STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315528	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jewish Home for Rehabilitation and Nursing, The	1151 West Main Street Freehold, NJ 07728

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to report to the State Survey Agency (SSA) an allegation of physical abuse and an injury of unknown source in a timely manner for two of three residents (Resident (R) 10 and R2) reviewed for Abuse of 24 sample residents. This failure had the potential to affect resident safety at the facility. Findings include: Review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised 09/22 revealed, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/ licensing the facility . 'immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury . 1. Review of R10's admission Record located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE]. Review of R10's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/02/24 and located in the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the interview. The resident was marked as severely impaired in cognition. Review of the abuse investigation, provided by the facility, revealed an incident dated 09/11/24 at 12:00 PM. The allegation was reported on 09/24/24 at 11:00 AM. The investigation revealed that Caring Partner (CP) 2 stated that on 09/11/24, she observed a Certified Nurse Aide (CNA) 1 pinching the hand of R10. It was documented that the CP2 did not report it to anyone further because she figured the Licensed Practical Nurse (LPN) 2 would report it and did not think anyone would believe her if she brought it forward. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/24/25 at 2:19 PM, the Director of Nursing (DON) stated there was an allegation from CP2 that CNA1 pinched a resident, and another LPN2 had witnessed the interaction. She stated the LPN2 denied witnessing any abuse. She stated the incident was reported to have occurred on 09/11/24 but CP2 did not report it to her until 09/24/24. She stated CP2 did not think anyone would believe her, so she reported it late. 2. Review of R2's admission Record in the Electronic Medical Record (EMR) indicated that R2 was admitted to the facility on [DATE]. Review of facility provided Reportable Event Record/Report dated 6/12/23 indicated, .on 06/09/23 at 4:45 PM the nurse supervisor was notified by the resident's spouse that R2 had some hand swelling. The nurse supervisor came to assess and noted that R2's right hand and right thumb swollen and slightly bruised. No complaint of pain upon assessment .On 06/12/23, the resident was reassessed, and the hand was still slightly bruised and swollen .Resident unable to provide an explanation of what happened to his/her hand. Review of facility provided Summary of Investigation dated 06/12/23 indicated, .Investigation: The resident was unable to offer an explanation related to cognitive impairment secondary to dementia. The resident is care planned for behaviors related to dementia including being resistant to care During an interview on 02/26/25 at 11:58 AM, the DON indicated that when staff became aware of the injury of unknown origin, it should have been reported to the SSA. She confirmed R2's injury was reported by the Administrator to the SSA late. Review of a document titled AAS-45 provided by the facility revealed that R2's injury was report to the SSA on 06/12/23 at 3:48PM.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policy, the facility failed to ensure that one of two residents (Resident (R) 4) reviewed out of a sample of 24 received their medications as ordered by the physician. This failure has the potential for R4 not to get the full benefit of her medication. Findings include: Review of the facility's policy titled, Administering Medications dated April 2019 indicated, .Medications are administered in accordance with prescriber orders, including any required time frame. Review of R4's admission Record in the Electronic Medical Record (EMR), under the Census tab indicated that R4 was re-admitted to the facility on [DATE] with a diagnosis of chronic pain syndrome, and rheumatoid arthritis (RA). Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/28/25 indicated a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R4's cognition was moderately impaired. Review of R4's Nursing Note dated 01/17/24 located under the Note tab revealed, R4 received incorrect dosage of fentanyl patch on 01/15/24. R4 is ordered to receive Fentanyl 12mcg, as well as Fentanyl 50mcg, for a total of 62mcg every 72 hours. During medication administration, Registered Nurse (RN) misread order and only administered Fentanyl 12mcg patch. Upon identifying that dosage was administered incorrectly, R4 was assessed for increased pain and denied any increase in pain. Review of facility provided Order Summary Report dated 02/25/25 indicated, . Fentanyl patch 72 Hour 50 microgram per hour (MCG/HR), apply one patch transdermal every 72 