STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLSIDE CARE AND REHAB	**3025 CHAPEL AVENUE WEST , CHERRY HILL, New Jersey, 08002**

(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 Complaint #: NJ00176090, NJ00175919, NJ00171909, NJ00169026, NJ00165303, NJ00181236, NJ00179553, NJ00179421, NJ00175629, NJ00177976, NJ00183043, NJ00167029, NJ00165390, NJ00165211, NJ00164234, NJ00181173, NJ00183473, N00183733. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure three residents (Resident (R)21, R22, and R24) were free from [NJ Exec Order 26.4b1] by R20 out of a total sample of 32 residents. Due to the vulnerable nature of the nursing home population, the potential for serious injury or serious physical or psychosocial impairment from being [NJ Exec Order 26.4b1] by R20 existed, and the likeliness of R20 [NJ Exec Orde] another resident in the facility was high and required immediate action to prevent further events of [NJ Exec Order 26.4b1] by R20. In addition, R20 [NJ Exec Order 26.4] three staff members (Certified Nursing Assistant (CNA)4, Licensed Practical Nurse (LPN)16, and LPN1). The facility's [U.S. FOIA (b)(6)] and [U.S. FOIA (b)(6)] were informed on 02/26/25 at 3:33 PM of the Immediate Jeopardy related to the failure to ensure R21, R22, and R24 were free from [NJ Exec Orde] from R20. The Immediate Jeopardy began on [NJ Exec Order 26] at 6:30 AM, which was the [NJ Exec Order] t. On 02/27/25 at 2:32 PM, the facility provided an acceptable Immediate Jeopardy Removal Plan. The survey team verified the implementation of the facility's IJ Removal Plan on 02/27/25 at 6:40 PM, which included the following: The [U.S. FOIA (b)(6)] immediately	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2025

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F0000	Continued from page 1 implemented [NJ Exec Order 26.4b1] for Resident #20 on all shifts. The in-service included the staff member assigned for [NJ Exec Order 26.4b1] and will not be assigned other duties. Resident # 20 will remain on [NJ Ex] per the physician's order indefinitely. The [NJ Exec Order 26.4b1] will be for 24 hours, including the 7-3PM, 3-11 PM, and 11PM-7AM shifts. On 2/26/25, the [U.S. FOIA] initiated verbal education for all working nursing staff, including agency staff. The in-service included is as follows: a Staff member will be assigned for [NJ Exec Order 26.4b1] and will not be assigned to any other duties. 2, The [U.S. FOIA (b)(6)] and supervisors will ensure [NJ Exe] is implemented and maintained at all times. Nursing staff reporting to duty will be educated by the supervisor/ designee prior to working unit 100% of the nursing staff education is completed. A staff member will be assigned to [NJ Exec Order 26.4b1] and will not be assigned to any other duties. All newly hired nursing staff will be educated during orientation by Human resources on [NJ Exec Order 26.4b1] per the facility's policy. The staff who received the education will verbalize understanding by signing the in-service as an acknowledgment of the education provided. After the Immediate Jeopardy was removed, the deficiency remained at a "G" scope and severity for actual harm due to R24 [NJ Exec Orde] that he/she was [NJ Exec Or] and kept his/her [NJ Exec Order 26.4b1]. Survey Dates: 02/24/25 - 02/27/25 Survey Census: 148 Sample Size: 32	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and	F0600	Corrective Action: Residents R20, R21, R22, and R24 have the potential to be affected by this deficient practice. The Director of Nursing immediately implemented [NJ Exec Order 26.4b1] for resident #20 on all shifts. The in-service included is as follows: a staff	04/10/2025

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F0600 SS = SQC-J	Continued from page 2 exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: NJ00176090, NJ00175919, NJ00171909, NJ00169026, NJ00165303, NJ00181236, NJ00179553, NJ00179421, NJ00175629, NJ00177976, NJ00183043, NJ00167029, NJ00165390, NJ00165211, NJ00164234, NJ00181173, NJ00183473, N00183733. Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure three residents (Resident (R)21, R22, and R24) were free from [NJ Exec Order 26.4b1] by R20 out of a total sample of 32 residents. Due to the vulnerable nature of the nursing home population, the potential for serious injury or serious physical or psychosocial impairment from being [NJ Exec Order 26.4b1] by R20 existed, and the likeliness of R20 [NJ Exec Orde] another resident in the facility was high and required immediate action to prevent further events of [NJ Exec Order 26.4b1] by R20. In addition, R20 [NJ Exec Order 26.4] three staff members Certified Nursing Assistant (CNA)4, Licensed Practical Nurse (LPN)16, and LPN1). The facility's [U.S. FOIA (b)(6)] and [U.S. FOIA (b)(6)] were informed on 02/26/25 at 3:33 PM of the Immediate Jeopardy related to the failure to ensure R21, R22, and R24 were free from [NJ Exec Orde] from R20. The Immediate Jeopardy began on [NJ Exec Order 26] at 6:30 AM, which was the [NJ Exec Order] On 02/27/25 at 2:32 PM, the facility provided an acceptable Immediate Jeopardy Removal Plan. The survey team verified the implementation of the facility's IJ Removal Plan on 02/27/25 at 6:40 PM, which included the following: The [U.S. FOIA (b)(6)] immediately implemented [NJ Exec Order 26.4b1] for Resident #20 on all	F0600	Continued from page 2 member will be assigned to for [NJ Exec Order 26.4b1] and will not be assigned any other duties. Resident #20 will remain on [NJ Exec Order 26.4b1] indefinitely per the physician order. The [NJ Exec Order 26.4b1] will be for 24 hours to include 7-3shift, 3-11 shift, and 11-7 shift. Identification of at-risk residents: All residents residing on resident #20's unit have the potential to be affected by the deficient practice. Systemic changes: On 2/26/2025, the DON initiated verbal education for all working nursing staff, including agency staff. The in-service included as follows: a staff member will be assigned for [NJ Exec Order 26.4b1] and will not be assigned to any other duties. The Unit Managers and Supervisors will ensure [NJ Ex] is implemented and maintained at all times. Nursing staff reporting to duty will be educated by Supervisors/designee prior to working until 100% of nursing staff education is completed. All newly hired staff will be educated during orientation on [NJ Ex] per the facility policy. The staff who received the education will verbalize understanding by signing the in-service as an acknowledgement of the education provided. Quality Assurance: The DON/designee will review and audit the nursign schedule daily to ensure all shifts are covered for an identified resident on [NJ Exec Order 26.4b1] for 3 months. The auditing will be done through a check list. The results from the audit will be reviewed by the QAPI an QA committee monthly for one quarter. The QA committee will determine if further actions are needed.	04/10/2025

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F0600 SS = SQC-J	Continued from page 3 shifts. The in-service included the staff member assigned for [NJ Exec Order 26.4b1] and will not be assigned other duties. Resident # 20 will remain on [NJ Ex] per the physician's order indefinitely. The [NJ Exec Order 26.4b1] will be for 24 hours, including the 7-3PM, 3-11 PM, and 11PM-7AM shifts. On 2/26/25, the [U.S. FOIA] initiated verbal education for all working nursing staff, including agency staff. The in-service included is as follows: a Staff member will be assigned for [NJ Exec Order 26.4b1] and will not be assigned to any other duties. 2, The [U.S. FOIA (b)(6)] and supervisors will ensure [NJ Ex] is implemented and maintained at all times. Nursing staff reporting to duty will be educated by the supervisor/ designee prior to working unit 100% of the nursing staff education is completed. A staff member will be assigned to [NJ Exec Order 26.4b1] and will not be assigned to any other duties. All newly hired nursing staff will be educated during orientation by Human resources on [NJ Exec Order 26.4b1] per the facility's policy. The staff who received the education will verbalize understanding by signing the in-service as an acknowledgment of the education provided. After the Immediate Jeopardy was removed, the deficiency remained at a "G" scope and severity for actual harm due to R24 [NJ Exec Order] that he/she was [NJ Exec Or] and [NJ Exec] his/her [NJ Exec Order 26.4b1]. Findings include: Review of the facility's "Abuse, Neglect, and Exploitation" policy dated 10/21/24 revealed, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse ... Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include ... certain resident to resident altercations ... Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm ... Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking ..."	F0600		04/10/2025

