| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315528 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/26/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| JEWISH HOME FOR REHABILITATION AND NURSING, THE | 1151 WEST MAIN STREET , FREEHOLD, New Jersey, 07728 |

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| F0000 | INITIAL COMMENTS<br><br>Complaint #'s: NJ00167590, NJ00175597, NJ00167530, NJ00179154, NJ00182605, NJ000171806, NJ00178325, NJ00177563, NJ00172514, NJ00170716<br><br>Survey Dates: 02/24/25 through 02/26/25<br><br>Survey Census: 146<br><br>Sample Size: 24<br><br>THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. | F0000 | | |
| F0609<br>SS = D | Reporting of Alleged Violations<br><br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations | F0609 | Resident R10 no longer resides at the facility. The Caring Partner that made the [NJ Exec Order 26.4] was [NJ Exec Order 26.4b] for failure to follow our [NJ Exec Ord] policy. The Caring Partner was brought back to work after the conclusion of the investigation and reeducated on the [NJ Exec Ord] policy and timely reporting. Currently, the caring partner is no longer employed at the facility.<br><br>Resident R2 no longer resides at the facility. The nursing supervisor who assessed the resident s [NJ Ex Orde] was reeducated on the facilities [NJ Exec Ord] policy and timely reporting.<br><br>All residents have the potential to be affected.<br><br>The DON/designee reviewed the facility grievances and incident reports for the last 30 days to validate findings that meet the requirement of abuse reported, resident safeguarded, and the allegation was thoroughly investigated. No variances identified.<br><br>The director of nursing/designee educated all staff on facility abuse policy to include types of abuse/neglect but not limited to physical abuse, the resident s right to be free from abuse, identification, the need to | 03/15/2025 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0609 SS = D | Continued from page 1<br>to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, interviews, and facility policy review, the facility failed to report to the State Survey Agency (SSA) an NJ Exec Order 26.4 of NJ Exec Order 26.4b1 and an NJ Exec Order 26.4b1 in a timely manner for two of three residents (Resident (R) 10 and R2) reviewed for NJ Exec Orde of 24 sample residents. This failure had the potential to affect resident safety at the facility.<br><br>Findings include:<br><br>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 ..."<br><br>1. Review of R10's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR) revealed the resident was admitted on NJ Ex Order 26, 4B<br><br>Review of R10's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Ex Order 26, 4B and located in the "MDS" tab of the EMR revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Ex which indicated the resident was NJ Exec Order 26.4b1 The resident was marked as NJ Exec Order 26 NJ Ex Order 26, 4B<br><br>Review of the 'NJ Ex Order 26, 4B1," provided by the facility, revealed an incident dated NJ Ex Order 26, 4B1 The NJ Ex Order 26.4b was reported on NJ Ex Order 26, 4B1 | F0609 | Continued from page 1<br>safeguard the resident, and reporting requirements and implementing interventions to protect all residents from abuse.<br><br>An audit of five random residents was completed for care/safety concerns to include staff interactions daily for seven days, weekly for four weeks, then monthly for two months.<br><br>An audit of the effectiveness of staff training will be conducted via random interviews daily for seven days, weekly for four weeks, then monthly for two months.<br><br>The Administrator will submit the findings from the audits to the Quality Assurance Performance Improvement committee meeting monthly for further review and additional recommendations as needed. Further audit frequency will be determined based on audit findings. The Administrator is responsible for the execution of this plan and the management/monitoring for ongoing compliance. | |

