STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

(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
F0000	INITIAL COMMENTS Survey Date: 5/29/2026 Census 28 Sample: 12 + 1 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		06/18/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices	F0812	F812_ Food Procurement, Store/Prepare/Serve-Sanitary Corrective Actions accomplished for the residents found to have been affected by the deficient practice: The U. S. FOIA (b) (2) immediately educated Dietary Aide #1 regarding appropriate dietary attire and jewelry restrictions in the dietary department. Dietary Aide #1 removed the NJ Exec Order 26.4b1. The U. S. FOIA (b) (2) reviewed and educated all dietary staff on the dietary dress code policy, especially pertaining to the prohibiting of wearing of NJ Exec Order 26.4b1 ings and any jewelry that may pose a food safety or sanitation risk while working in the food preparation and service areas. The four shelf dish storage rack was cleaned and sanitized immediately upon identification of the concern during survey. The six-burner range and griddle were thoroughly cleaned to remove all food debris and grease accumulation. Maintenance cleaned the fan covers in the walk in refrigerator to remove dust accumulation.	06/17/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

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F0812 SS = F	Continued from page 1 in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 5/26/26 at 5:25 PM, in the presence of U. S. FOIA [redacted] the surveyor observed the following 1. The Dietary Aide (DA#1) was observed wearing with NJ Exec Order 26.4b1 in the kitchen. DA#1 stated they were not aware they could not wear large NJ Exec Order 26 in the kitchen. The U. S. FOIA stated they would provide education the entire kitchen staff. 2. On a 4 shelf, dish storage rack, the surveyor observed a dust-like build up on each shelf. The U. S. FOIA stated the shelves would be cleaned immediately. 3. In the cooking area, on the 6-range stovetop the surveyor observed burnt on food-like particles and a blackish grease-like substance on the griddle. The U. S. FOIA stated there is a cleaning schedule and the equipment would be thoroughly cleaned. 4. In the walk-in refrigerator, the surveyor observed a dust-like substance on the fan covers. The U. S. FOIA stated they would contact maintenance to clean the fan covers. 5. In the dry storage room, the surveyor observed a thermometer that read 80 degrees Fahrenheit (F). The U. S. FOIA stated they are aware the dry storage room should be 70F or lower and would speak to maintenance about getting additional fans and an air conditioning unit. On 5/28/26 at 12:20 PM, the U. S. FOIA (b) (2) [redacted] provided the surveyor with multiple facility policies. The uniform policy with an approved date of 5/26/26 revealed under the procedures section, “4. Jewelry, open-toe shoes, and long nails are prohibited.” The cleaning of equipment policy with an effective date of 5/28/26 revealed under the cleaning frequency, “Every 4 hours, surfaces in continuous use must be sanitized to stop bacterial growth. Daily: thoroughly wipe down large appliances (ovens, stovetops, reach-in refrigerators handles) and wash floor mats.” The dry storage policy with an effective date of 7/2024 revealed under the procedure section, “Storage rooms may retain an environment of good ventilation and temperature between 50F and 70F.” On 5/28/26 at 12:42 PM, the surveyor met with the U. S. FOIA (b) (2) [redacted] to review concerns	F0812	Continued from page 1 Maintenance evaluated the dry storage room temperature concern, and a temporary cooling measure was implemented immediately, while arrangements were made for the installation of a dedicated air-conditioning/ventilation unit. It has been confirmed this unit will be installed on 06/29/2026. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All 28 residents receiving meals from the dietary department have the potential to be affected by the identified deficient practices. The U. S. FOIA (b) (2) conducted a comprehensive inspection of the kitchen, food storage areas, equipment, shelving, refrigeration units, and employee compliance with sanitation and dress code requirements. No additional concerns were identified requiring further resident-specific intervention. 3. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICENT PRACTICE WILL NOT RECUR: The Dietary Dress Code Policy was revised and reviewed during a dietary staff in-service given by the Food Service Director. During this in-service, all dietary employees were re-educated regarding: Food safety and sanitation requirements Personal hygiene standards Appropriate dress code and jewelry restrictions. Cleaning and sanitation expectations. The U. S. FOIA (b) (2) also reviewed and reinforced the facilities cleaning schedules for kitchen equipment, shelving, refrigeration units and food storage areas.	06/17/2026

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F0812 SS = F	Continued from page 2 found during the survey. The U. S. FOIA b stated they were addressing all kitchen concerns and corrective actions are being put in place On 5/29/26 at 12:01 PM, the surveyor met with the U. S. FOIA (b) (2) and the Prioress for the exit conference. No further pertinent information was provided. NJAC 8:39-17.2(g)	F0812	Continued from page 2 The cleaning schedule was revised to include documented routine inspection and cleaning of: Dish storage racks Cooking equipment and griddles Walk-in refrigerator fan covers. Other food service and storage equipment and storage surfaces 4. MONITORING OF CORRECTIVE ACTION A weekly sanitation audit tool was implemented by the Food Service Director. Maintenance staff will monitor and document dry storage room temperatures daily and implement interim cooling measures as needed. The Food Service Director or designee will conduct audits as follows: Dietary dress code compliance, including jewelry restrictions, will be audited weekly for four weeks and monthly thereafter for two additional months. Kitchen sanitation audits, including inspection of shelving, cooking equipment, refrigerator fan covers, and food storage areas, will be conducted weekly for eight weeks and monthly thereafter for two additional months. Once the facility approved installation of a new air-conditioning/ventilation unit in the dry storage room has been completed, the dry storage room will maintain a temperature between 50 degrees and 70 degrees Fahrenheit in accordance with facility policy and food safety standards. Dry storage room temperatures will be monitored and documented daily by the Maintenance Director following the installation of the new air-conditioning/ventilation unit. Audit findings will be reviewed by the Administrator and reported through the facility's Quality Assurance and Performance Improvement (QAPI)	06/17/2026

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F0812 SS = F		F0812	Continued from page 3 Committee. Any identified concerns will result in immediate corrective action, additional staff education given by the Food Service Director, and ongoing monitoring as deemed necessary by the QAPI Committee.	06/17/2026
F0811 SS = E	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is NOT MET as evidenced by: repeat deficiency	F0811	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Upon identification of the deficiency, the facility immediately discontinued the Paid Feeding Assistant Program effective date of May 29,2026. Resident #17 was removed from the NJ Ex Order 26, 4B1 roster or NJ Exec Order 26.4b1. Resident #17 was reassigned to U. S. FOIA (b) (2) and/or U. S. FOIA (b) (2) as appropriate. Resident #28 was NJ Exec Order 26.4b1 Resident #28 was reassigned to U. S. FOIA (b) (2) and/or U. S. FOIA (b) (2) as appropriate. All Paid Feeding Assistant assignments were immediately discontinued. The Paid Feeding Assistant roster was voided and removed from use. U. S. FOIA (b) (2) were educated by the U. S. FOIA (b) (2) egarding residents requiring assistance with nutritional and fluid intake will only be provided assistance by certified nursing assistants, licensed nurses, or other staff authorized under applicable regulations and facility policy. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected. The Director of Nursing/designee conducted a facility-wide audit of all residents, who may had been assigned to or identified to participate in the Paid Feeding Assistant Program by way of physician orders, dietary orders, care plan, MDS assessment, Speech recommendations. The audit confirmed that all residents previously identified for the Paid Feeding Assistant Program were removed from the program and reassigned to	06/18/2026