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F0600 SS = SQC-J	Continued from page 4 Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R20 was admitted to the facility on [redacted] diagnoses included [redacted] Review of the annual "Minimum Data Set (MDS)" with an assessment reference date (ARD) of [redacted] located in the EMR under the "MDS" tab revealed R20 was [redacted] in cognition with a BIMS score of [redacted] out of 15. R20 was [redacted] R20 did no[redacted] during the assessment period. The progression of R20's [redacted] behavior was as follows: a. Review of the "Reportable Event Record/Report" form dated [redacted] and provided by the facility revealed the type of [redacted] was [redacted], and it occurred on [redacted] at 6:10 PM. The [redacted] was called into the State Survey Agency on [redacted] at 11:33 AM. The description of the event read, "On [redacted] at about 6:10 PM, C.N.A [CNA4] in his/her w/c [wheelchair] between the A and B bed. The CNA [CNA4] called for help, resident [R20] was [redacted] of the room to [redacted] his/her [redacted] ..." Review of the undated "Investigation Summary" provided by the facility verified the [redacted] occurred as described on the "Reportable Event Record/Report" form dated [redacted], in which R20 became [redacted] which came in contact with R21's [redacted]. The "Investigation Summary" indicated both residents were assessed for [redacted] and [redacted] were noted. The "Investigation" read, " In conclusion, the [redacted] was [redacted] [R20] [redacted] [R21] when [redacted] ... On [redacted] both residents were interviewed by this writer, they had [redacted] of the [redacted] [R21] was [redacted] to a [redacted]. however, on [redacted] he/she [redacted] that he/she [redacted] his/her [redacted] and [redacted] ...	F0600		04/10/2025

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F0600 SS = SQC-J	Continued from page 5 Review of R20's "Care Plan" revised on [redacted] was included in the Event Reporting file dated [redacted] and revealed a [redacted] of "[R20] is/has potential to be NJ Exec Order 26.4b1 [redacted] care, and [redacted] to be [redacted] r/t [related to] NJ Exec Order 26.4b1 [redacted] [R20 NJ Exec Order 26.4b1 another resident [R21]." The goal was for R20 to [redacted] himself/herself or [redacted] Intervention in pertinent part[s] included [redacted] NJ Exec Order 26.4b1 [redacted]. CNA4 was an [redacted] member. The facility did not have a phone number for CNA4, who witnessed the [redacted] and an interview was not conducted with CNA4. b. Review of a "Nurse's Note" dated [redacted] at 10:56 PM revealed, "Resident [R20] was received (sic) in the hallway [redacted] Later he/she walked into room [redacted] and was NJ Exec Order 26.4b1 in the room... In an attempt to [redacted] him/her to his/her room he/she [redacted] me [LPN16] [redacted]. During an interview on 02/26/25 at 4:24 PM, LPN16 stated he was the nurse for the resident who resided in room [redacted] on [redacted] when the [redacted] with R20 occurred. LPN16 stated another nurse called him to go to room [redacted] to [redacted] R20 from the room, adding that the nurse told him R20 was [redacted] LPN16 stated that R20 was in the [redacted] in room [redacted] and went to use the resident's (who resided in room [redacted] [redacted] LPN16 said there were two other staff (a nurse and a CNA) in the room [redacted] LPN16 stated he tried to prevent R20 from using the [redacted] and he/she [redacted] him/her in the [redacted] LPN16 stated he quit trying to get him/her to come with him/her out of the [redacted] LPN16 stated it was [redacted] and he sustained a [redacted] to his [redacted] from being [redacted] During an interview on 02/26/25 at 2:12 PM, the [redacted] stated that he was not aware of this [redacted] c. Review of a "Nurses Note" dated [redacted] at 10:25 PM in the EMR under the "Progress Notes" tab revealed, "This nurse [LPN]1 was called by one of the aides reporting that patient [R20] had [redacted] and was [redacted] himself/herself in room #... This nurse [LPN1] went to room #... and attempted to [redacted] the patient	F0600		04/10/2025

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F0600 SS = SQC-J	Continued from page 6 [R20] out of the room. Patient then proceeded to [redacted] this nurse's [redacted] his/her [redacted]. This nurse stepped away and asked patient [resident] to [redacted] at which point the patient [R20] placed this nurse in a [redacted] and continued to [redacted] this nurse. This nurse called the [redacted] to [redacted] situation." During an interview on 02/25/25 at 2:45 PM, LPN1 stated R20 was [redacted] and was [redacted] to staff and residents. LPN1 stated R20 [redacted] her in the [redacted] and put her in a [redacted] on [redacted] when she tried to [redacted] R20 [redacted] resident's room. LPN1 stated she did not think it was [redacted] for residents with R20 [redacted] in the facility. LPN1 stated she reported the [redacted] to the supervisor on duty. During an interview on 02/26/25 at 2:12 PM, the [redacted] stated that he was not aware of this [redacted] d. Review of the "Reportable Event Record/Report" form dated [redacted] provided by the facility revealed the event occurred on [redacted] at 6:30 AM and was classified as [redacted]. The description of the event read, "Nurse reported to [redacted] that during 6 AM med [medication] pass on [redacted] CNA observed a [redacted] between the [redacted] [R20 and R22]. [R20] had [redacted] and [R22] had [redacted] to [redacted] area and [redacted] and [redacted] [R22] was transported to [the] hospital for evaluation and returned with no new orders. [R20] was escorted to [redacted] with [redacted] and returned with no new orders. Physician and family members were contacted and made aware. [redacted] applied to [R20] as primary intervention for [redacted] ..." Review of the undated "CNA Statement" provided by the facility revealed CNA5 documented, "I was doing my rounds and I asked [R21] where was his/her [redacted] [R20] and he/she (sic) was just here. Walked out of the room, heard talking so I went in the room and [R20] was [redacted] (sic) [R22] with his/her [redacted] on [R22's] [redacted] Review of the undated "Investigation Summary" revealed ... Upon further investigation, the CNA stated that both residents were both seen in their individual bedrooms at 0430 [4:30 AM] and upon	F0600		04/10/2025

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F0600 SS = SQC-J	Continued from page 7 another round @ 0500 [5:00 PM], residents were seen in a NJ Exec Order 26.4b1 in [R22] s room. Following [the] return from NJ Exec Ord staff attempted to NJ Exec Order 2 [R20] to NJ Exec Order 2 NJ Exec Ord however he/she NJ Exec Order 2 and became NJ Exec Order 26.4b with staff. NJ Exec Order 26.4b1 was then offered to [R22], and his/her family agreed to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 for NJ Exec Orde [R22] was to Exec Order 26.4b1 [R20] was placed on NJ Exec Order 26 and was then evaluated via NJ Exec Order 26.4b by NJ Exec Ord who gave [an] order to remove N and recommended med [medication] NJ Exec Order 26 pending NJ Exec Order 26.4b ... [R21 and [R20] have NJ Exec Order 26.4b1 and this NJ Exec Order 2 is isolated. It is concluded that [R20] may have entered [R22]'s room in a moment of NJ Exec Order 26.4b which then caused [R22] to get out of bed and approach him/her to NJ Exec Order him/her NJ Exec his/her NJ Exec Order 26.4 This may have led to the NJ Exec Order 26.4b ... Both residents also NJ Exec Order 26.4b1 the NJ Exec Order 2 when interviewed the following day ..." Interventions were NJ Exec Order 26.4b the residents immediately, NJ Exec evaluations, NJ Exec Ord notification, physician notification, families notified, [R22] transported to the emergency department and R20 transported to NJ Exec Ord NJ Exec Order 26.4b1 was removed on NJ Exec Order 26.4 Review of R22's "Weekly NJ Exec Evaluation" dated NJ Exec Order 26.4 revealed R22 had a NJ Exec Order on his/her NJ Exec Order 26.4b1 on his/her NJ Exec Order 26.4b1 on his/her NJ Exec Order 26.4b1 n, a NJ Exec Order 2 area NJ Exec Ord his/her NJ Exec O NJ Exec Order that was NJ Exec Order ollen NJ Exec Order 26.4 of his/her NJ Exec O NJ Exec Order 26.4 on the NJ Exec of his/her NJ Exec O NJ Exec Order 26.4b on the NJ Exec of his/her NJ Exec O a NJ Exec Order on the NJ Exec O on the NJ Exec Order 2 , and a NJ Exec Order NJ Exe NJ Exe The narrative read, "Resident was by NJ Exec Order 26.4b1 [R20]. He/She has NJ Exec Order to his/her NJ Exec and NJ Exec Order 2 NJ Exec Order 26.4b on his/her NJ Exec O NJ Exec Order 26.4b1 and a NJ Exec Orde on his/her NJ Exe .." Review of R20's "Weekly NJ Exec Evaluation" dated NJ Exec Order 26 revealed R20 had an NJ Exec Order 26 to the front of his/her NJ Exec Order 26.4b The narrative read, "The NJ Exec Order 26 is a result of NJ Exec Order 26.4b1 with NJ Exec O NJ Exec Order 26.4b1 applied. No NJ Exec verbalized or observed." Review of the "Order Summary Report" current through NJ Exec Order 26 in the EMR under the "Order" tab revealed the physician ordered a NJ Exec Order 26.4b1 for R20 for " NJ Exec Order 26.4b1 and NJ Exec Orde behavior" on NJ Exec Order 26 .	F0600		04/10/2025