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| F0609 SS = D | Continued from page 2<br>NJ Ex The investigation revealed that Caring Partner (CP) 2 stated that on NJ Ex Order 26, 4, she observed a Certified Nurse Aide (CNA) 1 NJ Ex Order 26, 4B1 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.<br><br>During an interview on 02/24/25 at 2:19 PM, the U. S. FOIA (b) (2) ) stated there was an NJ Exec Order 26,4 from CP2 that CNA1 NJ Ex Order 26,4 a resident, and another LPN2 had witnessed the interaction. She stated the LPN2 NJ Exec Orde witnessing any NJ Exec Orde She stated the incident was reported to have occurred on NJ Ex Order 26, 4B but CP2 did not report it to her until NJ Ex Order 26,4 . She stated CP2 did not think anyone would believe her, so she reported it late.<br><br>2. Review of R2's "Admission Record" in the Electronic Medical Record (EMR) indicated that R2 was admitted to the facility on NJ Ex Order 26, 4B .<br><br>Review of facility provided "Reportable Event Record/Report" dated NJ Ex Order 26, indicated, " ...on NJ Ex Order 26, 4B1 the nurse supervisor was notified by the resident's NJ Exec Order that R2 had some NJ Exec O NJ Exec Order 26 The nurse supervisor came to assess and noted that R2's NJ Ex Order 26, 4B1 . No NJ Ex Order 26, 4B1 upon assessment ...On NJ Exec Order 26, the resident was reassessed, and the NJ Ex Order 26, 4B1 ...Resident NJ Exec Orde to provide an explanation of what happened to NJ Ex Order 26, 4B1 . "<br><br>Review of facility provided "Summary of Investigation" dated NJ Ex Order 26, 4B indicated, " ...Investigation: The resident was unable to offer an explanation related to NJ Ex Order 26, 4B1 . The resident is care planned for NJ Exec Order 26,4 related to NJ Ex Order 26, 4B including being NJ Exec Order 2 to care ...."<br><br>During an interview on 02/26/25 at 11:58 AM, the U. S. FOIA indicated that when staff became aware of the NJ Ex Orde of NJ Ex Order 26, 4B1 , it should have been reported to the U.S. FOIA She confirmed R2's NJ Exec O was reported by the U. S. FOIA (b) (2) to the U.S. FOIA late.<br><br>Review of a document titled "AAS-45" provided by the | F0609 | | |

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| F0609 SS = D | Continued from page 3<br>facility revealed that R2's injury was report to the SSA on 06/12/23 at 3:48PM. | F0609 | | |
| F0684 SS = D | Quality of Care<br><br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br><br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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 [redacted] medication.<br><br>Findings include:<br><br>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."<br><br>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 [redacted] with a diagnosis of NJ Ex Order 26, 4B1 [redacted]<br><br>Review of R4's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] indicated a "Brief Interview for Mental Status (BIMS)" score of [redacted], which indicated R4's [redacted].<br><br>Review of R4's "Nursing Note" dated [redacted] located under the "Note" tab revealed, "R4 received incorrect dosage of NJ Ex Order 26, 4B1 [redacted]. R4 is ordered to receive [redacted], as well as [redacted], for | F0684 | Resident R4 was, at the time, evaluated for [redacted] and error was rectified at the time, resident received the [redacted] as prescribed. The facility completed an internal review of the medication variance with resident s physician and resident representative notification were completed.<br><br>All residents that are receiving a fentanyl patch have the potential to be affected.<br><br>An audit was completed on all residents receiving fentanyl patches with no additional variances identified.<br><br>The director of nursing/designee will educate the nursing staff on residents who are prescribed multiple fentanyl patches to monitor placement of both fentanyl patches for integrity and placement q shift.<br><br>Audit of residents receiving multiple fentanyl patches will be completed weekly for four weeks, then monthly for two months. Audit will include residents who are prescribed multiple fentanyl patches to monitor placement of both fentanyl patches for integrity and placement q shift.<br><br>The Director of Nursing will submit the findings from the audits to the Quality Assurance Performance Improvement committee meetings monthly for further review and additional recommendations as needed. Further audit frequency will be determined based on audit findings. The director of nursing is responsible for the execution of this plan and the management/monitoring for ongoing compliance. | 03/15/2025 |

