4 oz: 63.9 degrees F Mashed potatoes 4 oz: 122.2 degrees F Chicken patty 1 portion topped with brown gravy: 121.1 degrees F Corn O'Brien 4 oz: 117 degrees F Coffee 6 oz: 119.4 degrees F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 1/30/25 at 1:43 PM, the surveyor interviewed the Food Service Director (FSD), in the presence of survey team. He stated he was not sure what the minimum temperature was for hot food once it arrived to the units; however, his expectation would have been 150 degrees F. He stated the cold food was 35 degrees F in the kitchen before delivery and so maybe it would arrive at the unit five to eight degrees higher (40-43 degrees F). He stated he conducted random test tray audits (2-3 a month). He also confirmed that both the induction plate liners and plate warmers were working and should have kept the food hot. The surveyor requested copies of the last three months of test tray audits to review. On 1/30/25 at 1:46 PM, the Interim Regional FSD joined the FSD and stated there was a guideline on the test tray audit form for proper food temperatures. On 1/30/25 at 1:58 PM, after the surveyor reviewed the test tray temperatures with the FSD, he stated, I am not happy about the temps. On 1/31/25 at 12:26 PM, the DON provided the surveyor with documents from the FSD and acknowledged the FSD did not provide her with test tray audits. A review of the facility's policy Food Temperature Policy dated 8/2024, included foods sent to the units for distribution such as meals, will be transported and delivered to maintain temperature at or below 45 degrees F for cold foods and at or above 135 degrees F for hot foods. It also included to avoid holding foods in the temperature danger zone (41 to 135 degrees F). A review of the facility policy Test Tray Policy and Procedure dated 1/3/2024, included the test tray evaluation process provides the food service management with a tool that measures the quality level of the meal service and identifies areas of substandard quality requiring corrective action. It also included to follow the schedule of three test trays per week. A review of the facility Test Tray Evaluation form dated 12/16/21, included cold food and beverages should be at or below 41 degrees F and hot foods and beverages should be 135 degrees F or above. It also included to develop an action plan if the overall score was less than 90%. A review of the facility's undated FSD Job Description, included the responsibility to oversee dietary aides and cooks and to ensure all aspects of food service operations provide culinary excellence with nutritional and regulatory compliance. A review of the undated Clinical Dietitian Job Description, provided by the contracted company [name redacted] included to Monitor food service operations to ensure adherence to nutritional standards . and quality requirements in accordance with all applicable state and federal regulations. NJAC 8:39-17.2(g), 17.4(e)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 40042 Based on observations, interviews, record review and review of pertinent facility documents, it was determined that the facility failed to provide the correct diet consistency according to physician's orders (PO). This deficient practice was identified for 1 of 3 residents (Resident #62) reviewed for food and evidenced by the following: On 1/24/25 at 12:15 PM, the surveyor observed the resident groomed and seated in a wheelchair with an overbed table over their lap area. There was yogurt in a plastic cup, a liquid supplement and a six-ounce (oz) [name redacted] juice on the table. The resident's representative was present, and the surveyor interviewed them in the presence of a second surveyor. The resident's representative stated the resident had a PO for a puree diet. The surveyor reviewed the electronic medical record for Resident #62. A review of the Admission Record (an admission summary) which included diagnoses but were not limited to; dementia and oral phase dysphagia (difficulty swallowing). A review of a quarterly Minimum Data Set (a tool to facilitate the management of care) dated 12/26/24, reflected the resident had a Brief Interview for Mental Status score of 2 out of 15, which indicated severely impaired cognition. The resident was also coded for dementia and oral phase dysphagia as well as receiving a mechanically altered diet. A review of the individualized comprehensive care plan, reflected a nutrition care plan initiated 11/1/22. It included a goal for the resident to tolerate the diet consistency without difficulty swallowing and an intervention for a PO puree diet. A review of the Order Summary Report, reflected a PO for a pureed texture diet dated 11/28/24. It also reflected a PO dated 1/3/25, Nursing - please check breakfast, lunch, and dinner tray to ensure texture is puree prior to feeding. Thank you before meals. A review of the electronic medication administration record for January 2025 reflected the above PO's. A review of the Registered Dietitian (RD) progress note dated 1/15/25, reflected the resident received a pureed diet and experienced a planned weight gain. On 1/24/25 at approximately 1 PM, the surveyor observed Resident #62's lunch tray in the presence of a second surveyor and Registered Nurse / Unit Manager (RN/UM) #1. The resident's meal ticket indicated the resident was on a pureed diet. RN/UM #1 lifted the lid that covered the meal. The meal ticket indicated there should have been mashed potatoes, pureed chicken, pureed fish and pureed vegetable on the plate. With the exception of mashed potatoes, the other three scoops of food were observed to be crumbly and dry, not smooth and cohesive. RN/UM #1 acknowledged the same. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/24/25 at approximately 1:15 PM, the surveyor went to kitchen, with a second surveyor. The surveyor observed [NAME] #1 cleaning up food from the steam tables on the tray line. The surveyor observed pureed food in a 1/3 size, six-inch-deep stainless-steel pans (spinach, fish and breaded chicken as per COOK #1). [NAME] #1 stated the food items were an appropriate pureed consistency. The Food Service Director (FSD) and the interim Regional FSD joined. The FSD stated that he prepared the pureed food for lunch the night before and that [NAME] #1 heated it up. The FSD scooped the three pureed items spinach, fish and breaded chicken onto a plate and with a gloved hand manipulated the pureed food. He acknowledged that they were dry. He could not speak to the process of preparing pureed food, other than a [name redacted] blender type machine was used. On 1/29/25 at 11:30 AM, the surveyor interviewed the Division Director of Food and Nutrition Operations. He stated that a pureed consistency should be smooth, without chunks or particles, and should not be dry. On 1/29/25 at 11:41 AM, the surveyor interviewed RN/UM #1. He stated he and the staff check the resident's meal ticket to make sure it matched what was on the tray which included consistencies and textures. On 1/29/25 at 11:50 AM, the surveyor interviewed the RD. She stated that a pureed diet should be smooth like a mashed potato or pudding consistency. The RD further stated it should not be crumbly or dry. She acknowledged Resident #62's had a PO for a pureed diet. The RD stated she was unaware of any consistency concerns related to the puree diet. On 1/29/25 at 12:18 PM, the surveyor interviewed the Speech Language Pathologist (SLP). She stated that a puree diet should be a smooth texture, like mashed potatoes or pudding, that required no effort to chew at all. She further stated a crumbly consistency would be more like a ground diet. The SLP stated if food was not pureed enough or properly, that could cause a resident to cough or overly aspirate depending on if they have an oral deficit (trouble breaking down/chewing/and moving food back in the oral cavity) or if the resident had a swallowing deficit. She also stated, this could be harmful. She stated that if the puree diet was not prepared properly, it could be unsafe. The SLP stated she had issues with the puree consistency being more like a ground consistency and she addressed it with the FSD and nursing verbally right away. She stated she has seen improvement but that it still pops up. On 1/30/25 at 10:10 AM, the surveyor conducted a follow up interview with the SLP, in the presence of the survey team. She stated she provided Resident #62 therapy related to swallowing for approximately three weeks in December 2024 after the resident returned from a hospitalization . She stated the resident had been on a ground consistency diet and returned to the facility downgraded to a puree diet. However, even with therapy the resident was safest with a PO for a pureed consistency. On 1/30/25 at 3:49 PM, the survey team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The DON stated that she expected the nurses to check the resident's meal trays to ensure the texture they received is consistent with their PO for diet consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the undated facility provided Diet/Consistency Modifications guidelines, reflected that the puree diet should be pureed, homogenous, cohesive, pudding-like food that is in a form of an easy to swallow bolus (a round mass); and should be a moist, pudding-like consistency without particles which is easily swallowed with minimal chewing. A review of the facility policy Puree Texture Modification Policy dated 9/15/24, included the interdisciplinary care team determines modifications and orders them from the physician. It also included the regular menu items are pureed to a smooth pudding/mashed potato-like consistency. It further included; items must be homogenous, cohesive, mashed potato/pudding-like without particles. A review of the facility's undated FSD Job Description, included the FSD oversees all aspects of food service operations to ensure high standards of culinary excellence, and nutritional and regulatory compliance. In addition, it included the FSD should collaborate with other departments and services to plan and implement patient care as necessary in meeting the nutritional needs of the patients. A