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F0600 SS = SQC-J	Continued from page 8 Review of the investigation file revealed [redacted] was conducted on [redacted]. Review of the [redacted] clinical consultation form dated [redacted] revealed R20 [redacted] on another resident and had his/her [redacted] the resident's [redacted] No [redacted] were sustained. [redacted] support was requested. The form read, "Risk factors: [redacted] at [the] time of assessment for [redacted] Recommendations included [redacted] with residents, [redacted] for unmet needs, and follow up with [redacted] with NJ Exec Order 26.4b1 of behavior. Training recommended included staff training on Resident [redacted] in LTC. CNA5, an [redacted] was called on the phone on 02/26/25, and a message was left by the surveyor. CNA5 did not return the call, and CNA5, who was a [redacted] to the [redacted] was not interviewed. LPN14, an agency staff assigned to R20 on [redacted] was called on 02/26/25; there was no answer, and voice mail was not activated to leave a message. LPN14 was not interviewed. There was no written statement by LPN14 regarding the [redacted] During an interview on 02/26/25 at 2:04 PM, the U.S. FOIA stated he completed the investigation and stated R20 was sent to the [redacted] of the ER [emergency room] following this [redacted] The U.S. FOIA stated it was common, as in this case, that the hospital reported the resident had [redacted] and they sent R20 back to the facility. The [redacted] stated R20 was initially on NJ Exec Order 26.4b1 then [redacted] and then the U.S. FOIA (b)(6) recommended the discontinuation of [redacted] The U.S. FOIA stated R20's NJ Exec Order 26.4b1 medication with [redacted] was [redacted] after this [redacted] The [redacted] verified there were no additional staff statements and no staff training after the [redacted] (as recommended in the [redacted] evaluation). The U.S. FOIA stated both residents had [redacted] of behaviors. During an interview on 02/27/25 at 7:03 PM, the U.S. FOIA was asked if the [redacted] was NJ Exec Order 26.4b1 as this was not documented on the "Investigation Summary." The U.S. FOIA stated he was not sure if it was NJ Exec Order 26.4b1	F0600		04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2025

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F0600 SS = SQC-J	Continued from page 9 e. Review of the "Reportable Event Record/Report" form dated [redacted] provided by the facility revealed the [redacted] was classified as [redacted] that occurred on [redacted] at 5:45 PM and was reported to the state on [redacted] at 7:40 PM by the [redacted]. The "Reportable Event Record/Report" revealed that the [redacted] occurred in R24's bedroom, and it was reported to the [redacted] that R20 had [redacted] into R24's bedroom. Staff intervened and attempted to [redacted] R20 [redacted] R20 became [redacted] and a [redacted] started between the residents. Both residents were [redacted] and [redacted]) was called. R24 was transported to the hospital for evaluation and returned on [redacted] with no new orders or [redacted] was requested to send R20 to [redacted] but they [redacted] R20 was placed on [redacted] immediately. [redacted] evaluations were completed, and [redacted] issues were noted; however, what the [redacted] were was not documented. [redacted] included [redacted] the residents, [redacted] evaluations, [redacted] evaluations, [redacted] notification, emergency contacts and physician notified, [redacted] implemented, [redacted] consult ordered, [redacted] consult, as well as [redacted] being provided. Review of LPN15's "Employee Statement" revealed the [redacted] occurred at 5:30 PM as follows, "Resident was last seen in [the] hallway going to dayroom for dinner. Was notified by aide that resident [R20] was in R24's room following a [redacted] and [redacted] the room. Resident became [redacted] with staff upon entry. [redacted] resulted in another resident [R24] being [redacted] and sent to the hospital with [redacted] to the [redacted] of his/her [redacted] Review of R20's "Weekly [redacted] Evaluation" dated [redacted] and provided to the surveyor revealed R20 was not documented with any [redacted] [redacted]s. Review of R24's "Weekly [redacted] Evaluation" dated [redacted] and provided to the surveyor revealed R24 was observed with a "[redacted]" to the [redacted] of his/her [redacted] that "[redacted]" per the [redacted] R24 was noted with [redacted] on the [redacted] of his/her [redacted] and the narrative read, "Resident [redacted] when he/she [redacted] Sent to ER for evaluation and treatment."	F0600		04/10/2025

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F0600 SS = SQC-J	Continued from page 10 Review of the "Emergency Department" report dated [redacted] and provided by the facility revealed R24's diagnoses of, "[redacted], initial encounter, [redacted] of [redacted] ..." Review of the "Order Summary Report" dated [redacted] in the EMR under the "Orders" tab revealed a physician's order on this date for, "[redacted] every shift for observation and [redacted] and document." During observation on 02/26/25 at 6:09 AM, R20 was in his/her room. R20's [redacted] was in bed with his/her eyes closed. There was no CNA providing [redacted] in the room, and no CNA was observed in the hallway outside R20's room. A second observation on the same day, 8:15 AM through 8:30 PM, revealed that R20 was under [redacted] During an interview on 02/26/25 at 2:12 PM, the [redacted] stated that there should be [redacted] on all shifts. The [redacted] stated usually R20 was a [redacted] but when anyone tried to [redacted] him/her, there was no [redacted] him/her. The [redacted] stated that it was his/her [redacted] During an interview on 02/26/25 at approximately 5:15 PM, R24 recalled the [redacted] on [redacted] R24 stated he/she was eating dinner in his/her room, and R20 [redacted] and [redacted] him/her that [redacted]. R24 stated he/she told R20 [redacted] and asked him/her to [redacted] R24 stated that R20 [redacted] at the head of the bed with his/her cell phone in it. R24 stated that two staff members came into the room and [redacted], but R20 said [redacted] and [redacted]. R24 stated he/she got up and walked to the door and R20 [redacted] him/her, the staff having already left the room. R24 stated he/she was standing by the door, and R20 [redacted] him/her, and he/she [redacted] in the hallway, [redacted] the [redacted] of his/her [redacted] on the [redacted] which caused him/her [redacted] to the [redacted] of his/her [redacted] R24 stated the [redacted] came, and he/she was asked by the nurse if they wanted to go to the hospital, which he/she stated he/she did. R24 stated the [redacted] on [redacted] was not the first time R20 [redacted]. R24 stated, a few days	F0600		04/10/2025

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F0600 SS = SQC-J	Continued from page 11 before that, R20 NJ Exec Order 26.4b1 , NJ Exec Order 26.4 [redacted]. R24 reported it to the CNA and asked if she could see what R20 was doing. R20 NJ Exec Order 26.4b1 [redacted]. R24 stated after the NJ Exec Order 2 on [redacted] he/she was in the dining area, and she saw R20 walking around and did not see any staff with him/her. R24 stated he/she was NJ Exec Order 2 about that. R24 stated he/she was NJ Exec Order 26.4b1 by the NJ Exec Order 2 on NJ Exec Order 26.4 R24 stated he/she was keeping [redacted] so NJ Exec Order 26.4b1 [redacted] R24 stated none of the staff came and asked him/her to give them a statement of what occurred on NJ Exec Order 26. or came to discuss how he/she was doing. Review of R20's " NJ Exec Order 26.4b1 Progress Note" dated NJ Exec Order 26 and provided by the facility, revealed recommendations were made regarding R20 to consider NJ Exec Order 26.4b and NJ Exec Order 26.4b1 approaches, [redacted] provide NJ Exec Order 26. provide NJ Exec Order 2 NJ Exec Order 26.4b1 , treat NJ Exec Order 26.4b1 encourage participation in activities, and social engagement. The recommended medication changes were to add NJ Exec Order 26.4b1 q day at 2:00 PM and NJ Exec Order 2 the bedtime dose to NJ Exec mg, with the morning dose remaining unchanged. Review of the "Order Summary Report" current through NJ Exec Order 26.4 in the EMR under the "Orders" tab revealed the recommended changes to NJ Exec Order 26.4 were ordered. LPN15 was called on 02/26/25, and a message was left. LPN15 did not return the surveyor's call, and she was not interviewed. CNA6 was called on 02/26/25 at 3:57 PM, and a message was left. CNA6 did not return the surveyor's call and was not interviewed. During an interview on 02/26/25 at 6:19 AM, CNA7 stated she had an assignment of residents, including R20. CNA7 stated there was no permanent CNA completing NJ Ex on the night shift; NJ Ex for R20 was completed on the day shift and evening shift only. CNA7 was in the hallway after coming out of a different resident's room and stated she had a NJ Exec [redacted] e of R20's room for NJ Exec [redacted] when she was not providing care or doing rounds.	F0600		04/10/2025