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| F0684 SS = D | Continued from page 4<br>a total o[NJ Ex Order 26, 4B1]. During medication administration, [U. S. FOIA (b) (2)]) misread order and only administered[NJ Ex Order 26, 4B1]. Upon identifying that dosage was administered incorrectly, R4 was assessed for [NJ Exec Order 26.4b1] [NJ Exec] and [NJ Exec Orde] any [NJ Exec Order 26] in [NJ Exec Ord]<br><br>Review of facility provided "Order Summary Report" dated [NJ Ex Order 26, 4B] indicated, " ... [NJ Ex Order 26, 4B1] Give [NJ Ex Order 26, 4B1] [NJ Ex Order 26, 4B1], starting [NJ Ex Order 26, ]; and [NJ Ex Order 26, ], apply [NJ Ex Order 26], give with [NJ Ex Order 26]<br><br>Review of facility provided "Medication Administration Record (MAR)" for [NJ Ex Order 26, 4B1] indicated the [NJ Ex Order 26, ] was not applied to [NJ Ex ] on [NJ Ex Order 26,]<br><br>Review of the facility provided "Grievance Report" date[NJ Ex Order 26] revealed, "On [NJ Ex Order 26] it was discovered that R4 did not receive [NJ Ex Order 26, 4B1] on [NJ Ex Order 26, ] .. [U. S. FOIA (b) (2)]) stated that when resident discharged [NJ Ex Order 26, 4B1], resident was noted to only have [NJ Ex Order 26, 4B1]. "<br><br>Interview on 02/26/25 at 10:30 AM, the [U. S. FOIA (b) (2)]) confirmed that the [U. S.] was unaware of the [NJ Ex Order 26] physician order for the [NJ Ex Order 26, 4B1] and thought it was a duplicate order, which was the reason she did not apply it. The [U. S. FOIA] stated she expects that the medications are given as ordered. | F0684 | | |
| F0690 SS = D | Bowel/Bladder Incontinence, Catheter, UTI<br><br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br><br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the | F0690 | Residents R7 and R6 were evaluated for any [NJ Exec Order 2] were noted.<br><br>All residents that are incontinent have the potential to be affected.<br><br>Audits were completed on 5 residents during [NJ Exec Order 26.4b1] care by the IP nurse, no deficient practice was noted.<br><br>The IP nurse/designee will educate all nursing staff on proper perineal care. | 03/15/2025 |

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| F0690 SS = D | Continued from page 5<br>facility must ensure that-<br><br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br><br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br><br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, interviews, and record review, the facility failed to ensure that thorough [redacted] 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 [redacted] if inappropriate care was provided.<br><br>Findings include:<br><br>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 [redacted] with a diagnosis of [redacted]<br><br>Review of the admission "Minimum Data Set (MDS)" with assessment reference date (ARD) of [redacted] indicated that R7 was always [redacted]. Further, the "MDS" revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] which indicated that R7 was [redacted] was [redacted].<br><br>During R7's [redacted] observation on [redacted] | F0690 | Continued from page 5<br>The IP nurse/designee will complete 1 perineal competency on 1 employee q shift for 1 week, then daily for 3 weeks, then 3 random employees weekly for 4 weeks, and then 10 employees monthly for 2 months. The IP nurse/designee will submit the findings from the audits to the Quality Assurance Performance Improvement committee meeting monthly for further review and additional recommendations as needed. Further audit frequency will be determined based on audit findings. | |