review of the undated Clinical Dietitian Job Description, provided by the contracted company [name redacted] included to Monitor food service operations to ensure adherence to nutritional standards . and quality requirements in accordance with all applicable state and federal regulations. NJAC 8:39-17.4(a)(1,2); 27.1 (a)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 40042 Based on interview, and review of pertinent facility documents, it was determined that the facility failed to serve and document residents received a nourishing snack in the evening when there was more than a 14-hour span between dinner and breakfast mealtimes. This deficient practice was identified for 8 of 8 (Resident's #9, #13, #15, #44, #49, #61, #73 and #80) residents during the resident council meeting and was evidenced by the following: On 1/24/25 at approximately 11:00 AM, the surveyor conducted a group meeting with eight residents who were alert and oriented and selected by the facility to participate. Seven out of eight residents stated they did not receive snacks in the evening. Two residents stated they were never offered evening snacks (Resident #13 and #61). On 1/29/25 at 11:30 AM, the surveyor interviewed the Divisional Director of Food Service Operations, who stated that if there was more than 14 hours between dinner and breakfast, the facility was required to provide the residents with a nourishing evening snack such as milk and half a sandwich. He acknowledged there was more than 14 hours between dinner and breakfast. He was unaware if there was an accountability system in place to ensure snacks were provided to the residents. On 1/29/25 at 11:50 AM, the surveyor interviewed the Registered Dietitian (RD) who stated that if there was more than 14 hours between dinner and breakfast, the facility was required to provide the residents with a nourishing evening snack . She acknowledged there was more than 14 hours between dinner and breakfast. The RD stated the kitchen provided snacks and there was accountability in the electronic medical record (EMR). On 1/29/25 at 12:41 PM, the surveyor interviewed the Licensed Practical Nurse / Unit Manager (LPN/UM) #1 on the Emerald unit (3rd floor), who stated she was not working when evening snacks were supposed to be delivered. In addition, she stated she was not sure if there was snack accountability unless there was a physician's order (PO) in the EMR. On 1/29/25 at 12:22 PM, the surveyor interviewed the LPN/UM #2 on the Diamond unit (1st floor) who stated the kitchen brought snacks to the pantry and when the nurses made rounds and if a resident was alert and oriented the nurse could provide a snack in the evening; however, she was not sure if there was documentation and accountability for the provision of snacks unless there was a PO. She further stated, snacks are not documented on all residents. On 1/29/25 at 12:52 PM, the surveyor interviewed the Registered Nurse #1 on the Sapphire unit (2nd floor), who stated he was not in the building when evening snacks were delivered, and he was not sure if there was accountability. He also stated that he was not sure if the nurses sign that snacks are sent from the kitchen as they do for meal trays. On 1/29/25 at 1:06 PM, the surveyor conducted a follow up interview with the Divisional Director of Food Service Operations. He was unsure how nurses document and account for snack delivery; however, he stated as of yesterday, the kitchen implemented a snack delivery form. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 1/30/25 at 9:20 AM, in the presence of the survey team, the Director of Nursing (DON) provided the surveyor with a copy of the tasks lists from the EMR for the residents who attended resident council and stated it did not include evening snack accountability. She stated, we do not record consumption of 9 PM snacks. On 1/30/25 at 3:49 PM, the surveyor interviewed the DON, in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. She stated that nurses documented the provision of evening snacks to diabetic residents in the EMR; however, she was unaware that the provision of evening snacks needed to be documented and accounted for as well. The DON stated, I did not recognize it was not being done. A review of the facility's undated FSD Job Description, included to collaborate with other departments and services to plan and implement patient care as necessary in meeting the nutritional needs of the patients. A review of the undated Clinical Dietitian Job Description, provided by the contracted company [name redacted] included to Monitor food service operations to ensure adherence to nutritional standards . and quality requirements in accordance with all applicable state and federal regulations. NJAC 8:39-17.2 (f))(1) (i) (ii)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41858 Complaint #: NJ 168006 Based on observations, interviews, record review and review of pertinent facility documents, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure staff, as well as himself, implemented the facility's abuse policies and procedures to ensure resident safety and well-being by ensuring a.) an allegation of rape was thoroughly investigated and reported to the New Jersey Department of Health (NJDOH) for Resident #155. This deficient practice was identified for 1 of 2 residents reviewed for abuse (Resident #155). 