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F0600 SS = SQC-J	Continued from page 12 During an observation on 02/26/25 at 7:00 AM, R20 was observed in his/her room. There were no staff in the room providing NJ Exec Order 26.4b1 At this time, the day shift CNA came on duty and went to R20's room. During an interview on 02/26/25 at 10:55 AM, the U.S. FOIA (b)(6) stated NJ Exec Order 26.4b and NJ Exec Order 26.4b1 residents were a big concern, and they looked at each case and patient individually. The U.S. FOIA (b)(6) stated he was not aware of any residents that were currently having a problem with NJ Exec Order 26.4b or of NJ Exec Order 26.4b1 incidents. The U.S. FOIA (b)(6) stated he would like to be involved in the plan to address these incidents. The U.S. FOIA (b)(6) reviewed R20's Physician's Orders and stated the NJ Exe should be on all shifts per the orders. The U.S. FOIA (b)(6) stated he was not the attending physician of R20. During an interview on 02/26/25 at 5:10 PM, the U.S. FOIA (b)(6) stated U.S. FO required staff to be in the resident's NJ Exec Order 26.4b1 During an interview on 02/27/25 at 11:57 AM, CNA8 stated that R20 tended to be NJ Exec Order 26.4b1 towards staff and could also be NJ Exec Order 26.4b1 towards residents. CNA8 stated that R20 said, " NJ Exec Order 26.4 at times when trying to provide care or and he/she was very NJ Exec O and NJ Exec Order 26.4b1 CNA8 stated that the main approach was to NJ Exec Order R20 when he/she became NJ Exec Order 26.4b1 and to keep him/her NJ Exec O to NJ Exec Order 26.4b1. During an interview on 02/27/25 at 3:01 PM, LPN9 stated R24 was NJ Exec Order 26.4b1 by the NJ Exec Order with R20. During an interview on 02/27/25 at 6:39 PM, the U.S. FOIA stated he had spoken with R24 on the phone after the NJ Exec Order occurring on NJ Exec Order 26.4 The U.S. FOIA stated R24 reported to him that R20 NJ Exec Order 26.4b into his/her room and the staff NJ Exec Order 26.4b1. The U.S. FOIA stated R24 told him R20 NJ Exec Order him/her NJ Exec Ord The U.S. FOIA stated R24 had not reported R20 NJ Exec Order and NJ Exec Or NJ Exec Or1 his/her NJ Exec Order 26.4b . The stated he was aware that there were NJ Exec Order 26.4b1 on the NJ Exec Order 26.4 unit. The staff had talked with families, offered NJ Exec Order 26.4b to residents to place on their NJ Exec Ord put NJ Exec Orde on the	F0600		04/10/2025

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F0600 SS = SQC-J	Continued from page 13 [redacted] so residents NJ Exec Order 26.4b1. The [redacted] stated the [redacted] occurred mostly in the evenings, and they could not [redacted] residents. The [redacted] stated they had consulted [redacted] and did [redacted] R20. The [redacted] stated the facility was seeking NJ Exec Order 26.4b1 for R20, although his/her family was not open to it. The [redacted] stated R20 would be more NJ Exec Order 26.4b1 [redacted] so her [redacted] could be [redacted]. Additionally, the [redacted] stated that their regular night shift nurse was [redacted] and the night [redacted] was not provided. The [redacted] stated that LPN17 should have assigned a CNA for [redacted] for R20 and should not have given that CNA any other assignment. The [redacted] verified that there was a U.S. FOIA (b)(6) working the night shift who also could have caught the error of R20 not having a staff member assigned for [redacted] N.J.A.C. 8:39-4.1(5)	F0600		04/10/2025
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to monitor and assess a resident's [redacted] around a [redacted] and notify the physician timely when [redacted] was found around the [redacted] for one of one (Resident (R)14) reviewed for timely monitoring and assessments of 32 sampled residents. This failure resulted in [redacted] when R14 was sent to the hospital, [redacted] was required, and a [redacted] was found under the [redacted] Findings include: Review of R14's undated "Face Sheet" located	F0684	Corrective Action: Resident #14 is no longer a resident at this facility. All nurses were in-serviced, begining on 3/10/2025, on notifying the physician in a timely manner. Identification of Resident at Risk: All residents have the potential to be at risk by this deficient practice. Systemic change: The Director of Nursing (DON) began an in-service on 3/10/2025 for an education program for staff nurses on the facility notification policy and the importance of promptly notifying the physician on the residents change in condition as well as the resident/resident representative and documenting the notification in the progress notes. Quality Assurance (QA): The DON will do a random audit of 5 residents with a change in condition weekly for 12 weeks to ensure any change in a resident condition has been communicated to the physician /family promptly and documented in the progress notes. This audit will be completed utilizing QA auditing tool. Any findings from the audit will be addressed immediately and the results from the audit will be reviewed by the QAPI and Quality Assurance (QA) Committee monthly for one quarter. The QA committee will determine if further actions	04/10/2025

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F0684 SS = G	Continued from page 14 under the "Profile" tab in the electronic medical record (EMR) revealed that R14 had been admitted to the facility initially on [redacted] 2 with the diagnosis of NJ Exec Order 26.4b1. The resident [redacted] at the facility on [redacted]. Review of R14's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab in the EMR with an "Assessment Reference Date (ARD)" of [redacted] revealed that he/she had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated he/she was NJ Exec Order 26.4b1. Review of R14's "Progress Notes" dated [redacted] at 4:25 AM, located under the "Progress Note" tab in the EMR, revealed that the resident had an NJ Exec Order 26.4b1. The resident was assessed; his/her [redacted] was noted with [redacted] and he/she was [redacted]. Emergency Medical Services (EMS) was notified, and the resident was transferred to the emergency room (ER). The "Progress Note" further revealed at 10:31 AM, and the resident returned to the facility with a diagnosis of [redacted] with a [redacted] to [redacted] his/her [redacted]. At 11:56 AM, the resident was sent to the hospital to have a [redacted] placed on his/her [redacted] due to him/her [redacted]. At 8:16 PM, the resident was admitted to the hospital for [redacted] of his/her [redacted]. The resident returned to the facility on [redacted] with a [redacted] in place. There was no further documentation of any assessments or monitoring of the resident's [redacted] or [redacted] around the [redacted] unti [redacted]. Review of R14's "Progress Note" dated [redacted] revealed that the resident [redacted] of [redacted] in his/her [redacted]. After the [redacted] was assessed, [redacted] and an opening under the [redacted] were noted around the resident's [redacted]. The supervisor was notified. There was no further documentation or assessment of the resident's [redacted] until [redacted]. Review of R14's "Progress Note" dated [redacted] at 12:55 PM revealed, a [redacted] was noted from the resident's [redacted]. The physician was notified and an order was received for [redacted]) for [redacted] days. There was no documentation showing that the physician had been notified of the [redacted] found two days prior.	F0684	Continued from page 14 are needed and necessary adjustment to the corrective action.	04/10/2025

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F0684 SS = G	Continued from page 15 Review of R14's "Progress Note" dated [redacted] at 8:19 AM revealed the resident was noted with a [redacted] on his/her [redacted]. The physician was made aware, and the resident was sent to the ER and admitted with a [redacted] Review of R14's "Admission Worksheet" located under the "MISC" tab in the EMR dated [redacted] revealed the resident returned to the facility with the diagnosis of [redacted] hardware removal and [redacted] An attempt was made to contact Licensed Practical Nurse (LPN)18, who was identified by the [redacted] as the [redacted] on 06/18/23 when the [redacted] was identified. A voice message and no return call was received prior to the survey's on exit 02/27/25. An attempt was made to contact LPN19 on 02/26/25 at 2:57 PM, who had been assigned to the care of R14 from [redacted]. A voice message was left, but no return call was received prior to the survey's exit on 02/27/25. An attempt was made to contact LPN20 on 02/26/25 at 4:10 PM, who had previously been the [redacted] where R14 had resided. A voice message was left, but no return call was received prior to the survey's exit on 02/27/25. During an interview on 02/26/25 at 5:50 PM, LPN8 stated, "I know that he/she [R14] [redacted] his/her [redacted] and we sent him/her [R14] out to the hospital. He/She [R14] came back and [redacted] at the [redacted], and then we had to send him/her [R14] back out to the hospital, at which time he/she had a [redacted] on his/her [redacted]. I remember that he/she [R14] had to go to the hospital to have it [redacted] and then he/she came back to us." An attempt was made to contact the [redacted] for R14 on 02/27/25 at 4:00 PM. A voice message was left, but no return call was received prior to the survey's exit on 02/27/25.	F0684		04/10/2025