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| F0690 SS = D | Continued from page 6<br>at 5:39 AM, Certified Nursing Assistant (CNA) 2 donned gloves after washing his hands. CNA2 removed R7's NJ Ex Order 26, 4B1, did not doffed gloves and applied clean gloves. CNA2 took a washcloth and washed R7's NJ Ex O NJ Ex Order 26, 4B1 in a circular motion several times; however, CNA2 did not wash R7's NJ Ex Order 26. CNA2 did not NJ Ex Order 26, 4B1 R7. R7 NJ Ex Order 26, 4B1 so CNA2 obtained R7's NJ Ex Order 26, f the nightstand. After R7 NJ Ex Order 26, 4B1, without changing gloves and performing hand hygiene, CNA2 finished NJ Ex Order 26, 4B1 care and NJ Ex Order 26, 4B1 on R7's NJ Ex Order 26, 4B1. CNA2 assisted R7 to his/her NJ Ex Order 26, 4B and NJ Ex Order 26, 4B1 to R7's NJ Ex Order 26, 4B1 without NJ Ex Order 26, 4B1 NJ Ex Or CNA2 doffed the gloves but did not perform hand hygiene. CNA2 donned clean gloves and assisted R7 to roll over to his/her NJ Ex Order 26, 4B1 and turned R7 back to his/her back. CNA2 exited R7's room without performing hand hygiene.<br><br>Interview on 02/25/25 at 6:18 AM, CNA2 stated that the facility uses no rinse soap. When asked about how NJ Ex Order 26, 4B1 was to be provided, CNA2 was unable to state the procedure.<br><br>2. Review of R6's "Admission Record" in the EMR under "Census" tab indicated that R6 was admitted to the facility on NJ Ex Order 26, 4B with a diagnosis of NJ Ex Order 26, 4B1 .<br><br>During R6's NJ Exec Order 26.4b1 care observation on 02/25/25 at 6:06 AM, CNA3 donned gloves after entering R6's room. CNA3 assisted R6 to NJ Ex Order 26, 4B1 NJ Ex Order 26, 4 . Without soap, CNA3 NJ Ex Order 2 R6's NJ Ex Order 26, 4B1 . CNA3 NJ Ex Order 26, 4B1 R6's NJ Ex Order 26, 4 ; however, NJ Ex Order 26, 4B1 to R6's NJ Ex Order 26, 4B1 . CNA3 NJ Ex Order 26, 4B1 R6's NJ Ex Orde CNA3 placed linen in a bag and placed a NJ Ex Order 26, 4B1 R6 before leaving the room.<br><br>Review of R6's admission "MDS" with an ARD of NJ Ex Order 26, 4B indicated that R6 was always NJ Ex Order 26, 4B1 and is NJ Ex Order 26, 4B1 . Further indication revealed that R6 has a "BIMS" score of NJ Ex , which indicated R6 was NJ Ex Order 26, 4B1 .<br><br>Interview on 02/26/25 at 9:30 AM, the U. S. FOIA (b) (2) confirmed that during NJ Ex Order 26, 4B1 , nursing staff are to wash the resident's NJ Ex Orde NJ Ex Order 26, 4B1 and the NJ Ex Order 26, 4B1 | F0690 | | |

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| F0690 SS = D | Continued from page 7<br><br>Interview on 02/26/25 at 10:15 AM, the [U. S. FOIA (b) (2)] [redacted] confirmed that she expected staff to wash all of the resident's [NJ Ex Order 26, 4B1] [redacted]. | F0690 | | |
| F0759 SS = D | Free of Medication Error Rts 5 Prcnt or More<br><br>CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>Findings include:<br><br>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."<br><br>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 [NJ Ex Order 26, 4] [redacted] with a diagnosis of [NJ Ex Order 26, 4B1] [redacted] | F0759 | Residents R4, R8, and R9 were evaluated for [NJ Exec Order 2] [redacted] were identified. The facility completed an internal review of the medication variance with the resident s physicians and residents representatives were notified.<br><br>All residents have the potential to be affected.<br><br>Medications administration competencies were completed on the LPNs administering medications to residents R4, R8, and R9. The LPNs were re-educated on policy related to medication administration and documentation of medication administration, inclusive to medications that are ordered to be given before meals and with meals.<br><br>Al[U. S. FOIA (b) (2)] staff were re-educated by the [U. S. FOIA (b) (2)] on the policy related to medication administration and documentation of medication administration, inclusive to medications that are ordered to be given before meals and with meals.<br><br>The Director of Nursing/designee will complete a medication administration competency on 1 random licensed nurse daily x 1 week, then 3 random licensed nurses weekly x 3 weeks, then will complete 5 random licensed nurses per month x 2 months. The results of the audits will be submitted to the QAPI Committee monthly for 3 months for review and recommendations as needed. Further audit frequency will be determined based on audit findings. | 03/15/2025 |