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F0811 SS = E	Continued from page 4 Based on observation, interview and review of pertinent facility documentation, the facility failed to ensure [redacted] Assistance staff" were assigned to [redacted] residents that did not have [redacted] (the NJ Exec Order 26.4b1 of the [redacted] This deficient practice was identified for 2 of 3 residents reviewed (Resident # 17 and Resident # 28) and was evidenced by the following: 1. A review of Resident #17's Admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted] A review of Resident #17's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1 which indicated NJ Ex Order 26, 4B1 . Further, section [redacted] revealed the resident was on NJ Ex Order 26, 4B1 [redacted] A review of the physician order set (POS) revealed an order dated [redacted] NJ Ex Order 26, 4B1 [redacted] A review of the care Individualized Care Plan (ICP) revealed a focus of NJ Ex Order 26, 4B1 related to [redacted] dated [redacted] and revised on [redacted]. It further revealed an intervention dated [redacted] and revised on [redacted] resident needs to be NJ Exec Order 26.4b1 to [redacted] and [redacted] all [redacted] by [redacted] assistance. A review of the medication administration record (MAR) revealed an order dated [redacted], that the resident was NJ Exec Order 26.4b1, the resident NJ Exec Order 26.4b1 . A review of the NJ Ex Order 26, 4B1 revealed clinical impression that NJ Ex Order 26, 4B1 and functions appear adequate for the purpose of NJ Exec Order 26.4b1 [redacted] 2. A review of Resident #28's Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26, 4B1	F0811	Continued from page 4 appropriate nursing staff. The Paid Feeding Assistant program has completely been eliminated. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The facility has permanently eliminated the Paid Feeding Assistant Program, as a result the following actions were implemented; • The Paid Feeding Assistant Program policy was revised to reflect discontinuation of the program. • All Paid Feeding Assistant rosters, assignment sheets, and program records were removed from active use. • All individuals previously functioning as Paid Feeding Assistants were notified in writing that the program has been discontinued and that they may no longer provide feeding assistance. • Education was provided by the U. S. FOIA (b) (2) to licensed nurses, certified nursing assistants, and dietary staff regarding; the discontinuation of the Paid Feeding Assistant program, the federal and state guidelines, and the staff who can assist the residents. • The facility revised the meal service procedures to ensure all residents who require assistance with meals/snacks are assigned only to licensed nursing staff and certified nursing assistants. Monitoring of Corrective Action The Director of Nursing or designee will conduct audits to ensure the Paid Feeding Assistant Program remains discontinued and that no unauthorized feeding assistance occurs. Weekly audits for eight (8) weeks of all meal service assignments on all units.	06/18/2026

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F0811 SS = E	Continued from page 5 NJ Ex Order 26 A review of Resident #28's most recent MDS reflected that the resident had a BIMS score of NJ Ex O indicating NJ Ex Order 26, 4B1. Further, section NJ revealed the resident had a NJ Ex Order 26, 4B1 and was prescribed a NJ Ex Order 26, 4B1 A review of the POS revealed an order dated NJ Ex Order 26, for NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1, and the resident to only be NJ Ex Order 26, 4B1. A review of the care ICP with an initiated date of NJ Ex Order 26, and revised on NJ Ex Order 26 revealed a focus of NJ Exec Order 26.4b1 causing NJ Exec Order 26.4b1 during the day. The ICP further revealed an intervention dated NJ Ex Order 26, that a NJ Ex Order 26, 4B1 evaluation was done and the resident's NJ Exec was NJ Exec Order 26.4b1 to NJ Ex Order 26, 4B1. A review of the MAR revealed an order dated NJ Ex Order 26, for NJ Ex Order 26, 4B1 with every meal and snack as necessary every shift. A review of the NJ Ex Order 26, 4B1 revealed a NJ Ex Order 2 that revealed the comprehensive findings were suggestive that the resident presents with NJ Ex Order 26, 4B1 that affected the NJ Ex Order 26, 4 . Further review revealed that the recommendation were for a NJ Ex Order 26, 4B1 with NJ Ex O precautions with nursing staff NJ Ex Order 26, 4B1 only when NJ Ex Order 26, 4B1 On 5/26/24 at 12:42 PM, in the presence of the survey team, the surveyor interviewed the U. S. FOIA (b) (2), who stated that she is the educator for the NJ Exec Order 2 assistances and the residents on the list provided by the facility were accurate for the NJ Exec Order 2 assistance assignments. The list consisted of 3 residents including resident #17 and #28. On 5/28/26 at 09:30 AM, the surveyor interviewed the U. S. FOIA, who stated that the NJ Exec Order 2 assistance helps the residents that NJ Exec Order 26.4b1. She further stated that the NJ Exec Order 2 assistance are not licensed to provide nursing assistance or are a professional nurse and could not assist in an emergency. The U. S. FOIA acknowledged and agreed that there was a safety concern with the NJ Exec Order 2 assistants assisting residents with an NJ Exec Orde or NJ Exec Order 26.4b1. On 05/29/26 at 10:49 AM, in the presence of the survey team, the U. S. FOIA (b stated that she did not have any further responses related to the concern.	F0811	Continued from page 5 Verification that no Paid Feeding Assistant roster exists or is being utilized. Observation of meal services to ensure feeding assistance is provided only by authorized nursing staff. Review of staffing assignments to verify no employee is functioning as a Paid Feeding Assistant. Any findings will result in immediate corrective action and re-education. The Nursing Director or Designee will review all audits of resident feeding assignments and response, ensuring the facility's policy is followed accordingly. Findings will be reported to Administrator and will be presented in the quarterly Quality Assurance meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	06/18/2026

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F0811 SS = E	Continued from page 6 A review of the facility provided policy titled, "Paid Feeding Assistance" with an effective date of 11/2025, included the nursing staff will identify residents who are approved to receive dining assistance by the paid feeding assistant. Eligible residents are without complicated feeding problems such as, but not limited to, difficulty swallowing…Resident criteria- the feeding assistant provides only assistance for those residents who have been identified as needing assistance and are without complicated feeding problems. A review of the facility provided policy titled, "Paid Dining Assistance training" with an effective date of 2025, revealed patient restrictions…Dining assistances in New Jersey cannot feed complex residents. N.J.A.C. 8:39-17.3(c)	F0811		06/18/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within the resident's reach (Resident #25). This deficient practice was identified for 1 of 28 residents reviewed for accommodation of needs (Resident #25, and was evidenced by the following: On 5/28/26 at 10:10 AM, the surveyor observed Resident #25 in their bed with the call bell at the bottom of the bed, wrapped around the bed frame not within the resident's reach. The surveyor reviewed the medical record for Resident #25. A review of the Admission Record reflected that the resident was admitted to the facility on [NJ Ex Order 26] with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1	F0558	F0558-Reasonable Accommodations Needs/Preferences CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #25 was immediately assessed upon identification of the concern. The resident's call bell was placed within reach and the nursing staff received education by the U. S. FOIA (b) (2) as to the facility's Policy and Procedure on the requirement to maintain resident call bells within reach at all times unless contraindicated by the resident's condition or documented preference. The assigned [U.S. FOIA] and the licensed nursing staff were counseled by the U. S. FOIA (b) (2) regarding the facility's policy requiring call bells to remain accessible to residents and the importance of prompt response to resident requests for assistance. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICENT PRACTICE: All residents have the potential to be affected by the same deficient practice. The Director of Nursing conducted an audit of all	06/18/2026

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F0558 SS = D	Continued from page 7 NJ Ex Ord A review of the quarterly Minimum Data Set (MDS) an assessment tool, dated NJ Ex Order 26, indicated the resident had NJ Ex Order 26, 4B1 and required staff assistance for activities of daily living (ADLs). A review of Resident #25's Care Plan (CP) included a focus area that the resident was at NJ Exec Order 26 for NJ Exec O with interventions that included but were not limited to: ensure the resident's call light is within reach…ensure the resident receives prompt response to all requests for assistance initiated NJ Ex Order 26 On 5/28/26 at 10:20 AM, the surveyor showed the above observation to the U. S. FOIA (b) (2) assigned to Resident #25. The U. S. FO acknowledged that the call bell should have been left within the resident's reach. On 5/28/26 at 12:40 PM, the surveyor discussed the above observations and concerns with th U. S. FOIA (b) (2) The U. S. FOIA (acknowledged that call bells should be within reach of all residents. On 5/29/26 at 11:45 AM, during a telephone interview with the U. S. FOIA (b) (2) assigned to Resident #25's care on 5/28/26 day shift (7AM-3 PM) confirmed that she should have placed the call bell within the resident's reach. On 5/29/26 at 12:02 PM, no further information was provided. NJAC 8:39- 31.8 (c)(9)	F0558	Continued from page 7 residents residing in the facility to verify that call bells were within reach and accessible according to each resident's needs, preferences, and care plan interventions. Any identified concerns were corrected immediately at the time of the audit. Residents admitted after the completion of the audit will be reviewed during the admission process by the Director of Nursing to ensure call bell accessibility is addressed and maintained. 3. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICENT PRACTICE WILL NOT RECUR: All staff were re-educated by the facility's Health Educator on the regulations governing F-558 and the facility policy and procedure for residents reasonable accommodations need/preferences including: Resident rights regarding reasonable accommodation of needs and preferences Facility policy requiring call bells to be placed within reach of residents. The requirement to verify call bell accessibility during routine care, room rounds, shift changes and upon leaving a resident's room. The importance of maintaining compliance with individualized care plan interventions related to call bell access and fall prevention. The facility has amended nurse assignments to include visualizing location of the call bell accessibility into routine nursing rounds and supervisory observations. 4. MONITORING OF CORRECTIVE ACTION: The Director of Nursing or designee will conduct audits of resident's rooms to verify that the call bells are within reach and accessible: Five residents weekly for four weeks	06/18/2026