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F0684 SS = G	Continued from page 16 During an interview on 02/27/25 at 7:00 PM, the [U.S. FOIA] was asked his expectations of the nurses caring for a resident, such as R14 with a [NJ Exec Order 26.4] and he stated, 'I would rather not speak to this as I was not the [U.S. FOIA] at that time." N.J.A.C. 8:39-3.2 (a)(b)	F0684		04/10/2025
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must	F0584	Corrective Measures for Resident(s) Affected: Residents R4,R17, R18, and R27 were affected by this deficient practice. The shower room on the [NJ Exec Order 26.4] unit was cleaned thoroughly by the housekeeping department. All common area floors were cleaned. Food carts with partially eaten foods removed. The scales, equipment, fabric pad, Geri chairs, walker, mats, garbage on floor, clothing and soiled briefs in the second-floor shower room area were removed. Floor in the second-floor shower room scrubbed and air fresheners installed. The hallways and walls on [NJ Exec Order 26.4] were cleaned. Garbage cans were emptied and removed from the shower room. Floor drain in [NJ Exec Order 26.4] shower room replaced. All shower chairs, mats and pads have been disinfected and allowed to air dry. Identification of Others with the potential to be Affected: All residents have the potential to be affected. The facility Environmental Services Director completed a physical plant audit with a specific focus on shower rooms, dining rooms and hallways on [NJ Exec Order 26.4] Unit. Measures to Prevent Recurrence: On 3/20/2025, the facility Administrator completed one on one education with the facility [U.S. FOIA (b)(6)]	04/10/2025

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(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
F0584 SS = E	Continued from page 17 maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure the environment was clean, sanitary, and homelike for four out of 11 sampled residents (Resident (R)4, R17, R18, R27) who resided on the [NJ Exec Order] floor ([NJ Exec Order 26.4] unit). Specifically, the only shower room on the [NJ Exec Order] floor ([NJ Exec Order 25.4] unit) and common area floors on the [NJ Exec Order] floor were unclean. Additionally, food carts with partially eaten meals from the previous day were observed in the hallway on the [NJ Exec] floor. Findings include: Review of the facility's "Homelike Environment" policy dated August 2024 revealed, "Residents are provided with a safe clean, comfortable and homelike environment ... The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary, and orderly environment ..." 1. Residents residing on the [NJ Exec Order]-floor reported concerns about cleanliness and the condition of the shower room on the [NJ Exec Order] floor: a. During an interview on 02/24/25 at 2:21 PM R4 stated the shower room that he/she utilized for showers on the [NJ Exec Order] floor was used as a storage area for scales, equipment, clothing from residents who had discharged, and soiled incontinence briefs were stored in the shower room creating terrible odors at times. R4 stated cleanliness on the [NJ Exec Order] floor was also a concern and reported that the hallway had not been mopped for four days. R4 stated the flooring in the common areas was disgusting. R4 reported there were concerns with the housekeeping shifts not being filled on the [NJ Exec Order] floor. Review of R4's quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of [NJ Exec Order 26] located in the electronic medical record	F0584	Continued from page 17 [U.S. FOIA (b)(6)] on the need to maintain a clean/safe/homelike environment. This education included the need to complete a physical plant audit with focuses on shower rooms, dining rooms and hallways throughout the facility focusing on [NJ Exec Order 26.4] Unit. Monitoring of Corrective Measures: The Facility Administrator will complete random physical plant audits to ensure that the shower rooms are clean and free of storage, garbage and odors. The Facility Administrator will complete random physical plant audits to ensure that dining rooms and hallways are clean and free of debris. Audits will occur twice weekly for 4 weeks, then weekly for 8 weeks. Audit results will be forwarded to the facility QAPI committee.	04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2025

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F0584 SS = E	Continued from page 18 (EMR) under the "MDS" tab revealed R4's cognition was [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15. b. During an interview on 02/24/25 at 3:32 PM, R17 stated "The shower is a mess." R17 stated staff used the shower room as a storage area and he/she was NJ Exec Order 26.4b1 due to the clutter and stated, "It was totally dirty." R17 stated there were two mats on the floor in the shower stalls, a shower bed in one shower stall and two chairs in the second shower stall. R17 stated the room was such a mess he/she [redacted]. Review of R17's quarterly "MDS" with an ARD of [redacted] located in the EMR under the "MDS" tab revealed R17's cognition was [redacted] with a BIMS score of [redacted] out of 15. c. During an interview on 02/24/25 at 4:08 PM, R18 stated he/she [redacted], reporting he/she could [redacted]. R18 stated the staff wanted him/her to lay [redacted] to be [redacted] R18 stated the [redacted] was not adequately cleaned. When staff had taken him/her in there, the [redacted] he was supposed [redacted] on was wet, soggy, and unclean. R18 stated he/she had [redacted] about this to staff and had [redacted] ever since. Review of R18's quarterly "MDS" with an ARD of [redacted] located in the EMR under the "MDS" tab revealed R18's cognition was [redacted] with a BIMS score of [redacted] out of 15. d. During an interview on 02/26/25 at 6:29 AM, R27 stated the shower room was unclean. R27 stated he/she [redacted] when taking him/her [redacted] and a few times the [redacted] had not been wiped off and there was stuff all over the floor. R27 stated someone's clothes were stored in the shower room in a pile. Review of the admission "MDS" with an ARD of [redacted] located in the EMR under the "MDS" tab revealed R27's cognition was [redacted] with a BIMS score of [redacted] out of 15.	F0584		04/10/2025

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F0584 SS = E	Continued from page 19 2. During an observation on 02/24/25 at 2:00 PM, the hallways of the [NJ Exec Order 26.4] unit were observed with numerous areas of sticky food/beverage spills and small white particles mostly concentrated on the floor by the walls. The dining common area had a large spill of several feet in length and approximately one foot in width near the windows. During an observation on 02/24/25 at 4:00 PM, the [NJ Exec Order 26.4] shower room was made with Licensed Practical Nursing (LPN)15. The shower room had three shower stalls. Each shower stall contained equipment. The first stall had a shower bed with two shower pads, one solid foam and one with fabric on top. The fabric pad was soiled with white residue, verified by LPN15 who agreed it was not clean. There were shower chairs in the other two shower stalls. There was garbage on the floor such as an empty plastic garbage bag and wadded up paper towels. LPN15 stated the Certified Nursing Assistants (CNAs) showered residents and it was the only shower room for [NJ Exec Order 26.4] which had a typical census of 57 residents. LPN15 stated housekeeping staff cleaned the shower room once a day, including sterilizing the shower pad daily. LPN15 stated CNAs were to clean up after each shower that was provided. The second shower stall was missing the floor drain; the hole approximately two inches in diameter was not covered. The area at the back of the shower room was used for dressing residents per LPN15. This area was cluttered and in a state of disarray with multiple pieces of equipment including two Geri chairs, a walker on top of one of the Geri chairs, curled up floor mats, two scales, and two large 55-gallon garbage cans. One garbage can did not have the lid on it; it contained garbage. LPN15 put the lid on the can and stated the lid should be on the can. The second can was opened by LPN15, and it was a third full of soiled linen including soiled incontinence briefs that were not individually bagged and it smelled when the lid was removed. On one of the Geri Chairs, there was a pile of clothing (at least 20 pieces) that overflowed onto the floor where there were about another 10 pieces of clothing in a pile on the floor. LPN15 verified the shower room was not clean and needed to be organized with excess equipment/items removed. LPN15 verified residents' clothing should not be stored in the shower room. During an observation on 02/24/25 at 4:05 PM, there was a large sticky area, approximately 12 inches in diameter, in the hallway on [NJ Exec Order 26.4] between room [NJ Exec] and [NJ Exec]. There was also a sticky area in hallway between [NJ Exec] and [NJ Exec] about 12 inches	F0584		04/10/2025