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|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| JEWISH HOME FOR REHABILITATION AND NURSING, THE | 1151 WEST MAIN STREET , FREEHOLD, New Jersey, 07728 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F0759 SS = D | Continued from page 8<br>NJ Ex Order 26.4(b)(1)<br><br>On 02/25/25 at 11:55 AM, Licensed Practical Nurse (LPN)3, prepared medication for R4, which included NJ Ex Order 26, 4B1 ) to be NJ Ex Order 26, 4B1 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.<br><br>Review of facility provided "Order Summary Report" dated NJ Ex Order 26, 4 indicated, 'NJ Ex Order 26, 4B1 for NJ Ex Order 26 , started NJ Ex Order 26, 4 ."<br><br>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.<br><br>2. Review of R8's "Admission Record" in the EMR, under the "Census" tab, indicated that R8 was admitted to the facility on NJ Ex Order 26, 4B with a diagnosis of NJ Ex O<br><br>On 02/25/25 at 8:29 AM, Registered Nurse (RN) 2 prepared R8's medication which included NJ Ex Order 26, 4B1 to be given at least NJ Ex Order 26, 4B1 according to medication blister package. In addition, RN2 had prepared NJ Ex Order 26 NJ Ex Order 26, 4B1 RN2 popped NJ Ex Order 26, 4B1 medication which she was unaware of and continued to prepare NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B from NJ Ex Order 26, 4B1 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 NJ Ex Order 26, 4B1 in the medication cup with an NJ Ex Order 26, 4B1 . There was no NJ Ex Order 26, 4B1 in the cup. At this time, RN2 stated that R8 only gets NJ Ex Order 26, 4B1 not NJ Ex O and that R2 receives NJ Ex Order 26, 4B1 . Upon entering R8's room, R8 had eaten breakfast.<br><br>Review of facility provided "Blister Package" indicated NJ Ex Order 26, 4B1 , give NJ Ex Order 26, 4B1 for | F0759 | | |

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| F0759 SS = D | Continued from page 9<br>edema."<br><br>Review of facility provided "Blister Package" indicated NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1. Give at least NJ Exec Order 26.4b1 to meals. Do not NJ Exec Or or NJ Exec Orde<br><br>Review of facility provided "Blister Package" indicated NJ Ex Order 26, 4B1 .<br><br>Review of facility provided "Medication Administration Audit Report" dated NJ Ex Order 26, 4 indicated, NJ Ex Order 26, 4B1 scheduled at 8:00 AM; NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1, scheduled at 9:00 AM; NJ Ex Order 26, 4B1 NJ Ex Order scheduled at 9:00 AM, and NJ Ex Order 26, 4B1 scheduled at 9:00 AM."<br><br>Interview on 02/26/26 at 12:29 PM, RN2 confirmed that NJ Ex Order 26, 4B1 should have been given prior to meals and that it was not.<br><br>3. Review of R9's "Admission Record" in the EMR, under the "Census" tab, indicated that R9<br><br>was re-admitted to the facility on NJ Ex Order 25 5 with a diagnosis of NJ Ex Order 26, 4B1<br><br>On 02/25/25 at 9:37 AM, LPN1 prepared R9's medication NJ Ex Order 26, 4B1 for R9 and stated that these were all of the medications at this time for R9. LPN1 gave R9 the medications however, LPN1 omitted NJ Ex Ord<br><br>Review of facility provided "Order Summary Report," dated NJ Ex Order 26, 4B indicated, "NJ Ex Order 26, 4B1 ] NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 , starting NJ Ex Order 26, 4B" This medication was omitted during medication observation with LPN1.<br><br>Review of facility provided "Medication Administration Audit Report dated NJ Exec Order 26.4 indicated, NJ Ex Order 26, 4B1 | F0759 | | |

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| F0759 SS = D | Continued from page 10<br>[redacted] scheduled at 9:00 AM and administered at 11:04 AM."<br><br>Interview on 02/26/25 at 12:43 PM, LPN1 confirmed that [redacted] was not given with the other medication as ordered. LPN1 confirmed that she gave the [redacted] medication later.<br><br>Interview on 02/26/25 at 2:24 PM, the [redacted] confirmed that she expects all nurses to pass medications according to physician orders. | F0759 | | |
| F0880 SS = D | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of | F0880 | Residents R4, R6 and R7 were evaluated for any [redacted] were noted.<br><br>All residents on Enhanced Barrier Precautions have the potential to be affected.<br><br>Audits were completed for 5 residents on EBP by the IP nurse, no deficient practice was identified.<br><br>The IP nurse/designee will educate all nursing staff on proper standard precautions and Enhanced Barrier Precautions.<br><br>The IP nurse/designee will complete 1 standard precaution and Enhanced Barrier Precautions competency on 1 employee q shift for 1 week, then daily for 3 weeks, then 3 random employees weekly for 4 weeks, and then 10 employees for 2 months. An audit of five random residents was completed for care/safety concerns to include staff interactions daily for seven days, weekly for four weeks, then monthly for two months.<br><br>An audit of the effectiveness of staff training will be conducted via random interviews daily for seven days, weekly for four weeks, then monthly for two months. The IP nurse/designee will submit the findings from the audits to the Quality Assurance Performance Improvement committee meeting monthly for further review and additional recommendations as needed. Further audit frequency will be determined based on audit findings. | 03/15/2025 |