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F0558 SS = D		F0558	Continued from page 8 Ten residents monthly for three (3) months thereafter. Any identified concerns will be corrected immediately and staff re-education by the Director of Nursing will be provided as indicated. The Director of Nursing or designee will review all audits of the nurse assignment visualizing location of call bell accessibility, ensuring the facility's policy is followed accordingly. Findings will be reported to the Administrator and will be presented at the quarterly Quality Assurance meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	06/18/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) ensure that a [NJ Exec Order 26.4b1] and monitored according to the resident's [NJ Exec Ord] for 1 of 3 residents (Resident #25) and b.) failed to provide a resident with a [NJ Ex Order 26] the necessary treatment and services consistent with professional standards of practice, to [NJ Ex Order 26, 4B1], [NJ Ex Order 26, 4B1] and [NJ Ex Order 26, 4B1] for 1 of 2 residents reviewed (Resident #4).	F0686	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #25, [NJ Exec Order 26.4b1] ; the setting was immediately corrected from [NJ Exec Order 26.4b1]. Resident #25 current [NJ Exec Ord] per physician order. The [NJ Exec Order 26.4b1] was immediately checked for function. [U. S. FOIA (b) (2)] received education from the [U. S. FOIA (b) (2)] at bedside on [NJ Exec Order 26.4b1] settings for each resident having a [NJ Exec Order 26.4b1]. This will be checked every shift. Resident #4 – [NJ Ex Order 26, 4B1] The [U. S. FOIA (b) (2)] provided Immediate education to assigned [U.S. FOIA (b)(6)] regarding; Proper hand hygiene technique, hand hygiene competency was completed. [NJ Ex Order 26, 4B1] care competency, includes preparing Resident #4 and the work area prior to placement of clean dressing and medication supplies was completed with the [U. S. FOIA (b) (2)]	06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

(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
F0686 SS = D	Continued from page 9 This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents and immediately after glove removal. In addition, when cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers, and this should be done outside the water when rubbing your hands, then rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take approximately 20 seconds. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." a. On 5/28/26 at 10:10 AM, the surveyor observed Resident #25 in bed and a NJ Ex Order 26, 4B1 in place. The resident's NJ Ex Order 26, 4B1 was set at [redacted] The surveyor reviewed the electronic medical record (E-mar) for Resident #25. A review of the Admission Record (AR) reflected that Resident #25 was admitted to the facility on [redacted] with diagnoses that included but were not limited to; NJ Ex Order 26, 4B1 [redacted]	F0686	Continued from page 9 The U. S. FOIA (b) (2) was also educated to the labeling of [redacted] prior to application on the Resident #4 [redacted] treatment procedure was reviewed and re-performed correctly by Licensed Nurse under supervision. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All 28 residents have the potential to be affected by inaccurate setting of the low air loss surfaces, and receiving of wound care without proper infection prevention measures: All residents on a Low Air Loss or pressure redistribution mattresses, all were checked for function and accurate weight setting, measure will be checked every shift. All Licensed Nurses will receive Wound treatment competency and Hand Hygiene competencies by both the Director of Nursing and the Health Educator. NJ Ex Order 26, 4B1 received education related to NJ Ex Order 26, 4B1 prevention interventions and the rationale for preventative measures by both the U. S. FOIA (b) (2) [redacted] MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Pressure Redistribution Device Process Improvement Implemented a "Two-Step Verification System": License Nurse obtains current weight as per physician order	06/18/2026

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F0686 SS = D	Continued from page 10 A review of the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] reflected that the resident had [redacted]. A review of the current Physician Order Summary Report (OSR) reflected a Physician's Order (PO) for an alternating [redacted]; to check that the [redacted] is set on the [redacted] with a start date of [redacted]. A review of the current Treatment Administration Record (TAR) included an [redacted] that was in place and to monitor every shift: check for [redacted] in place on [redacted] check to ensure [redacted], and that the [redacted] is set at the correct [redacted] with a start date of [redacted] and signed by nurses, which indicated it was being monitored. A review of the Vital Signs reflected the last [redacted] was [redacted]. A review of Resident #25's Care Plan revealed a focus that included the resident has potential for [redacted] to [redacted] related [redacted] and [redacted] with interventions that included but were not limited to: [redacted] On 5/28/26 at 10:20 AM, the surveyor showed the [redacted] assigned to Resident #25 the [redacted]. The [redacted] acknowledged that the setting was set to [redacted] and stated it should have been set to the resident's weight of [redacted]. The [redacted] confirmed that the [redacted] had been ordered to prevent and assist in preventing [redacted] and stated that maintaining the [redacted] was important to ensure the device's effectiveness. On 5/28/26 at 12:40 PM, the surveyor discussed the above observations and concerns with the [redacted] A review of the facility's "Pressure Relieving Devices" dated 2024 reflected...According to the	F0686	Continued from page 10 Licensed nurse verifies and adjusts mattress settings accordingly Added to TAR documentation checklist: "Mattress setting verified each shift" Wound Care Infection Control Reinforcement Reinforced adherence by way of education by the Director of Nursing and Health Educator to: CDC Hand Hygiene Guidelines CMS Infection Prevention Standards Facility Skin Integrity/Wound Care Policy Wound care competency; Hand hygiene technique verification Surface disinfection prior to supply placement Dressing labeling prior to application All Licensed Nursing staff (RNs/LPNs/CNAs involved in wound care) have completed; Hand hygiene competency Wound care infection control competency Pressure ulcer prevention device training Monitoring of Corrective Action The Nursing Director/designee will audit 3 times a week for (4) weeks, then weekly for (8) weeks all residents;	06/18/2026

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F0686 SS = D	Continued from page 11 National Pressure Injury Advisory Panel (NPIAP) support surface standards initiative, Low Air Loss (LAL) is defined as a support surface construction that uses a flow of air to assist in pressure redistribution and may assist in managing the heat and humidity of the skin...Indications for use...Residents at high risk for pressure injuries or with a current pressure injury unable to be adequately repositioned... b. On 5/26/26 at 7:30 PM, the surveyor observed Resident #4 in their room, seated in a wheelchair. The surveyor reviewed the E-mar for Resident #4. A review of the AR reflected that the resident was admitted to the facility on [NJ Exec Order 26] with diagnoses that included but were not limited to: [NJ Ex Order 26, 4B1] [redacted] A review of the most recent MDS, dated [NJ Ex Order 26], reflected the resident had a brief interview for mental status (BIMS) score of [NJ Ex Order 26, 4B1] indicating an [NJ Ex Order 26, 4B1] A review of the current OSR dated [NJ Ex Order 26] reflected a PO to [NJ Ex Order 26, 4B1] [redacted] A review of the CP identified a focus area indicating the resident had a [NJ Ex Order 26, 4B1] with interventions that included, but were not limited to, [NJ Ex Order 26, 4B1] [redacted] On 5/28/26 at 10:55 AM, the surveyor observed the [U. S. FO] perform a [NJ Ex Order 26, 4B1] to Resident #4's [redacted] The [U. S. FO] placed three paper towels on top of the resident's over-bed table (OBT) without disinfecting it. The [U. S. FO] assembled the needed supplies from the	F0686	Continued from page 11 Verify mattress settings matches documented weight Review wound care technique compliance Observe hand hygiene during wound treatments Wound Care audit (3) times a week for (4) weeks, then weekly for (8) weeks; 100% of active wound care residents Correct treatment application Infection control compliance Proper documentation (including labeling of dressings) Pressure Injury Prevention Education will continue annually and on orientation. Audit findings will be reviewed by the Licensed Nursing Home Administrator and reported for two quarters through the facility's Quality Assurance and Performance Improvement (QAPI) Committee . Any identified concerns will result in immediate corrective action, additional staff education, and ongoing monitoring as deemed necessary by the QAPI Committee.	06/18/2026