hours for pain. Give with 12 mcg to equal 62 mcg, starting 01/12/24; and Fentanyl transdermal patch 72 Hour 12 MCH/HR, apply 12 mcg transdermally every 72 hours for pain, give with 50 mcg to equal 62 mcg, starting 12/31/23. Review of facility provided Medication Administration Record (MAR) for January 2024 indicated the Fentanyl transdermal patch 50 mcg/hr was not applied to R4 on 1/15/24. Review of the facility provided Grievance Report dated 1/18/24 revealed, On 1/17/24 it was discovered that R4 did not receive one of her Fentanyl patches on 01/15/24 .Unit Manager (UM) stated that when resident discharged to the hospital, resident was noted to only have 12 mcg fentanyl patch on. Interview on 02/26/25 at 10:30 AM, the Director of Nursing (DON) confirmed that the RN was unaware of the 50-mcg physician order for the Fentanyl patch and thought it was a duplicate order, which was the reason she did not apply it. The DON stated she expects that the medications are given as ordered.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that thorough incontinence care was provided for two (Resident (R) 6 and R7) residents out of a sample of 24 residents. This failure has the potential to cause urinary tract infections (UTI) if inappropriate care was provided. Findings include: 1. Review of R7's admission Record in the Electronic Medical Record (EMR) under Census tab indicated that R7 was re-admitted to the facility on [DATE] with a diagnosis of major depressive disorder and muscle wasting. Review of the admission Minimum Data Set (MDS) with assessment reference date (ARD) of 02/04/25 indicated that R7 was always incontinent of bladder. Further, the MDS revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated that R7 was cognition was moderately impaired. During R7's incontinence care observation on 02/25/25 at 5:39 AM, Certified Nursing Assistant (CNA) 2 donned gloves after washing his hands. CNA2 removed R7's soiled brief, did not doffed gloves and applied clean gloves. CNA2 took a washcloth and washed R7's front perineal area in a circular motion several times; however, CNA2 did not wash R7's genitals. CNA2 did not rinse nor dry R7. R7 started to urinate so CNA2 obtained R7's urinal off the nightstand. After R7 finished urinating, without changing gloves and performing hand hygiene, CNA2 finished incontinence care and placed cream on R7's perineal area. CNA2 assisted R7 to his/her right side and applied cream to R7's buttocks area without washing the buttocks area first. CNA2 doffed the gloves but did not perform hand hygiene. CNA2 donned clean gloves and assisted R7 to roll over to his/her left side to adjust his/her brief and turned R7 back to his/her back. CNA2 exited R7's room without performing hand hygiene. Interview on 02/25/25 at 6:18 AM, CNA2 stated that the facility uses no rinse soap. When asked about how incontinence care was to be provided, CNA2 was unable to state the procedure. 2. Review of R6's admission Record in the EMR under Census tab indicated that R6 was admitted to the facility on [DATE] with a diagnosis of Urinary Tract Infection (UTI). During R6's incontinence care observation on 02/25/25 at 6:06 AM, CNA3 donned gloves after entering R6's room. CNA3 assisted R6 to his/her right side, removed the soiled bowel movement (BM) brief. Without soap, CNA3 wiped R6's buttocks area with a wet towel. CNA3 did not dry R6's buttocks; however, applied a cream to R6's buttocks area. CNA3 did not wash R6's front perineal area. CNA3 placed linen in a bag and placed a new brief on R6 before leaving the room. Review of R6's admission MDS with an ARD of 02/10/25 indicated that R6 was always incontinent of bladder and is not eligible for a toileting program. Further indication revealed that R6 has a BIMS score of 15 out of 15, which indicated R6 was cognitively intact. Interview on 02/26/25 at 9:30 AM, the Infection Preventionist (IP) confirmed that during incontinence care, nursing staff are to wash the resident's front genital area and the buttocks area. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/26/25 at 10:15 AM, the Director of Nursing (DON) confirmed that she expected staff to wash all of the resident's genital area and the buttocks.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and facility policy review, the facility failed to ensure a medication error rate of less than five percent. During observation of medication pass, there were six medication errors observed out of 29 opportunities, resulting in a 20.69% error rate. This had the potential to place three residents (Residents (R) 4, R8, and R9) at risk of not receiving the full benefit of their medication therapy. Findings include: Review of facility policy titled, Administering Medications, revised April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation .4. Medications are administered in accordance with prescriber orders, including any required time frame . 7. Medications are administered within one (l) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . 22. The individual administering the medication initials the resident's MAR [Medication Administration Record] on the appropriate line after giving each medication and before administering the next ones. Review of R4's admission Record in the Electronic Medical Record (EMR) under the Census tab indicated that R4 was re-admitted to the facility on [DATE] with a diagnosis of hypophosphatemia (low blood phosphate). On 02/25/25 at 11:55 AM, Licensed Practical Nurse (LPN)3, prepared medication for R4, which included Phos-Nak powder (phosphate supplement medication) to be given three times a day (TID) with meals. After LPN3 obtained all the medications needed for R4, she administered the medications. R4 was observed sitting up in his/her bed waiting on his/her lunch tray, which had not arrived yet. Review of facility provided Order Summary Report dated 02/25/25 indicated, Potassium and Sodium Phosphates Oral Packet 280-160-250 milligrams (mg), give one packet by mouth (PO) TID for prevent hypophosphatemia, started 01/21/25. Interview on 02/26/25 at 2:34 PM, LPN3 indicated that R4 usually gets all his/her medications around 12:30 PM to eat. 2. Review of R8's admission Record in the EMR, under the Census tab, indicated that R8 was admitted to the facility on [DATE] with a diagnosis of acid indigestion, edema, and atrial fibrillation. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/25 at 8:29 AM, Registered Nurse (RN) 2 prepared R8's medication which included omeprazole (medication for acid indigestion) 40 mg to be given at least half hour prior to meals according to medication blister package. In addition, RN2 had prepared Eliquis (medication for atrial fibrillation) 2.5 mg. RN2 popped two Eliquis medication which she was unaware of and continued to prepare zinc (supplement medication) 50 mg one tablet from over-the-counter medication. When RN2 finished and agreed that was all the medication she was going to give at this time, surveyor had RN2 to count the medications at her medication cart prior to entering R8's room. As RN2 went through the medications a second time, revealed there was only one zinc tablet in the medication cup with an extra Eliquis tablet. There was no furosemide 20 mg in the cup. At this time, RN2 stated that R8 only gets one pill of Eliquis not two and that R2 receives two tablets of zinc. Upon entering R8's room, R8 had eaten breakfast. Review of facility provided Blister Package indicated furosemide 20 mg, give one tablet by mouth daily for edema. Review of facility provided Blister Package indicated omeprazole 40 mg give one capsule by mouth daily for acid indigestion. Give at least half an hour prior to meals. Do not crush or chew. Review of facility provided Blister Package indicated Eliquis 2.5 mg give one tablet by mouth two times a day (BID) for a-fib[atrial fibrillation]. Review of facility provided Medication Administration Audit Report dated 02/25/25 indicated, omeprazole 40 mg, scheduled at 8:00 AM; zinc 50 mg give two capsules BID for wound healing, scheduled at 9:00 AM; furosemide 20 mg scheduled at 9:00 AM, and Eliquis 2.5 mg scheduled at 9:00 AM. Interview on 02/26/26 at 12:29 PM, RN2 confirmed that omeprazole should have been given prior to meals and that it was not. 3. Review of R9's admission Record in the EMR, under the Census tab, indicated that R9 was re-admitted to the facility on [DATE] with a diagnosis of wound healing. On 02/25/25 at 9:37 AM, LPN1 prepared R9's medication (Amiodarone 200 milligram (mg) one tablet, Wellbutrin 150 mg one tablet, Midodrine 10 mg one tablet, Multivitamin one tablet, Vitamin C 500 mg one tablet and Plavix 75 mg one tablet) for R9 and stated that these were all of the medications at this time for R9. LPN1 gave R9 the medications however, LPN1 omitted zinc 100 mg. Review of facility provided Order Summary Report, dated 02/25/25, indicated, zinc 100 mg PO [by mouth] BID [twice per day] for wound healing for 14 days, starting 02/18/25. This medication was omitted during medication observation with LPN1. Review of facility provided Medication Administration Audit Report dated 02/25/25 indicated, zinc 100 mg BID (9:00AM and 5:00PM) for wound healing, scheduled at 9:00 AM and administered at 11:04 AM. Interview on 02/26/25 at 12:43 PM, LPN1 confirmed that zinc was not given with the other medication as ordered. LPN1 confirmed that she gave the zinc medication later. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/26/25 at 2:24 PM, the Director of Nursing (DON) confirmed that she expects all nurses to pass medications according to physician orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, policy review, and interviews, the facility failed to ensure that staff changed gloves when going from a dirty area to a clean area during incontinence care for two of two resident (Resident (R) 6 and R7) and for one of one resident (R4) during suprapubic catheter care, to prevent possible cross contamination in a sample of 24. In addition, the facility failed to ensure that staff wore personal protective equipment (PPE) during incontinence care for one resident (R6) that was on enhanced barrier precaution (EBP). This failure has the potential to spread multi-drug-resistant organisms (MDROs) throughout the facility and/or has the potential to increase urinary tract infections (UTI). Findings include: Review of the facility's policy titled, Standard Precautions, revised September 2022, indicated, Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents .Gloves are changed and hand hygiene performed before moving from a contaminated body site to a clean-body site during resident care. Review of the facility's policy titled, EBP revised March 2024 indicated, EBP are utilized to reduce the transmission of MDROs to residents. Policy Interpretation and Implementation . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . f. changing briefs or assisting with toileting .g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) . 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. a. Wounds generally include chronic wounds (i.e. pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears. b. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies. Peripheral intravenous (IV) catheters are not considered an indwelling medical device for purposes of EBPs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's admission Record in the Electronic Medical Record (EMR), under the Census tab indicated that R4 was re-admitted to the facility on [DATE] with diagnoses of obstructive uropathy and neurogenic bladder. During suprapubic catheter care observation on 02/25/25 at 12:10 PM, Licensed Practical Nurse (LPN)3 applied PPE, gloves, mask and gown, prior to entering R4's room. LPN3 performed hand hygiene and donned her gloves then proceeded to wipe down the overbed table. Wearing the same gloves, LPN3 washed around R4's suprapubic catheter. LPN3 took a wipe, and vigorously wiped the catheter tubing, then LPN3 placed a new dressing around the suprapubic catheter. At this point, LPN3 emptied R4's catheter bag, while wearing the same gloves. LPN3 removed her gloves and performed hand hygiene prior to exiting the room. Interview on 02/25/25 at 12:25 PM, LPN3 indicated that gloves should be changed at least three times during catheter care change. LPN3 confirmed that she did not change her gloves and perform hand hygiene and she should have. 2. Review of R6's admission Record in the EMR, under Census tab, indicated that R6 was admitted to the facility on [DATE] with a diagnosis of UTI. During R6's incontinence care observation on 02/25/25 at 6:06AM, R6 was on EBP for a wound to the sacrum. PPE was outside the room. Certified Nursing Assistant (CNA)3 did not perform hand hygiene or apply a gown prior to entering R6's room. CNA3 donned gloves after entering R6's room. CNA3 removed R6's soiled brief, which contained bowel movement (BM), wiped R6's buttocks and applied a cream to the buttocks area wearing the same gloves. CNA3 placed a new brief on R6. CNA3 gathered all the items prior to leaving the room, removed his gloves; however, did not perform hand hygiene after leaving the room. 3. Review of R7's admission Record in the EMR under the Census tab indicated that R7 was re-admitted to the facility on [DATE] with a diagnosis of major depressive disorder and muscle wasting. During R7's incontinence care observation on 02/25/25 at 5:39 AM, CNA2 donned gloves after performing hand hygiene. CNA2 removed R7's soiled brief and washed R7's front perineal area. Without doffing her gloves, CNA2 obtained R7's urinal off the nightstand and held the urinal while R7 urinated. CNA2 took the urinal to the bathroom and washed it out then returned it to R7's nightstand. CNA2 finished incontinence care wearing the same gloves and applied cream to R7's perineal area. CNA2 assisted R7 to roll over to his/her right side, placed a new brief and applied cream to R7's buttocks. CNA2 changed his/her gloves and did not perform hand hygiene. CNA2 assisted R7 to his/her left side to adjust the brief, then turned R7 to his/her back. CNA2 left R7's room, without performing hand hygiene. Interview on 02/25/25 at 6:18 AM, CNA2 stated that gloves were to be changed every time something was done; however, was not able to state if he changed his gloves or not. Interview on 02/26/25 at 9:30 AM, the Infection Preventionist (IP) confirmed that gloves are to be changed when going from a dirty area to a clean area and PPE is to be worn when caring for residents that have wounds and/or catheters. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/26/25 at 10:15 AM, the Director of Nursing (DON) confirmed that she expects staff to change gloves when going from a dirty area to a clean area. Also, she expects staff to wear PPE for any resident that has a wound, catheter, and/or any other external device while completing incontinence care.