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F0584 SS = E	Continued from page 20 in diameter. During an observation on 02/25/25 at 11:19 AM, the floors in the [NJ Exec Order 26.4] hallways were observed with lots of sticky looking areas of food/beverage spills. During an observation on 02/27/25 at 1:13 PM, the surveyor and U.S. FOIA (b)(6) observed the [redacted] floors of both hallways and the dining room. There were numerous sticky areas, multiple smaller areas of accumulated spills, and small white flecks throughout the hallways and dining room floors. The U.S. FOIA (b)(6) stated the small white flecks were paint chips. The U.S. FOIA (b)(6) stated the floors needed a lot of attention; she stated they are not clean. There were sticky areas throughout the dining room floor. During an observation on 02/27/25 at 1:18 PM the surveyor and U.S. FOIA (b)(6) entered the [redacted] shower room. There was a balled-up paper towel, plastic pieces, and breadcrumbs on the floor. One of the garbage cans contained soiled incontinence briefs. The U.S. FOIA (b)(6) stated the shower room should be cleaner than it was and there should not be soiled incontinence briefs placed into the garbage bin. 3. During an interview on 02/25/25 at 2:45 PM, LPN1 stated some residents were showered on the shower bed on top of one of the pads. LPN1 stated the shower pad should be disinfected with purple top wipes after being used. LPN1 stated she went into the shower room on the afternoon of 02/24/25 and stated it was disorganized. LPN1 stated the extra wheelchairs, and walker had been removed and should not be stored there. LPN1 stated a resident's clothing was stored in the shower room but it was not normal to store residents' clothing in the shower room. LPN1 stated there were times when she had scraped stuff off the floors and the shower rooms were not as clean as it should be. During an interview on 02/27/25 at 11:57 AM, CNA8 stated the CNAs were responsible for cleaning and sanitizing the shower chairs/bed. She further stated the shower room should be maintained in a clean and tidy manner.	F0584		04/10/2025

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F0584 SS = E	Continued from page 21 During an interview on 02/27/25 at 12:50 PM, the U.S. FOIA (b)(6) stated there should be two housekeepers per day on the NJ Exec Order 26 unit and a U.S. FOIA (b)(6) to clean the common area floors. The U.S. FOIA (b)(6) stated one staff member had been out with illness. She further stated the common areas should be cleaned daily and each housekeeping was responsible for about 16 rooms. The U.S. FOIA (b)(6) stated that every day the U.S. FOIA (b)(6) cleaned the floors. The U.S. FOIA (b)(6) stated after each shower the CNAs should wipe down the area. The U.S. FOIA (b)(6) stated that extra equipment should not be stored in the shower room. She stated her housekeeping staff went into the shower room first thing in the morning to ensure cleanliness and to check for garbage. The U.S. FOIA (b)(6) stated she had heard residents' concerns about housekeeping and the shower room from resident council meetings. During an interview on 02/27/25 at 6:21 PM, the U.S. FOIA (b)(6) stated a lack of cleanliness had been brought up by the resident council. The U.S. FOIA stated clothing and extra equipment should not be stored in the shower room. The U.S. FOIA stated the CNAs should clean up after themselves after giving showers. 4. During an observation on 02/26/25 at 6:10 AM of the hallway between A and B wing outside of the dining room doors revealed two carts stacked full of dirty dishes and old food. The carts were placed outside the dining room door that was locked. During an interview on 02/26/25 at 6:15 AM with Unit Manager/Licensed Practical Nurse (LPN)11 revealed she was the U.S. FOIA (b)(6) on duty. She stated she was aware that the carts had been left there but she wasn't sure why. She did not offer any additional information. During an interview on 02/26/24 at 6:20 AM with Certified Nurse Aide (CNA)1 revealed the U.S. FOIA (b)(6) had the key to access the room and that the dinner carts should have been stored in the dining room overnight. She stated the carts should not have been left in the hallway where residents had access to them.	F0584		04/10/2025

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F0584 SS = E	Continued from page 22 During an interview on 02/26/24 at 6:28 AM with U.S. FOIA (b)(6) revealed he was a dishwasher and had just got to work. He stated the carts are usually placed in the back of the kitchen and not in the hallway for them to clean the dishes in the morning. He stated they should not have been left in the hallway like this. During an interview 02/26/25 at 5:10 AM the U.S. FOIA (b)(6) stated the carts should not have been left in the hallway outside dining room door. The U.S. FOIA said the carts should have been left inside a locked area by the back of the dining room behind a locked door. He said staff should be rounding every hour to ensure things like this do not happen it was a hazard and puts residents at risk. N.J.A.C. 8:39-4.1a(11)	F0584		04/10/2025
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, review of Resident Council Meeting Minutes, and policy review, the facility failed to provide palatable food to eight out of 32 sampled residents (Residents (R)4, R17, R18, R26, R1, R28, R6, and R30). Additionally, there were complaints from Resident Council Meetings without responses. The food was not at an appetizing temperature when residents received their meals, the food was bland, food was not prepared appropriately, and condiments were not available or served. This created the potential for weight loss and resident dissatisfaction. Findings include:	F0804	Corrective Measures for Resident(s) Affected: Food temperatures were immediately addressed at the time of discovery. For R4, R17, R18, R26, R1, R28, R30, R6 All affected meals were monitored, and necessary corrective actions (e.g., reheating or discarding food) were taken to ensure safe and acceptable food temperatures for the affected residents. Identification of others with the potential to be affected: All residents in the facility have the potential to be affected by the failure to provide palatable food. Based on interviews and observations, the following residents were specifically identified as having concerns about food quality, including temperature, taste, and availability of condiments: A complete audit of all residents meal preferences, food quality concerns, and temperature-related issues was completed on 3-26-25 by the dietary director and social services to ensure no other residents are affected. This included a review of food satisfaction surveys, interviews with residents, and a detailed review of meal service logs. No	04/10/2025

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F0804 SS = E	Continued from page 23 Review of the facility's undated "Food Preparation Guidelines" policy revealed, "It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status ... Food palatability refers to the taste and/or flavor of the food. Proper (safe and appetizing) temperature means both appetizing to the resident and minimizing the risk for scalding and burns ...Food shall be prepared by methods that conserve nutritive value, flavor and appearance." 1. Resident interviews revealed concerns about the food: a. During an interview on 02/24/25 at 2:21 PM, R4 stated he/she was not served sweetener with hot beverages. R4 stated he/she NJ Exec Order 26.4b1 his/her lunch; the noodles were dry, and vegetables were mashed up/overcooked and it was terrible. R4 stated he/she could not get relish, ketchup, or mustard for hot dogs. R4 stated he/she was recently served fish sticks that were so hard he/she could no NJ Exec Order 26.4 and could not NJ Exec Order 26.4b1. R4 stated that one night last week he/she was served bean soup with only three beans in his/her bowl of soup. Review of the quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ Exec Order 26 located in the electronic medical record (EMR) under the "MDS" tab revealed R4's cognition was NJ Exec O with a Brief Interview for Mental Status (BIMS) score of NJ E out of 15. b. During an interview on 02/24/25 at 3:32 PM, R17 stated, "Condiments are few and far between." R17 stated sometimes he/she was not served creamer or any type of sugar with NJ Ex coffee. Review of the quarterly "MDS" with an ARD of NJ Exec Order 26 located in the EMR under the "MDS" tab revealed R17 was NJ Exec O in cognition with a BIMS score of NJ E out of 15. c. During an interview on 02/25/25 at 11:11 AM, R18 stated he/she NJ Exec Order 26.4b1 and further stated, "It NJ Exec Order 26.4b1, NJ Exec Order 26.	F0804	Continued from page 23 additional findings were identified. All facility residents have the potential to be affected by food temperature issues. A comprehensive audit will be conducted to ensure all residents' meals meet the proper temperature standards. Systemic changes The Dietary manager and the Regional Dietary director completed training with the dietary department 3-26-25 on the record of food temperatures policy. This education included: Temperature Monitoring Procedures: All food items prepared in the dietary department will be checked for temperatures. Hot foods will be held at 135¿F or greater, and cold foods will be held at 41¿F or below to prevent the growth of harmful bacteria. Handling of Hot Foods: Hot foods will be stirred during holding to ensure even heat distribution throughout the food product. Temperature Logging: Temperatures will be measured and recorded for each food product and milk at every meal. These temperatures will be documented on the Temperature Log. Monitoring During Tray Line Service: When hot foods are placed on the tray line, their temperature will be measured to ensure they are at or above 135¿F. Any food that falls below the acceptable temperature range will immediately follow the procedure for reheating or replacement.	04/10/2025