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F0686 SS = D	Continued from page 12 treatment cart and placed them on the [NJ Exec O] in the resident's room. Among the supplies were [NJ Ex Order 2] pads, NJ Ex Order 26, 4B1 NJ Exec Order 26.4b1 . The surveyor observed the [U. S. FO] perform hand hygiene. The [U. S. FO] applied soap to her hands and immediately placed them under running water without first lathering. The [U. S. FO] NJ Ex Order 26, 4B1 [redacted] The [redacted] wrote directly on the [NJ Exec Order 26] after it was applied rather than labeling it prior to application. The surveyor observed the [U. S. FO] perform hand hygiene. The [U. S. FO] applied soap to her hands and immediately placed them under the running water without first lathering. The surveyor discussed the breaches in infection control with the [U. S. F], who acknowledged that she should have lathered her hands for 20 seconds before placing them under the water and should have initialed and dated the [NJ Exec Order 26] prior to its application. On 5/28/26 at 12:40 PM, the survey team discussed the above observations and concerns with the [U. S. FOM] [redacted] A review of the facility's Skin Integrity/Wound Care policy dated 2/2025 reflected...The Nursing staff is knowledgeable and competent in providing basic prevention, assessment, and treatment to Residents with wounds. On 5/29/26 at 12:02 PM, no further information was provided. NJAC 8:39-19.4(a); 27.1 (a)	F0686		06/18/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F0689	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Resident #27 NJ Ex Order 26, 4B1 was immediately reviewed, and the interdisciplinary team reviewed the resident's [NJ Ex Order 26, 4B] and current	06/18/2026

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F0689 SS = D	Continued from page 13 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interview, record review, and review of facility policies, it was determined the facility failed to provide NJ Ex Order 26 interventions following a residents NJ Ex Or accurately code the Minimum Data Set ((MDS), an assessment tool used to facilitate the management of care), follow a Physician Order (PO) for residents who had a NJ Ex Order 2 This deficient practice was identified for 2 of 2 residents (Resident #25 and #27) NJ Ex Order 26, 4B1. The deficient practice was evidenced by the following: On 5/26/26 at 6:39 PM, the surveyor observed Resident #27 in bed with the eyes closed. Resident #27's bed was observed in the NJ Ex Order 26, 4B1 and had a NJ Ex Order 26, 4B1 t of bed and to assist with NJ Exec Order 26 4 On 5/26/26 at 7:29 PM, the surveyor reviewed the electronic medical record (E-mar) for Resident #27. A review of the resident's Face sheet (FS) (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1 A review of the quarterly MDS, with a reference date NJ Ex Order 26, 4 reflected that the resident had a Brief Interview for Mental Status (BIMS) score NJ Ex Order 26, 4B indicating that the resident had NJ Ex Order 26, 4B1 . The MDS further revealed that Resident #27 has had a NJ Ex Order 26, 4B1. A review of Resident #27's care plan report (CPR) revealed a care plan (CP) for NJ Ex Or with a revision date of NJ Ex Order 26, 4B1 and a focus area, "Resident is at NJ Ex Order 26, 4B1 related NJ Ex Order 26, 4B1 The CP's last initiated and revised interventions was on NJ Ex Order 26, 4B1 "The resident uses	F0689	Continued from page 13 NJ Ex Order 26, 4B1 • Resident #27 care plan was revised to include individualized NJ Ex Order 26, 4B1 interventions based on the resident #27 NJ Ex Order 26, 4B1 , NJ Ex Order 26, 4B1 • Resident #27, MDS was reviewed and corrected to accurately reflect Resident 27 NJ Ex Order 26, 4B1 accordance with RAI manual coding requirements. • U. S. FOIA (b) (2) were re-educated by the NJ Ex Order 26, 4B1 immediately regarding NJ Exec Orde ll assessment requirements, implementation of new interventions, care plan updates, and communication of changes to the interdisciplinary team. Resident #27, the NJ Ex Order 26, 4 was immediately placed on the NJ Ex Order 26 of Resident #27 bed in accordance with the physician's order and care plan. Resident #27 NJ Ex Order 26, 4B1 interventions were reviewed for appropriateness and continued effectiveness. • U. S. FOIA (b) (2) assigned to resident #27 were re-educated by the U. S. FOIA (b) (2) regarding the physician orders and Resident #27 plan of care with attention to fall prevention interventions. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All 28 residents may be affected by this deficient practice. An audit was conducted by the U. S. FOIA (b) (2) of all 28 residents identified as having a history of NJ Ex Order 26, 4B1 prevention interventions, floor mats, low beds, alarms, or other safety devices. Audits included verification of physician orders, care plans, NJ Ex Order 26, and nursing assistant Tasks. Resident rooms reviewed for accurate reflection of ordered interventions and that interventions were in place. An audit of residents experiencing falls within the previous six months was completed to ensure; post fall assessment was completed, any new intervention were implemented and the care plan was revised to reflect the same. Post-fall assessments were completed at the time of	06/18/2026

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F0689 SS = D	Continued from page 14 NJ Ex Order 26, 4B1 [redacted]. On 5/28/26 at 9:13 AM, the U. S. FOIA (b) (2) [redacted] provided the surveyor with NJ Ex Order 26, 4B1 from Resident #27 for the past 18 months. The investigation revealed the resident NJ Ex Order 26, 4B1 [redacted] A review of Resident #27's quarterly MDS from with a reference date of NJ Ex Order 26 [redacted] revealed the resident's NJ Ex Order 26, 4B1 5 was not coded. On 5/28/26 at 12:21 PM, the surveyor interviewed the U. S. FOIA [redacted], who stated care plans should be updated with new interventions following a residents NJ Ex O as well as the MDS for NJ Ex Order 26, had failed to capture to Resident #27's NJ Ex Order 26, 4B1 On 5/28/26 at 12:30 PM, the Licensed Nursing Home Administrator provided the surveyor with multiple facility policies. The "MDS-Comprehensive" policy with a revised date of 4/2025 revealed, "the facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity. The "Fall Management" policy with a revised date of 2/2025 revealed under the procedure section, "5. Interventions may be implemented as Nursing and Therapy deems appropriate to the individual resident's needs…8. The Interdisciplinary Committee Team will meet to discuss the resident's assessments/observations and the appropriateness of interventions." b. On 5/28/26 at 10:10 AM, the surveyor observed Resident #25 in bed with their eyes closed. The surveyor observed a NJ Exec Order 26.4b1 against the wall not on the floor next to the Resident's bed. The surveyor reviewed the e-MAR for Resident #25. A review of the AR reflected that the resident was admitted to the facility on NJ Exec Order 2 [redacted] with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1 [redacted] A review of the quarterly MDS dated NJ Ex Order 26, 4B [redacted] indicated the resident had NJ Ex Order 26, 4B1	F0689	Continued from page 14 incident. The residents' MDS were reviewed to ensure accurate coding of fall occurrences. Any identified discrepancies were corrected immediately. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The facility revised its system for processing Fall Management by the following; All Licensed nurses received education by the Director of Nursing and Health Educator of their responsibility to follow up with the post-fall investigation procedures, obtaining a physician order for preventative measures, and Care plan updates to reflect the resident fall incident. The U. S. FOIA (b) (2) [redacted] received education by the U. S. FOIA (b) (2) [redacted] of their responsibility to maintain fall prevention devices in accordance with the physician's order, and the immediate notification to the licensed nurse when devices are not in place. Compliance with resident-specific safety interventions. An interdisciplinary review as soon as possible following every fall. Documentation of root cause analysis. Implementation of individualized interventions when appropriate. Verification that physician orders for fall prevention devices are implemented and maintained. Timely updates to the care plans of resident with fall incidents.	06/18/2026