1. Resident #155, who was cognitively intact with diagnoses which included but not limited to; depression (a mental illness that can cause severe symptoms that affect a person's mood, thoughts, and daily activities) and heart failure (a condition in which the hear does not pump blood as well as it should). Resident #155 reported on 9/30/23, to the Registered Nurse (RN #1) an allegation of rape. RN #1 documented the allegation in the electronic medical record and reported the incident to the Registered Nurse Supervisor #1 and the Director of Nursing (DON) on 9/30/23. The facility did not implement their abuse policy to investigate and report the allegation. The facility's failure to ensure all staff, including the LNHA, implemented their facility policies to ensure all residents were free from abuse by not investigating and reporting an allegation of rape (Resident #155) posed a serious and immediate threat for abuse that can cause serious physical and emotional harm or impairment. This resulted in an Immediate Jeopardy (IJ) situation which the facility became aware of on 1/28/25 at 4:59 PM. Refer to F 600, F 609, F 610. This resulted in an IJ situation that began on 9/30/23, after Resident #155 reported to RN #1 an allegation of sexual abuse that they were raped, and the facility was aware of the allegation and did not report the incident to the NJDOH or investigate the allegation. The facility Administration was notified of the IJ on 1/30/25 at 4:59 PM. The facility submitted an acceptable Removal Plan (RP) on 1/31/25 at 10:32 AM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 1/31/25. The facility further failed to ensure b.) an allegation of neglect and intimidation was investigated and reported to the NJDOH in a timely manner when a cognitively intact resident made an allegation of not receiving a respiratory treatment as it was requested and was spoken to by staff in an intimidating manner. This deficient practice was identified for 1 of 2 residents reviewed for abuse (Resident #73). The evidence was as follows: Part A A review of the Administrator-Job Description provided by the facility revealed the following: (continued on next page)

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	315520	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Woods Rehabilitation & Nursing Center	780 Old New Brunswick Road Somerset, NJ 08873

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Position Summary: this position is responsible to establish and maintain systems that are efficient and effective to operate the nursing home in a manner to safely meet resident's needs in accordance with federal, state and local regulation. Also, develop and maintain systems that are effective and efficient to operate the facility in a financially sound manner. Essential Requirements, Duties, and Responsibilities: -Develop, maintain and implement operation policies and procedures to meet resident's need compliance with federal, state and local requirements. -Develop and enforce a monitoring program to assure compliance with federal, state, and local requirements. -Serve as a representative of the facility to residents, family and the general public. -Establish systems to enforce the facility policies and procedures. -Serve as an active member of all committees as appropriate. -Arbitrate complaints and disputes concerning residents, families or personnel. -Interpret all federal, state and local regulations for the facility staff. -Establish systems to ensure compliance with all federal, state, and local regulations. -Observe all facility policies and procedures. On 1/24/25 at 2:44 PM, the surveyor interviewed the DON in the presence of the survey team, regarding the allegation of rape by Resident #155. At that time, the DON stated the LNHA had already left for the day. The DON stated the police were called to the facility by the resident. The DON further stated she notified the LNHA the police were here. At that time, the DON stated she was not sure it (the allegation of rape) was a reportable event (to the NJDOH) as the resident did not return to the facility. The DON stated the allegation was made on a Saturday, and when she came in on Monday, the hospital's Social Worker (HSW) called her. The DON reported that the HSW stated the resident was not sexually assaulted. On 1/28/25 at 2:19 PM, the surveyor interviewed the Infection Prevention Nurse (IPN), who stated if a resident told you a concern, you told the Unit Manager and informed the DON or LNHA, and an investigation would occur. The IPN stated a grievance should be made available to the resident. The IPN stated it (the concern) would follow the chain of events, and then I would give a statement, and all parties involved would also need to give one, including the resident. The IPN added, he would go straight to the DON or LNHA, if the concern was mistreatment, he stated that was a serious situation because I believe they would have to report it to the state and start an official investigation. On 1/28/25 at 2:39 PM, the survey team interviewed the Activities Director (AD), who stated examples of abuse were physical, sexual, financial, emotional, restraining, withholding things and it should be reported to the DON. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/28/25 at 5:55 PM, the survey team met with the LNHA and the DON. The LNHA stated types of abuse were physical, sexual, verbal. The LNHA stated an allegation of sexual abuse was reason to suspect something happened and he should be notified as soon as possible. The LNHA stated, I would typically report before and do an investigation after. The LNHA added the DON had a soft file for Resident #155's allegation of abuse. The LNHA could not speak to why the facility did not follow their policy and use the forms in their policy. No evidence of an investigation was provided to the surveyors regarding the allegation of rape. The soft file was not provided to surveyors when previously asked for any investigation, grievance, reportable events. On 1/30/25 at 9:07 AM, the surveyor interviewed the Assistant Administrator (AA), who stated any type of abuse: verbal, physical, or sexual should be discussed with the LNHA and the DON, and it would be discussed as a team. The AA stated an investigation included to check on the resident, interview them and staff, reach out to the families, do a body assessment and call the police if warranted. The AA stated report any allegation of abuse to the NJDOH as soon as we find out an incident occurred. The AA stated, if a resident made a statement of rape, they should be assessed. The LNHA should be called and an investigation started. The AA stated she could not recall the above mentioned event. On 1/30/25 at 9:37 AM, the surveyor interviewed the Medical Director (MD), who stated he was not aware of the reason for the Immediate Jeopardy situation during the current survey. The MD stated he recently reviewed the abuse policy because he was asked to but he went through it quickly, because I thought it was routine. The MD added if staff called him regarding an allegation of abuse with a resident, he would have the resident sent to the hospital for evaluation and tell the staff to follow the facility's protocol for investigation. On 1/30/25 at 9:58 AM, the surveyor interviewed the LNHA and asked who was ultimately responsible for the building, he stated, I am as the administrator. I am expected to be notified everyday of anything going on in the building. My staff are instructed to make me aware of everything. I understand it to be my responsibility. The LNHA stated typically he would be notified right away, but if he was unavailable, the AA should field that call. The LNHA stated if staff left him a voicemail, it will also went to his email. The LNHA stated ultimately the DON knew what to do when he was not there and knew what should be reported. The LNHA stated, Monday morning anything that happened over the weekend, I expect my staff to tell me and make me aware. The LNHA stated he instructed his staff to keep soft files in case there was ever a question about an event, but he could not explain the purpose of keeping a soft file. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/30/25 at 10:15 AM, the surveyor interviewed the DON, regarding Resident #155's allegation. The DON stated, I knew right away who (which resident) they (the survey team) were asking about. The DON stated she received a phone call from RNS #1 to say the police came to the building and he notified the doctor. The DON stated she informed the LNHA or the AA. She could not recall if she reported the event to the LNHA. The DON stated she kept a soft file on the event in case there was a question, she added it was not part of the medical record. The surveyor asked was that not the purpose of an investigation, and the DON stated yes. The DON could not explain why she did not offer the soft file to the survey team during the interview on 1/24/25. The DON stated she normally discussed any significant events that happened over the weekend at the Monday morning meeting, which included all the department heads: the DON, the Assistant Director of Nursing (ADON), the LNHA, and the AA. When asked if an allegation of rape or if the police came to the building was a significant event, she stated yes. The DON stated, I cannot remember if I discussed it (the allegation of abuse and the police coming to the building) in morning meeting. On 1/30/25 at 12:22 PM, the surveyor interviewed the Director of Social Work (DSW), who stated the LNHA was the abuse officer. The DSW further stated that if she was aware of any type of abuse allegation, she would have addressed it in morning meeting and that the DON and LNHA would follow up immediately. On 1/31/25 at 10:31 AM, the surveyor interviewed the LNHA in the presence of the survey team. The LNHA acknowledged he was the abuse