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F0804 SS = E	Continued from page 24 Review of the quarterly "MDS" with an ARD of [redacted] located in the EMR under the "MDS" tab revealed R18's cognition was [redacted] with a BIMS score of [redacted] out of 15. d. During an interview on 02/26/25 at 7:05 AM, R26 stated his/her breakfast was, "cold as ice." During a subsequent interview on 02/26/25 at 1:15 PM, R26 stated his/her lunch meal consisting of grilled cheese sandwiches and greens was cold and he/she [redacted]. Review of the annual "MDS" with an ARD of [redacted] located in the EMR under the "MDS" tab revealed R26 was [redacted] in cognition with a BIMS score of [redacted] out of 15. e. During an interview on 02/25/25 at 11:44 AM, R1 stated, "The [redacted]. There is no seasoning." R1 stated he/she was recently served pea soup with three 3 peas in the soup. R1 stated he/she would [redacted] but did not receive or was not offered either. Review of the quarterly "MDS" with an ARD of [redacted] located in the EMR under the "MDS" tab revealed R1 was [redacted] in cognition with a BIMS score of [redacted] out of 15. 2. Review of "Resident Council Minutes" revealed that dietary/food service concerns were not discussed in resident council in [redacted] until [redacted] at which time Food Service was added. Concerns with the taste, temperature, and/or appearance of the food in "Resident Council Minutes" between [redacted] included: a. Review of "Resident Council Minutes" dated [redacted] revealed a resident report, "Food is poor." b. Review of "Resident Council Minutes" dated [redacted] revealed residents' comments including "Hamburger without cheese ... " c. Review of "Resident Council minutes" dated [redacted] revealed, "Food Committee Meeting to be reschedule to discuss food reference, breakfast is the only good meal ... Food Committee meeting is	F0804	Continued from page 24 Condiments and Meal Accuracy: The facility will ensure that condiments such as ketchup, mustard, salt, pepper, and sugar are available and served with all appropriate meals. All dietary staff, including kitchen staff, servers, and nursing assistants, was completed on 3-26-25 by the regional dietary director to monitor trays for accuracy, including the inclusion of necessary condiments for all meals and offering condiments regularly completed on 3-25-25. A checklist was developed for dietary staff to ensure all required condiments are provided A new feedback form was created to allow residents to voice their opinions regarding the menu. The Menu Committee will now meet weekly x 3 months to review any feedback from residents and adjust the meal offerings accordingly then monthly ongoing. The dietician will implement a regular review of the meal offerings weekly to ensure they are diverse, flavorful, and cater to the preferences and dietary needs of residents. Monitoring of Corrective Measures Random Food Temperature Audits: The Dietary Director and/or designer will complete random weekly food temperature audits. The food temperature audits will verify that hot foods are served at 135¿F or greater, and cold foods are served at 41¿F or below. A 10% sample census of meals will be included in the audit each week. Audits will be conducted weekly until 100% compliance is achieved for four consecutive weeks. Once compliance is achieved, audits will be conducted monthly for a minimum of three months or until substantial compliance is demonstrated.	04/10/2025

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F0804 SS = E	Continued from page 25 not effective ...." 3. "Menu Committee Minutes" were requested for [NJ Exec Order] through [NJ Exec Order 26.4b1]. Four months of "Food Committee Minutes" were provided [NJ Exec Order 26.4b1] [redacted]. Review of the "Food Committee Minutes" revealed concerns with the palatability of food included: a. Review of "Menu Committee Minutes" dated [NJ Exec Order 26] revealed new concerns including hot food being served cold and cold food being served warm and condiments missing on the trays. Action taken was, "Staff are trained in holding temperatures, batch cooking, reheating foods. QAPI, test trays, competencies, and monitoring started. Food temperatures still an issue at this meeting." b. Review of "Menu Committee Minutes" dated [NJ Exec Order 26] revealed a resident did not like what was for dinner. He/She called down to change the meal and it was the same one. The response was that the menu was still in effect. Another resident reported there were no condiments for breakfast and there was no cheese served on a hamburger. There was no response to this comment. c. Review of the "Menu Committee Minutes" dated [NJ Exec Order 26] revealed concerns of no ketchup or mustard with a hot dog meal. Two residents reported their food was cold. A resident reported the pork chops were too salty. A resident reported there was no cheese for hamburgers. A resident reported the rice was cooked too hard. A resident reported no jelly was available with an English muffin. Residents reported artificial sugar was missing and there was no salad dressing available. The response to these comments was to order jelly and condiments. d. Review of handwritten "Menu Committee Minutes" dated [NJ Exec Order 26] revealed concerns with cold food and the lack of availability of salt and pepper. There was no documentation of the response to these concerns. 4. Observations of the tray line in the kitchen on 02/25/25 at 12:10 PM revealed the lunch meal consisted of turkey chili, corn, rice, a piece of bread and applesauce. All tray line hot food holding temperatures prior to serving were in the acceptable	F0804	Continued from page 25 The Dietary director and / or designee will implement a weekly audit of food quality, including random checks of meal trays for condiments and resident satisfaction. A 10% sample censure of meals will be included in the audit each week. Audits will be conducted weekly until 100% compliance is achieved for four consecutive weeks. Once compliance is achieved, audits will be conducted monthly for a minimum of three months or until substantial compliance is demonstrated. The facility implemented a new system for collecting resident feedback, including a comment box to identify any concerns about food temperature, quality, or condiments. A food satisfaction survey will be conducted monthly to gather resident feedback on food satisfaction, which will be reviewed by the Quality Assurance (QA) team. Documentation and Review: The results of the food temperature and of food quality, including checks of meal trays for condiments and resident satisfaction audits will be documented and forwarded to the Quality Assurance and Performance Improvement (QAPI) Committee. for review during monthly meetings. The QAA/QA team will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, they will make adjustments to protocols of corrective actions to ensure continued compliance and improvement.	04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLSIDE CARE AND REHAB	3025 CHAPEL AVENUE WEST , CHERRY HILL, New Jersey, 08002

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F0804 SS = E	Continued from page 26 range, greater than 140 degrees Fahrenheit (F). Tray line service to the first cart on the first floor was observed. Trays were observed to include a margarine packet, salt and pepper packets, a sugar or sugar substitute packet and a creamer packet. The U.S. FOIA (b)(6) stated the nursing department served the beverages and distributed residents' trays. A regular diet test tray was placed on the first cart and the cart left the kitchen at 12:32 PM and was wheeled to the first floor. Once the food cart was delivered to the first floor at 12:32 PM, there were two CNAs passing the trays. The cart included meals for two hallways and for a few residents eating in the dining area on the unit. All trays were served at 12:46 PM. The test tray temperatures were measured by the surveyor once the last resident was served their tray. The temperatures were observed and verified by Licensed Practical Nurse (LPN)10. Temperatures of the foods of the regular diet test tray were acceptable (between 129 degrees and 142 degrees F); however, the rice was dry and chewy and the corn was bland. The applesauce was cool but not cold at 59 degrees F. Observations were made in the first-floor main dining room from on 02/25/25 from 12:48 PM - 12:59 PM. All 18 residents were served their meals and were eating lunch. None of the 18 residents had been served condiment packets that the residents' trays on the first cart received such as salt, pepper, sugar, or sugar substitute. a. R28 was observed eating lunch in the first-floor dining room and having a NJ Exec Order 26.4b1 in it next to his/her meal; he/she stated it was NJ Exe that he/she brought it from his/her room. R28 stated NJ Exe was not provided by the facility. Review of R28's quarterly "MDS" with an ARD of NJ Exec Order 26.4 in the EMR located under the "MDS" tab revealed he/she was NJ Exec Order 26.4b1 in cognition with a BIMS score of NJ E out of 15. Review of R28's tray card for lunch on 02/26/25 revealed he/she was prescribed a NJ Exec Order 26.4b1 . His/Her tray card indicated he/she should be served a NJ Exec Order 26.4b1 .	F0804		04/10/2025

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F0804 SS = E	Continued from page 27 b. R30 was observed eating lunch in the first-floor dining room and stated he/she NJ Exec Order 26.4b1 to his/her food but he/she was not served any. Review of the quarterly "MDS" with an ARD of NJ Exec Order 26.4 located in the EMR under the "MDS" tab revealed R30 was NJ Exec Order 26.4b1 in cognition with a BIMS score of NJ E out of 15. Review of R30's tray card for lunch on 02/26/25 revealed he/she was on a NJ Exec Order 26.4b1 and should receive a NJ Exec Order NJ Exec Orde with lunch. c. R6 was observed eating lunch in the first-floor dining room and his/her rice had been coated with the chili. R6 stated he/she NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1 R6 stated he/she NJ Exec Order 26.4b1 R6 stated he/she was not offered salt or pepper. Review of R6's quarterly "MDS" with an ARD of NJ Exec Order 26 located in the EMR under the "MDS" tab revealed R6 was NJ Exec O in cognition with a BIMS score of NJ E out of 15. Review of R6's tray card for lunch on 02/26/25 revealed he/she was prescribed a NJ Exec Order 26.4b1 and should be NJ Exec Order 26.4b1 t. During an interview on 02/25/25 at 1:00 PM with the U.S. FC in the first-floor dining room, he verified salt and pepper packets had not been provided to residents in the first-floor dining room. The U.S. FC stated the small ceramic condiment containers should be filled with condiments such as salt and pepper packets and a condiment containers should be placed on each table in the dining room prior to meal service. The U.S. FC stated he was short staffed for lunch and it hadn't been done (condiment containers filled and placed on the tables) prior to meal service. During an observation on 02/26/25 revealed the second food cart was delivered to the second floor at 1:03 PM. There were 19 residents in the second-floor dining room.	F0804		04/10/2025