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F0689 SS = D	Continued from page 15 NJ Ex Order 26, 4B1 and required staff assistance for activities of daily living (ADLs). A review of the current PO for Resident #25 included a PO dated NJ Ex Order 26, 4B, NJ Ex Order 26, 4B1 every shift for safety while the resident is in bed. A review of Resident #25's CP included a focus area that the resident was at NJ Ex Order 26, 4B1, with interventions that included but were not limited to: NJ Ex Order 26 in place. On 5/28/26 at 10:20 AM, the surveyor showed the above observation to the NJ Ex Order 26, 4B1 of the resident's bed per the PO, and confirmed that the resident was at NJ Ex Order 26, 4B1. On 5/28/26 at 12:40 PM, the surveyor discussed the above observations and concerns with th U. S. FOIA (b) (2) The U. S. FOIA confirmed that the mat should have been placed to the left of Resident #25's bed per the PO. On 5/29/26 at 11:45 AM, during a telephone interview with the U. S. FOIA (b) (2) assigned to Resident #25's care on the day shift of NJ Ex Order 26, 4 confirmed that the NJ Ex Order 26, 4 should have been placed on the NJ Ex Order 26, 4B1 resident's bed in accordance with the resident's NJ Exec Order 26.4b1 interventions. The U. S. FOIA acknowledged that the NJ Exec O was not in place and stated that she may have forgotten to position it properly. On 5/29/26 at 12:01 PM, the surveyor met with the U. S. FOIA (b) (2) and the Prioress for the exit conference. No further pertinent information was provided. NJAC 8:39-27.1(a); 31.4(a); 33.1(d)	F0689	Continued from page 15 The U. S. FOIA (b) (2) was re-educated regarding accurate coding of resident incidents in accordance with current RAI Manual guidelines. The U. S. FOIA (b) (2) together with the Interdisciplinary team will review the residents' MDS for coding accuracy. Monitoring of Corrective Action The Director of Nursing or designee will conduct audits as follows: Weekly audits of 10 residents with fall prevention interventions for four (4) weeks. Monthly audits of 10 residents with fall prevention interventions for two (2) additional months. Audits will verify: Ordered safety devices are in place and function as ordered. Care plans are updated following falls. Post-fall investigations include evaluation of additional interventions. MDS coding accurately reflects documented falls. The Nursing Director or Designee will review all audits and response, ensuring the facility's policy is followed accordingly. Findings will be reported to Administrator and will be presented in the quarterly Quality Assurance meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	06/18/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F0690	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	06/18/2026

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ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

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F0690 SS = D	Continued from page 16 §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (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 (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. §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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined that the facility failed to follow Physician Orders (PO), individualized care plan (ICP), and facility policy by not providing a [redacted] for a resident with an [redacted]). This deficient practice was noted for 1 of 1 resident's reviewed with [redacted], (Resident #6). This deficient practice was evidenced by the following: On 5/26/26 at 6:24 PM, the surveyor observed Resident #6 in bed with a [redacted] Resident#6 stated they do not recall having a [redacted]	F0690	Continued from page 16 Resident #6 was immediately assessed by the [redacted], and a [redacted] to the resident #6 [redacted] to ensure compliance with the physician order. The individualized care plan was reviewed to ensure the intervention of a [redacted] is in place, and facility policy requiring [redacted] to have a [redacted]. Resident #6 [redacted] was re-assessed to ensure proper placement, [redacted] and integrity. Resident #6's plan of care and physician orders were reviewed with licensed nursing staff. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All 28 residents may be affected by this deficient practice, an audit was conducted of all 28 residents with indwelling urinary catheters and suprapubic catheters was completed by the Director of Nursing, Infection Preventionist to verify: • Presence of a privacy bag covering the drainage bag. • Compliance with physician orders regarding catheter care. • Compliance with individualized care plan interventions. • Compliance with facility catheter maintenance policy. Any identified concerns were corrected immediately upon discovery. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Licensed nurses and certified nursing assistants received immediate re-education by the Director of Nursing and the Health Educator regarding the facility's "Indwelling Catheter Maintenance Care" policy, including the requirement that all urinary drainage bags are to be covered with a privacy bag when resident(s) are in bed or in a wheelchair.	06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

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F0690 SS = D	Continued from page 17 On 5/26/26 at 6:49 PM, the surveyor reviewed the electronic medical record (E-mar) for Resident #6. A review of the resident's Face sheet (FS) (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1 [redacted]). A review of the quarterly Minimum Data Set ((MDS), an assessment tool used to facilitate the management of care), with a reference date [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) [redacted] indicating that the resident had NJ Ex Order 26, 4B1. The MDS also noted that Resident #6 had an [redacted]. A review of the Physician Orders Summary (POS) revealed a Physician Order (PO) dated [redacted] "please do not leave NJ Ex Order 26, 4B1 and dressing out in view." A review of Resident #6's ICP revealed a focus area, "resident had a NJ Ex Order 26, 4B1 due to long time [redacted]" and an intervention, "please make sure the [redacted] is not twisted, and the [redacted] is always covered." On 5/27/26 at 10:35 AM, the surveyor had an additional observation of Resident #6 in bed with their NJ Ex Order 26, 4B1. On 5/27/26 at 10:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN#1) who stated Resident #6 has a NJ Ex Order 26, 4B1 but was unable to explain why Resident #6 did not have a [redacted] as per PO and ICP. On 5/28/26 at 11:11 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated all residents with NJ Ex Order 26, 4B1 On 5/27/26 at 11:28 AM, the DON provided the surveyor with a facility policy, "Indwelling Catheter Maintenance Care" with a revised date of 1/2025. The procedures potion of the policy revealed, "4. Position urinary bag off the floor at all times and cover with a privacy bag when in bed and in wheelchair." On 5/28/26 at 12:42 PM, the surveyor met with the U. S. FOIA (b) (2) and	F0690	Continued from page 17 Education included the importance of following physician orders, individualized care plan interventions, resident dignity and privacy requirements, infection prevention practices, and proper catheter maintenance. The Licensed nurses were instructed to include verification of drainage bag with privacy bag placement during routine rounds and catheter care observations. The facility's catheter care audit tool was revised to include verification that drainage bags are covered with privacy bags in accordance with physician orders, care plans, and facility policy. VI. Monitoring of Corrective Action The Director of Nursing, Infection Preventionist, or designee will conduct audits of all residents with indwelling urinary catheters and suprapubic catheters as follows; • Weekly audits for four (4) weeks. • Monthly audits for two (2) additional months. Audits will verify: • Presence of drainage bag with privacy bags. • Compliance with physician orders. • Compliance with care plan interventions. • Compliance with facility catheter maintenance policy. The Nursing Director or Designee will review all audits and response, ensuring the facility's policy is followed accordingly. Findings will be reported to Administrator and will be presented in the quarterly Quality Assurance meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

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F0690 SS = D	Continued from page 18 U. S. FOIA to review concerns found during the survey. The U. S. FOIA stated Resident #6 now has an NJ Ex Order 26, 4B1 NJ Exec and corrective actions are being put in place. On 5/29/26 at 12:01 PM, the surveyor met with the U. S. FOIA (b) (2) and the Prioress for the exit conference. No further pertinent information was provided. NJAC 8:39-19.4 (a)4,5,6	F0690		06/18/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined that the facility failed to follow a Physician's Order (PO) for an NJ Ex Order 26, 4B1) dependent resident and failed to include or revise the person-centered Comprehensive Care Plan (CCP) for NJ Exec Order 26.4b1, in accordance with professional standards of practice. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act	F0695	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #20 was immediately assessed by the licensed nurse for NJ Ex Order 26, 4B1 status, NJ Ex Order 26, 4B1 The attending physician and NJ Ex Order 26, provider were notified of the survey findings, and a review of the resident #20 NJ Ex Order 26, 4B1 orders was completed. Conflicting NJ Ex Order 26, 4B1 were reviewed and clarified with the physician, those NJ Ex Order 26, 4B1 were discontinued, and a current physician order was entered reflecting the resident #20 prescribed NJ Ex Order 26, 4B1 A physician order for NJ Exec Order 26.4b1 monitoring was obtained and implemented. Resident #20's electronic Medication Administration Record (eMAR) and Treatment Administration Record (eTAR) were updated to accurately reflect current NJ Ex Order 26, 4B1 orders with monitoring requirements. Resident #20's Comprehensive Person-Centered Care Plan was reviewed and revised to include a specific focus addressing NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1, monitoring requirements, physician-prescribed NJ Ex Order 26, 4B1, NJ Ex Order 26, coordination, and interventions necessary to maintain NJ Ex Order 26, 4B1 status. Licensed nursing staff were educated regarding Resident #20 NJ Ex Order 26, orders and care plan interventions, facility policy was reviewed with all licensed nursing staff.	06/18/2026