officer and it was his responsibility to ensure allegations of abuse were reported and fully investigated. The LNHA stated he was responsible to oversee this process and that it was done in accordance to the facility's abuse policy. An acceptable removal plan was received on 1/31/25 at 10:32 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: the Clinical Consultant and Governing Body educated the Administrator regarding Administration, and the abuse policy including; reporting abuse and conducting a thorough investigation to ensure resident's safety. The survey team verified the implementation of the removal plan during the continuation of the on-site survey and determined the IJ for F 835 was removed on 1/31/25. Part B Refer F 600, F 609, F 610 On 1/24/25 at 3:56 PM, the surveyor interviewed the Director of Nursing (DON) regarding an allegation of neglect and intimidation for Resident #73, the DON acknowledged that the Activities Director (AD) sent her an email regarding the allegation. The DON stated that the AD used the previous director's email, and she acknowledged that the subject indicated 1/14 Resident Council. The DON stated, I just didn't get a chance to see that. The DON also stated that the Licensed Practical Nurse/Unit Manager (LPN/UM #1) denied awareness of the incident, and that the resident had no history of making accusatory or inaccurate statements. The DON stated the AD should have brought this to her attention immediately. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/28/25 at 2:39 PM, the survey team interviewed the AD, who stated examples of abuse were physical, sexual, financial, emotional, restraining, withholding things and it should be reported to the DON. On 1/28/25 at 3:32 PM, the surveyor interviewed LPN/UM #1, who stated that if a resident stated they rang the call bell for help and did not receive it, she would interview the staff identified and report this to the DON and LNHA. LPN/UM #1 stated that if staff denied the allegation, she reassured the resident and still reported it to the LNHA. LPN/UM #1 stated, she reported all incidents to the DON. On 1/28/25 at 5:55 PM, the survey team met with the LNHA and the DON. The LNHA stated types of abuse were physical, sexual, verbal. The LNHA stated an allegation of sexual abuse was reason to suspect something happened and he should be notified as soon as possible. The LNHA stated, I would typically report before and do an investigation after. On 1/30/25 at 9:07 AM, the surveyor interviewed the Assistant Administrator (AA), who stated any type of abuse: verbal, physical, or sexual should be discussed with the LNHA and the DON, and it would be discussed as a team. The AA stated an investigation included to check on the resident, interview them and staff, reach out to the families, do a body assessment and call the police if warranted. The AA stated report any allegation of abuse to the NJDOH as soon as we find out an incident occurred. On 1/30/25 at 9:58 AM, the surveyor interviewed the LNHA and asked who was ultimately responsible for the building, he stated, I am as the administrator. I am expected to be notified everyday of anything going on in the building. My staff are instructed to make me aware of everything. I understand it to be my responsibility. The LNHA stated typically he would be notified right away, but if he was unavailable, the AA should field that call. The LNHA stated if staff left him a voicemail, it will also went to his email. The LNHA stated ultimately the DON knew what to do when he was not there and knew what should be reported. On 1/30/25 at 12:22 PM, the surveyor interviewed the Director of Social Work (DSW), who stated the LNHA was the abuse officer. The DSW further stated that if she was aware of any type of abuse allegation, she would have addressed it in morning meeting and that the DON and LNHA would follow up immediately. On 1/30/25 3:49 PM, the surveyor interviewed the DON and LNHA in the presence of the survey team. The LNHA stated he would have expected the AD to go directly (physically) to the DON with Resident #73's allegation brought up at Resident Council and that email communication was not typical procedure. The LNHA stated that he addressed this with the AD and the AD stated he did not feel it was abuse. The DON stated that in the past, the AD reported concerns to her verbally. In addition, she stated she was the only department the AD emailed, and not the LNHA as well. The LNHA stated that he was shocked. On 1/30/25 at 4:19 PM, in the presence of the survey team, the LNHA stated that the AD did not feel like the resident was intimidated. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 1/31/25 at 10:31 AM, the surveyor interviewed the LNHA in the presence of the survey team. The LNHA acknowledged he was the abuse officer and it was his responsibility to ensure allegations of abuse were reported and fully investigated. The LNHA stated he was responsible to oversee this process and that it was done in accordance to the facility's abuse policy. NJAC 8:39-9.2(a) NJAC 8:39-9.3(a) NJAC 8:39-27.1(a)