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| F0880 SS = D | Continued from page 11<br>communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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 NJ Exec Order 26.4b1 care for two of two resident (Resident (R) 6 and R7) and for one of one resident (R4) during NJ Ex Order 26, 4B1 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 NJ Ex Order 26, 4B1 for one resident (R6) that was on NJ Exec Order 26.4b1 This failure has the potential to | F0880 | | |

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| F0880 SS = D | Continued from page 12<br>spread [redacted] )<br>throughout the facility and/or has the potential to [redacted] ).<br><br>Findings include:<br><br>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."<br><br>Review of the facility's policy titled, "EBP" revised March 2024 indicated, " EBP are utilized to reduce the transmission of MDROs to residents.<br><br>Policy Interpretation and Implementation ...<br><br>3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:<br>... f. changing briefs or assisting with toileting<br>...g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.)<br>...<br><br>5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.<br><br>a.<br><br>Wounds generally include chronic wounds (i.e. pressure ulcers, diabetic foot ulcers, venous<br><br>stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears.<br><br>b. | F0880 | | |

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| F0880 SS = D | Continued from page 13<br><br>Indwelling medical devices include central lines, urinary catheters, feeding tubes, and<br><br>tracheostomies. Peripheral intravenous (IV) catheters are not considered an indwelling medical device for purposes of EBPs."<br><br>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 [redacted] with diagnoses of [redacted]<br><br>During [redacted] 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 [redacted] LPN3 took a wipe, and vigorously wiped the [redacted], then LPN3 placed a [redacted] around the [redacted]. At this point, LPN3 emptied R4's [redacted], while wearing the same gloves. LPN3 removed her gloves and performed hand hygiene prior to exiting the room.<br><br>Interview on 02/25/25 at 12:25 PM, LPN3 indicated that gloves should be changed at least three times during [redacted] change. LPN3 confirmed that she did not change her gloves and perform hand hygiene and she should have.<br><br>2. Review of R6's "Admission Record" in the EMR, under "Census" tab, indicated that R6 was admitted to the facility on [redacted].<br><br>During R6's [redacted] observation on 02/25/25 at 6:06AM, R6 was on [redacted] for a [redacted]. 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 [redacted], [redacted] R6's [redacted] wearing the same gloves. CNA3 placed a [redacted] on R6. CNA3 gathered all the items prior to leaving the room, removed his gloves; however, did not perform hand | F0880 | | |

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| F0880 SS = D | Continued from page 14<br>hygiene after leaving the room.<br><br>3. Review of R7's "Admission Record" in the EMR under the "Census" tab indicated that R7 was re-admitted to the facility on [redacted] with a diagnosis of [redacted].<br><br>During R7's [redacted] observation on 02/25/25 at 5:39 AM, CNA2 donned gloves after performing hand hygiene. CNA2 removed R7's [redacted] R7's [redacted]. Without doffing her gloves, CNA2 obtained R7's [redacted] and held the [redacted] R7 [redacted]. CNA2 [redacted] to the [redacted] out then returned it to R7's nightstand. CNA2 [redacted] wearing the same gloves and applied [redacted] to R7's [redacted] CNA2 assisted R7 to [redacted], placed a [redacted] and [redacted] to R7's [redacted] CNA2 changed his/her gloves and did not perform hand hygiene. CNA2 assisted R7 to his/her [redacted], then [redacted] R7 to his/her [redacted] CNA2 left R7's room, without performing hand hygiene.<br><br>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.<br><br>Interview on 02/26/25 at 9:30 AM, the [redacted] 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 [redacted].<br><br>Interview on 02/26/25 at 10:15 AM, the [redacted]) 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 [redacted], and/or any other [redacted] while completing [redacted] | F0880 | | |

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| F0000 | INITIAL COMMENTS<br><br>No Information | F0000 | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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