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F0695 SS = D	Continued from page 19 for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 5/26/26 at 6:55 PM the surveyor observed Resident #20 in bed with their eyes closed. Resident #20 was observed receivin NJ Ex Order 26, 4B1 [redacted] The surveyor observed the setting on the NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 [redacted] The surveyor asked the U. S. FOIA (b) (2) [redacted]) on duty about Resident #20's NJ Ex Order 26, 4B1 The U. S. FOIA stated that it is given at NJ Ex Order [redacted] On 5/27/26 at 11:07 AM, the surveyor Observed Resident #20's NJ Ex Order 26, 4B1. The setting was observed as NJ Ex Order [redacted] On 5/27/26 at 11:30 AM, the surveyor reviewed Resident #20's electronic medical record (e-MAR) which revealed the following: The surveyor reviewed Resident #20's Admission Record (an admission summary) which revealed that the resident had been admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26, 4B1 [redacted] and NJ Ex Order 26, 4B [redacted] A review of the Quarterly Minimum Data Set Assessment (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) NJ Ex Order 26, 4B1, revealed that the resident had a score o NJ Ex Order 26, 4B1 on the Brief Interview for Mental Status (BIMS), which indicated NJ Ex Order 26, 4B1. The MDS also reflected that the resident received NJ Ex [redacted] A review of the May 2026 PO for Resident #20	F0695	Continued from page 19 IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All 27 residents have the potential to be affected by this deficient practice. An audit was conducted by the U. S. FOIA (b) (2) of all 28 residents who may have oxygen orders or receiving NJ Ex Order 26, 4B1 therapy, NJ Ex Order 26, 4B1 treatments, or other NJ Ex Order 26, 4B1 support services to ensure the following; • Current physician orders are present and accurately transcribed. • Oxygen flow rates and administration methods match physician orders. • Oxygen saturation monitoring orders are present when indicated. • Documentation is present in the medical record, eMAR, and/or eTAR as ordered. • Care plans accurately reflect oxygen use and respiratory care needs. • Discontinued respiratory orders have been properly removed from active records. Any discrepancies identified during the audit were corrected immediately, physician notification was completed as necessary, and care plans were updated accordingly. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: • U. S. FOIA (b) (2) were re-educated by the U. S. FOIA (b) (2) [redacted] regarding physician order verification, oxygen administration, respiratory care documentation requirements, and compliance with the New Jersey Nurse Practice Act. • NJ Ex Order 26, 4B1 were re-educated by the U. S. FOIA (b) (2) [redacted] regarding the requirement to ensure oxygen delivery devices are set according to physician orders and verified each shift. • The facility's admission, quarterly, significant change, and care plan review processes were revised to require review of all respiratory-related	06/18/2026

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F0695 SS = D	Continued from page 20 included a PO dated [redacted], NJ Ex Order 26, 4B1 [redacted] a PO dated [redacted], "Check if [redacted] in use whether prn or [redacted] that [redacted] matches physician's orders, every shift for NJ Ex Order 26, 4B1", a PO dated [redacted]; "NJ Ex Order 26, 4B1 [redacted] A review of the May 2026 electronic medication administration record (eMAR) revealed the [redacted] and [redacted] orders but did not reflect the [redacted] order. The eMAR did not reveal any documentation for NJ Ex Order 26, 4B1 [redacted] readings. A review of the [redacted] electronic treatment administration record (eTAR) did not reveal any of the orders. The eTAR did not reveal any documentation for [redacted] readings. The EMR revealed, under vitals, that the last time [redacted] saturation was recorded [redacted] Resident #20's Care Plan Report (CPR) revealed a personalized care plan with a focus statement that Resident #118 is on [redacted] services. A focus statement that the resident has [redacted] with an intervention of NJ Ex Order 26, 4B1 [redacted] revised [redacted] The CPR did not reveal any focus for [redacted] use or [redacted] The surveyor reviewed the facility policy titled Oxygen Administration, dated 12/2023, provided by the LNHA. The policy reflected under Purpose: Administer oxygen therapy in accordance with the attending physician's orders. The surveyor reviewed the facility policy titled Comprehensive Care Plan, dated 3/2024, provided by the LNHA. The policy reflected under 3.i. Reflect currently recognized standards of practice for problem areas and conditions. 5. …team is responsible for periodic review and updating of care plans. On 5/28/26 at 12:42 PM, the surveyor met with the U. S. FOIA (b) (2) [redacted] for concerns regarding Resident #20's [redacted]. The surveyor asked the	F0695	Continued from page 20 physician orders and verification that respiratory care interventions are reflected in the Comprehensive Person-Centered Care Plan. • A respiratory care audit tool was developed to verify consistency among physician orders, eMAR/eTAR documentation, oxygen equipment settings, oxygen saturation monitoring, and care plan interventions. The U. S. FOIA (b) (2) were educated by the [redacted] on the new audit tool, respiratory orders and oxygen settings being routinely checked on clinical rounds every shift. • The Interdisciplinary Team will review residents receiving oxygen therapy during care plan meetings to ensure ongoing consistency between physician orders, hospice plans when applicable, and resident care plans. VI. Monitoring of Corrective Action The Director of Nursing or designee will conduct audits of all residents receiving oxygen therapy as follows: • Weekly audits of five residents receiving oxygen therapy for four (4) weeks. Monthly audits of 10 residents receiving oxygen therapy for two (2) months Audit elements will include; Accuracy of oxygen physician orders. Oxygen equipment settings matching physician orders. Presence required oxygen saturation monitoring. Accurate eMAR/eTAR documentation. Care plan inclusion of respiratory care interventions. Documentation of physician notification and order changes when applicable.	06/18/2026

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F0695 SS = D	Continued from page 21 U. S. FOIA about the conflicting orders for NJ Ex Order 26, 4B1. The U. S. FOIA stated that the older order should have been discontinued and a separate order for oxygen saturation included. The surveyor asked the U. S. FOIA if oxygen use should have a separate focus in the CCP. The U. S. FOIA stated yes, there should be one and it should be clear and in line with the NJ Ex Order 26, 4 Care Plan. On 5/29/26 at 10:32 AM, the survey team met with the U. S. FOIA (b) (2) for responses to concerns. The facility did not provide any further pertinent information. NJAC 8:39-11.2(b); 27.1(a)	F0695	Continued from page 21 The Nursing Director or Designee will review all audits of resident feeding assignments and response, ensuring the facility's policy is followed accordingly. Findings will be reported to Administrator and will be presented in the quarterly Quality Assurance meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	06/18/2026
F0730 SS = D	Nurse Aide Perform Review – 12Hr/Year In- service CFR(s): §483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that all certified nursing assistants (CNA) received 12 hours of mandatory in-service training as required annually. This deficient practice was identified for 3 of 5 CNA files reviewed and was evidenced by the following: A review of the in-service records for 5 randomly selected CNAs revealed that 3 of 5 CNAs did not have the required 12 hours of annual in-service training by their anniversary date. 1. CNA #1 had a hire date of NJ Ex Order 26, 4B1 and completed 11 hours, 12 minutes of training. 2. CNA #2 had a hire date of NJ Ex Order 26, 4B1 and completed 6 hours of training. 3. CNA #3 had a hire date of NJ Ex Order 26, 4B1 and completed 11 hours, 42 minutes of training.	F0730	F730- Nurse Aide Perform Review Corrective Action(s) accomplished for those residents affected by the deficient practice: The facility immediately reviewed the education records of the CNA #1, CNA#2 and CNA#3 identified during the survey. CNA #1 completed the deficient in-service hours and now exceeds the required 12 annual in-service hours. CNA#2 completed the deficient in-service education hours and now exceeds the required 12 annual in-service hours. CNA#3 completed the deficient in-service education hours and now meets the required 12 annual in-service hours. Documentation of completed training was placed in each employee's education file. Performance reviews were conducted and education needs were assessed to ensure compliance with federal requirements. 2. Identification of residents who have the potential to be affected by the same deficient practice:	06/18/2026

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F0730 SS = D	Continued from page 22 On 05/28/26 at 11:27 AM, the surveyor reviewed the in [NJ Ex Order 26, 4B1 redacted], who was also the Staff Educator. The IP stated that the 3 CNAs did not meet the annually required 12 hours of in-services. On 5/28/26 at12:45 PM, the surveyor team met with the [U. S. FOIA (b) (2) redacted] to convey their concerns and findings. The [U. S. FOIA (b) (2)] both acknowledged and agreed that the CNA's did not meet the 12 hours of required education. On 5/29/26 at 10:30 AM, the [NJ Ex Order 26, 4B1] had no further information to provide. A review of a document "job description", "CNA" revealed a requirement of CNA certification that is active and in good standing with the state registry. A review of nursing policy and procedures, dated 1/15/2025, titled "Education of Nursing Staff" revealed…our facility has scheduled required 12 hours mandatory In-Service training for the nurse aids (CNA)…staff in-service training to be completed yearly… Resourced by the State Operations Manual (SOM). NJAC 8:39-43.17(b)	F0730	Continued from page 22 An audit of all active CNA's personnel files was completed to verify compliance with the annual requirement for at least 12 hours of in-service education and annual performance review. Any CNA identified as not meeting the required annual education hours was immediately scheduled to complete the outstanding education and documentation was updated accordingly. 3. Measures put into place or systemic changes to ensure that the deficient practice will not recur: The [U. S. FOIA (b) (2) redacted] were re-educated by the [U. S. FOIA (b) (2)] regarding federal requirements and facility policy "Education of Nursing Staff". The [U. S. FOIA (b) (2)], along with the [U. S. FOIA (b) (2)] met with the CNAs to reiterate the importance and requirement to complete their 12 hours of education. The [U. S. FOIA (b) (2)] will maintain a centralized tracking log of CNA's annual in-service hours and performance review due dates. Monthly reports will be generated identifying CNA's approaching year end date, and any employee lacking 12 hours in-service hours will receive a written notice of their hours not yet met. CNA's will be taken off the schedule until they have completed this requirement. CNA annual performance reviews will include verification of completed annual education requirements. Newly hired CNA's will be entered into the tracking system upon hire to ensure ongoing monitoring of annual education requirements. 4. Monitoring of corrective action: The Health Educator will conduct monthly audits of CNA education records to verify: Completion of annual performance reviews Completion of at least 12 hrs. of annual in-service	06/18/2026

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F0730 SS = D		F0730	Continued from page 23 education prior to year end date. Accurate maintenance of training documentation. Audits will be conducted monthly for three months and quarterly thereafter. Audit findings will be reviewed by the Administrator and reported through the facility Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional staff education and ongoing monitoring as deemed necessary by the QAPI Committee.	06/18/2026

New Jersey Department of Health

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S0000	Initial Comments The facility was not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		06/18/2026
S1410	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(b)(1) (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documentation it was determined that the facility failed to ensure newly hired employees completed the required NJ Exec Order 26.4b1 upon hire. This deficient practice was identified for 3 of 20 employee health files that were reviewed for employees who were hired since the last	S1410	S1410- Mandatory Infection Control and Sanitation CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Human Resource staff member immediately reviewed the employee health records of Employees #10, #12 and #20. Employee #10's [redacted] screening documentation was reviewed and updated to ensure compliance with current facility requirements. Employee #12 and #20 were contacted and scheduled for completion of the required [redacted]. Documentation of completed testing was placed in each employee's health file. 2. IDENTIFICATION OF RESIDENTSWHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: A comprehensive audit was conducted by the Infection Preventionist of all active employees health files to identify any additional employees hired since last survey who may have incomplete tuberculosis	06/17/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1B4IGL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

(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
S1410	Continued from page 1 recertification survey of 01/07/2025, and was evidenced by the following: 1. Employee#10's date of hire (DOH) was [NJ Ex Order 26, 4B1], and their [NJ Ex Order 26, 4B1] that was on file was dated [NJ Exec Order 26.4b1]. 2. Employee #12's DOH was [NJ Ex Order 26, 4B1], and their [NJ Exec Order 26.4b1] was administered on [NJ Exec Order 26.4b1]. The [NJ Exec Order 26.4b1] was not documented as administered. 3. Employee #20's DOH was [NJ Ex Order 26, 4B1] and their [NJ Exec Order 26.4b1] was administered on [NJ Exec Order 26.4b1]. The [NJ Exec Order 26.4b1] was not documented as administered. On 05/29/2026 at 11:17 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the [NJ Exec Order 26.4b] needed to be completed prior to the staff starting and that the facility needed to do better with the hiring process. The LNHA further stated [NJ Exec Order 26.4b] was completed so the residents would not be exposed to [NJ Exec]. A review of the policy titled "Employee Health Protocol and Immunizations with a revision date of October 2025, indicated that all new staff members are required to have a two-step tuberculin test and those who had positive [NJ Exec Order 26.4b1] would be scheduled for a [NJ Exec Order 26.4b1].	S1410	Continued from page 1 screening documentation. Any identified deficiencies were immediately addressed and corrected. The audit included verification of pre-employment health requirements, TB screening results, chest x-ray documentation when applicable, and documentation of medical contraindications or positive test follow-up. 3. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICENT PRACTICE WILL NOT RECUR: The Director of Nursing and the Health Educator/Infection Preventionist reviewed the new State Statues; N.J.A.C. 8:39-19.5(b)(1) to ensure understanding of the requirements of new employees before working in the facility. Effective immediately, it was determined to utilize QuantiFER-TB Gold (IGRA) blood testing for all newly hired employees as the primary method of tuberculosis screening, when appropriate and available, in accordance with current public health recommendations and applicable state regulations. This process eliminates the need for two-step PPD testing and improves compliance with pre-employment tuberculosis screening requirements. The Employee Health Policy has been updated to reflect the same. 4. MONITORING OF CORRECTIVE ACTION: A tracking log has been implemented to monitor completion of all required employee health screenings prior to the employee's first day on the schedule. Employee health file will be reviewed by the Director of Nursing or Infection Preventionist to verify completion of all required testing and documentation before a new employee is permitted to start orientation and begin work assignments involving resident contact. The Director of Nursing or the Infection Preventionist will conduct weekly audits of all newly hired employee health records for four weeks to ensure compliance with tuberculosis screening requirements. Thereafter, monthly audits will be conducted for three months. Audit findings will be reviewed by the Administrator and reported through the facility's Quality Assurance and Performance Improvement (QAPI)	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1B4IGL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

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S1410		S1410	Continued from page 2 Committee. Any identified concerns will result in immediate corrective action, additional staff education by the Director of Nursing or the Infection Preventionist , and ongoing monitoring as deemed necessary by the QAPI Committee.	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

(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
F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 06/24/2026 in relation to the 05/29/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Lo ng Term Care Facilities.	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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1B4IGL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 06/24/2026 in relation to the 05/29/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities.	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	**7 RYERSON AVENUE , CALDWELL, New Jersey, 07006**

(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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/28/2026 and 05/29/2026, St. Catherine of Siena was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. St. Catherine of Siena is a 3-story building with a full basement that was built in the 1960's. It is composed of Type I (222) construction. The facility is divided into 3 smoke zones on the second floor. The facility had a 300-Kilowatt diesel powered exterior generator that does 100% of the building. There were 4 private fire hydrants maintained by the facility. There was an electric vertical in line fire pump with jockey pump serving the 1 wet sprinkler system. The sprinkler system is supplied by city water. There was a fire alarm system with smoke detection in the corridors and common areas, smoke detection in the resident sleeping rooms was from battery operated single station smoke alarms. The first floor had administration offices, and the second floor had the Long-Term Care unit and resident sleeping rooms, and the 3rd floor was an occupied convent. There were 30 licensed beds and 28 were occupied at the time of survey.	K0000		06/25/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by:	K0345	K0345 – Fire Alarm System – Testing and Maintenance SS = F The deficient practice had the potential to affect all 28 residents residing in the facility. The two smoke detectors located in the elevator shafts were tested by the facility's licensed fire alarm contractor and verified to be operating properly. Documentation of the completed testing is maintained in the facility's Life Safety Code compliance records.	07/06/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

(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
K0345 SS = F Bldg. 01	Continued from page 1 Based on observation, interview and record review on 05/28/2026 and 05/29/2026 in the presence of the U. S. FOIA (b) (2) it was determined the facility failed to ensure: 1. all smoke detectors were tested annually, 2. battery operated single station smoke alarms were tested in accordance with manufacturers specifications, in accordance with NFPA 72: 2010 Edition. This deficient practice has the potential to affect all 28 residents and was evidenced by the following: 1. Record review on 05/28/2026 at 12:30 PM of the fire alarm system inspection and testing reports revealed, 2 smoke detectors located in the elevator shafts of the 2 facility's elevators were not tested in the last 12 months. In an interview at the time, the U. S. FO confirmed the record review. 2. Observations and interview on 05/28/2026 during a facility tour revealed the resident rooms were equipped with battery operated single station smoke alarms. Record review on 05/29/2026 at 9:55 AM of the single station smoke alarm inspection report revealed they were tested monthly. Further record review of the manufacturers specifications listed on the back of a device that was provided revealed, the manufacturer requires weekly testing of their devices. In an interview at the time, the U. S. FO confirmed the record review. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 05/29/2026 at 11:54 AM. N.J.A.C 8:39-31.2(e) NFPA 72	K0345	Continued from page 1 All battery-operated single-station smoke alarms throughout the facility were tested in accordance withthe manufacture's specifications. Weekly testing of all battery-operated smoke alarms has been implemented in accordance with the manufacturer's required testing frequency. Documentation of the completed testing is maintained by the Maintenance Department. A facility-wide review was completed to verify that: All required smoke detectors, including elevator shaft smoke detectors, are included in the annual fire alarm inspection and testing program. All battery-operated single-station smoke alarms are tested in accordance with the manufacturer's required testing frequency. Fire alarm inspection, testing, and maintenance documentation is complete and readily available. III. Measures Put Into Place or Systemic Changes to Ensure the Deficient Practice Will Not Recur The U. S. FOIA (b) (2) revised the facility's Fire Safety Testing and Preventive Maintenance Program to include: Verification that all elevator shaft smoke detectors are included in the annual fire alarm contractor inspection. Weekly testing of all battery-operated single-station smoke alarms in accordance with the manufacturer's instructions. A preventive maintenance tracking log identifying all required inspection and testing frequencies. Review of all annual fire alarm inspection reports upon receipt to ensure every required fire alarm device has been inspected and tested. Maintenance of all inspection, testing, maintenance, and corrective action records in the Life Safety Code compliance binder. IV. Staff Education On 06/01/2026, the U. S. FOIA (b) (2) conducted an in-service with the	07/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

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K0345 SS = F Bldg. 01		K0345	Continued from page 2 U. S. FOIA (b) (2) compliance. The education included: NFPA 72 requirements for inspection, testing, and maintenance of fire alarm systems. Annual testing requirements for elevator shaft smoke detectors. Manufacturer requirements for testing battery-operated single-station smoke alarms. Documentation requirements for fire alarm inspections and weekly smoke alarm testing. Procedures for reviewing contractor inspection reports to ensure all required fire alarm devices have been tested and documented. V. Monitoring The Director of Maintenance or designee will: Audit weekly battery-operated smoke alarm testing documentation weekly. Review annual fire alarm inspection reports upon receipt to verify that all required devices, including elevator shaft smoke detectors, have been tested and documented. Report audit findings to the Licensed Nursing Home Administrator and the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. Any identified deficiencies will be corrected immediately, and additional education will be provided as necessary. Responsible Persons: Licensed Nursing Home Administrator and Director of Maintenance. See attached: Fire alarm contractor inspection report showing the two elevator shaft smoke detectors were tested. Inspection logs or documentation showing the battery-operated smoke alarms were tested in accordance with the manufacturer's required	07/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

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K0345 SS = F Bldg. 01		K0345	Continued from page 3 frequency. Revised weekly smoke alarm testing log.	07/06/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on interview and record review on 05/28/2026 and 05/29/2026 in the presence of the [redacted], it was determined the facility failed to ensure sprinkler system deficiencies identified during inspections are addressed timely in accordance with NFPA 25: 2011 Edition. This deficient practice has the potential to affect all 28 residents and was evidenced by the following: Record review on 05/28/2026 at 11:57 AM of the fire pump inspection and testing reports revealed 2 deficiencies listed by the inspection service company; 1) Fire pump was unable to operate within design, and 2) Pitot pressure dropped after alternate power was active. The deficiencies appeared on the last 2 reports dated 05/04/2026 and 04/07/2026 and on the annual flow test report dated 10/10/2025. There was no evidence the issues were repaired. In an interview on 05/29/2026 at 9:55 AM, the [redacted]	K0353	Plan of Correction (K353 – Sprinkler System Maintenance and Testing) The identified deficiency was corrected by having the licensed fire protection contractor inspect, repair, and test the fire pump and associated alternate power operation. All deficiencies identified on the reports dated 10/10/2025, 04/07/2026, and 05/04/2026 were corrected. A follow-up inspection on 06/25/2026 and operational test confirmed that the fire pump operated within its design parameters and that the alternate power transfer function operated as required by NFPA 25. Documentation of the completed repairs and satisfactory testing has been maintained on-site and has been uploaded as supporting evidence. The facility conducted an audit of all available sprinkler system and fire pump inspection, testing, and maintenance reports to verify that there were no additional unresolved deficiencies. Any identified issues requiring corrective action were addressed, documented, and placed on a tracking log until completion. To prevent recurrence, the [redacted] implemented a Life Safety deficiency tracking process requiring all inspection, testing, and maintenance reports to be reviewed immediately upon receipt. Any cited deficiencies will be documented on a corrective action log, assigned for repair, tracked through completion, and verified by obtaining documentation from the licensed contractor before the item is closed. The Administrator or designee will review the log monthly to ensure timely completion of all outstanding Life Safety deficiencies. Education: On 06/01/2026 the [redacted] provided education/discussed with the [redacted] compliance regarding NFPA 25 requirements for timely correction of sprinkler and fire pump deficiencies, documentation requirements, review of contractor inspection reports, and maintenance of repair records. The Administrator or designee will audit fire protection inspection, testing, and maintenance reports monthly for three months to ensure all identified deficiencies are corrected promptly and supporting documentation is maintained. Results of	06/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

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K0353 SS = F Bldg. 01	Continued from page 4 stated that he was not aware of any issues with the fire pump and was having trouble communicating with the service company about the deficiencies at the time. No further documentation was provided. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 05/29/2026 at 11:54 AM. N.J.A.C 8:39-31.2(e) NFPA 25	K0353	Continued from page 4 these audits will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program, and corrective actions will be implemented as indicated. See Documents attached : Fire pump repair invoice/work order. Contractor service report showing repairs completed. Follow-up fire pump test report showing the system passed. Deficiency correction report from the fire protection vendor.	06/25/2026
K0374 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 05/28/2026 in the presence of the U. S. FOIA (b) (2) it was determined the facility failed to ensure smoke barrier doors are self-closing all the way into their frame in accordance with NFPA 101: 2012 Edition, Sections 8.5.4, 7.2.1.8, and 19.2.2.2.7 and NFPA 105: 2010 Edition. This deficient practice has the potential to affect 16 of 28 residents and was evidenced by the following: Observations at 11:03 AM of the double smoke barrier doors by room [redacted] revealed, the doors were on hold open devices and when tested the left door leaf didn't close all the way into its frame. In an interview at the time the [redacted] confirmed the	K0374	Completion Date: (X5): 06/12/2026 The left leaf of the smoke barrier doors located by Room [redacted] was inspected and adjusted by the U. S. FOIA (b) (2) on 06/02/2026, after the survey exit date of 05/29/2026. The door was tested multiple times to verify that it fully self-closes and seats completely into the frame when released from the hold-open device, in accordance with NFPA 101 (2012 Edition) and NFPA 105 (2010 Edition). To ensure that other residents are not affected by this deficient practice, all smoke barrier doors throughout the facility were inspected by the U. S. FOIA (b) (2) by 06/05/2026 to verify proper self-closing operation and complete latching into the frame. Any deficiencies identified during the inspection were corrected immediately. The U. S. FOIA (b) (2) reviewed/ educated the [redacted] 06/06/2026 regarding the NFPA requirements for smoke barrier doors, including proper self-closing operation, routine inspection procedures, documentation requirements, and the importance of ensuring doors fully close and seat in the frame. Documentation of the education has been completed and maintained by the facility. To ensure ongoing compliance, the Maintenance Director will include all smoke barrier doors in the facility's monthly Life Safety inspection program. The inspections will verify that each smoke barrier door closes completely into the frame and functions as required. Any identified deficiencies will be corrected immediately. The Administrator or	06/12/2026

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K0374 SS = E Bldg. 01	Continued from page 5 observation. The facility's [U. S. FOIA (b) (2)] was informed of the deficient practice at the Life Safety Code exit conference on 05/29/2026 at 11:54 AM. N.J.A.C 8:39-31.2(e) NFPA 105	K0374	Continued from page 5 designee will review the monthly inspection documentation for three months to ensure compliance and follow-up as needed. Evidence of Correction Submitted: Video demonstrating the Room [NJ Ex Ord] smoke barrier door operating correctly and fully closing into the frame. See attached documentation/video.	06/12/2026

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ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

(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
E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/29/2026. St. Catherine of Siena was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		06/18/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **08/19/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	**7 RYERSON AVENUE , CALDWELL, New Jersey, 07006**

(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
K0000 Bldg. 01	INITIAL COMMENTS INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 8/19/2026 in relation to the 5/29/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE , CALDWELL, New Jersey, 07006

(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
E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 08/19/2026 in relation to the 05/29/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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