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F0804 SS = E	Continued from page 28 During an observation at 1:16 PM revealed all trays served from the second cart on the second floor were served at 1:16 PM and a pureed test tray was evaluated with LPN18. The pureed chili was thin and spread across the plate and the temperature was 115 degrees F. The surveyor and LPN18 sampled it and agreed it was lukewarm. The pureed bread was pasty, verified by LPN18. The pureed corn and mashed potatoes were bland, verified by LPN 18. The juice was cool but not cold at 63 degrees F and the applesauce was cool but not cold at 61 degrees F. 5. During an interview on 02/25/25 at 2:45 PM, LPN1 stated residents complained to her about the food. LPN1 stated the food looked terrible and she could not always identify what was being served. LPN1 stated the vegetables were overcooked and residents had recently been served fish sticks that were so hard, they could not be broken in half. LPN1 stated that at least once a day, the residents asked for condiments. LPN1 stated condiments were not routinely available. During an interview on 02/25/25 at 5:14 PM, CNA3 stated she served residents their meals and condiments like ketchup or mustard might or might not be provided. CNA3 stated there was usually one condiment packet on the tray such as sugar or sugar substitute packet. During an interview on 02/27/25 at 11:57 AM, CNA8 stated sometimes the kitchen ran out of condiments and they were not included on the meal trays. During an interview on 02/27/25 at 2:24 PM, LPN9 stated residents reported to her that sugar substitute was not always available. LPN9 stated it should be sent on the residents' meal trays. During an interview on 02/27/25 at 4:08 PM, the [redacted] stated he had been working on the menus. The [redacted] stated residents hated rice for example so he was trying to get this changed. The [redacted] stated the residents had not told him the food was bad. The [redacted] stated he had heard complaints about the food not being hot enough. The [redacted] stated he had fielded four or five Menu Committee Menus but did not have minutes for all the meetings because he did not	F0804		04/10/2025

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F0804 SS = E	Continued from page 29 have time to write them all up. The U.S. FO stated food temperatures as served to residents should be 140 degrees F for hot food and 40 degrees F or below for cold foods. The U.S. FO stated that the rice on 02/25/25 for lunch looked, "a little sticky." The U.S. FO verified that the dietary staff put condiments on the residents' trays or in the condiment holders in the dining room and nursing staff was not responsible for this. The U.S. FO stated he had been working on getting condiments ordered so they would be available to residents. During an interview on 02/27/25 at 5:58 PM, the U.S. FOIA (b)(6) stated she was not aware of residents' food complaints. The U.S. FO stated residents should get condiments such as ketchup and mustard with hamburgers or hot dogs. The U.S. FO stated food temperatures for the time residents receive their trays should be 40 degrees F or below for cold foods and beverages and above 165 degrees F for meats. N.J.A.C. 8:39-17.4(a)(2)	F0804		04/10/2025
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the NJ Exec Order 26 and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure NJ Exec Orde	F0610	Corrective Action: Resident # 20, 21, 22, and 24 NJ Exec Order 2 investigation reports reviewed by the Regional Director of Nursing for deficient practice. The identified residents were affected by the deficient practice with NJ Exec Order 26.4b1. On 3/18/25, The Regional Director of Nursing in-serviced the U.S. FOIA on Abuse investigation per the facility policy to include thorough investigation of an incident, including interviewing residents, alleged victims, perpetrators, and witnesses. Identification of At-Risk Residents: The facility has determined that all resident residing in the facility are potentially at risk for the deficient practice. Systemic Change: On 3/18/25, an Inservice education began by Regional Director of Nursing and the DON with the direct care staff addressing through investigation of all potential abuse allegation to include interview of the alleged victims, perpetrators, witnesses, and to determine whether abuse occurred. The facility has also developed a system on Quality Assurance (QA) checklist for thoroughly completing an investigation to ensure compliance.	04/10/2025

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F0610 SS = D	Continued from page 30 investigations were thoroughly investigated for three out of five investigations reviewed affecting four out of 32 sampled residents (R20, R21, R22, and R24) Specifically, the facility failed to interview the [NJ Exec Order] NJ Exec Order 26.4b1 , and failed to determine whether [redacted] occurred, the extent, the cause, and failed to ensure complete and thorough documentation was maintained. This created the potential for [NJ Exec Ord] to occur unchecked. Findings include: Review of the facility's, "Abuse, Neglect, and Exploitation" policy dated 10/21/24 revealed, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse ... Written procedures for investigations include: ... 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause and 6. Providing complete and thorough documentation of the investigation ..." 1. Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R20 was admitted to the facility on [NJ Exec Order 26.4] diagnoses included NJ Exec Order 26.4b1 [redacted] Review of the annual "Minimum Data Set (MDS)" with an assessment reference date (ARD) of [NJ Exec Order 26] in the EMR under the "MDS" tab revealed R20 was NJ Exec Order 26.4b1 in cognition with a BIMS score of [NJ Exec O] out of 15. R20 was independent [redacted]. R20 did not NJ Exec Order 26.4b1 during the assessment period. Review of R21's annual "MDS" with an ARD of [NJ Exec Order 26] in the EMR under the "MDS" tab revealed R21 was NJ Exec Order 26.4b1 in cognition with a BIMS of [NJ Ex] out of 15. Review of the [NJ Exec Order 26] Reportable Event file	F0610	Continued from page 30 Quality Assurance: The Administrator /designee will audit and review all reportable incidents investigations to ensure thorough investigation of the incident, interview witnesses and conclusion summary to includes if alleged abuse was substantiated or not. This audit will be done utilizing a check list. Any findings from the audit will be addressed immediately and the results from the audit will be reviewed by the QAPI and Quality Assurance (QA) Committee monthly for one quarter. The QA committee will determine if further actions are needed and necessary adjustment to the corrective action.	04/10/2025

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F0610 SS = D	Continued from page 31 provided by the facility revealed there were [redacted] in the file, one from Certified Nursing Assistant (CNA)4 and one from Licensed Practical Nurse (LPN)13: Review of the undated "CNA Statement" from CNA4 revealed, "[R20] was trying to [redacted] while [R21] was [redacted]. [R20] expressed interest in going to another hallway upstairs to his/her [redacted] I [CNA4] attempted to shut the door as [R21] was [redacted], in an attempt to [redacted]. [R20] [redacted], I [redacted] him/her towards the dining room, and he/she [redacted] his/her [redacted] stating [redacted] I asked [R20] to [redacted], guiding his/her [redacted] in a [redacted], to keep from being [redacted], and to [redacted] [R21], as he/she was sitting in his/her wheelchair next to me. [R20] is [redacted] and began to [redacted] [R21] in the [redacted] of his/her [redacted] [R21] put his/her [redacted] up to [redacted] [R20] and [R20] also [redacted] [R21] in his/her [redacted] [R21] wasn't being [redacted] as I saw the nurse heading to room [redacted] Nurse came immediately and attempted to [redacted]. [R20] then [redacted] the nurse and ended up [redacted] [CNA4] in the [redacted] We then [redacted] the other resident [R21] to keep him/her [redacted] ..." The CNA statement did not document CNA4's name. Nowhere in the investigation file was CNA4's name documented. Review of the [redacted] from LPN13 read, "This nurse [LPN13] was called to room [R21's room] by CNA [CNA4]. CNA then informed this nurse that resident [R20] was [redacted] during CNA [redacted] [R21] and at some point, made it in [redacted] his/her [redacted] where other resident [R21] was then [redacted] in the [redacted] and [redacted] This nurse [LPN13] attempted to [redacted] resident [R20]. However, resident started [redacted] his/her [redacted] again at this nurse however CNA [CNA4] was [redacted]. This nurse [redacted] other resident [R21] [redacted] for [redacted] Review of the undated "Investigation Summary" provided by the facility verified the [redacted] occurred on [redacted] There was no documentation of the actual statements taken from either R20 or R21 on [redacted] or thereafter, in the Report Event File dated [redacted] Neither of the residents' [redacted] assessments following	F0610		04/10/2025

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F0610 SS = D	Continued from page 32 the [redacted] on [redacted] were in the Reportable Event [redacted] file. The [redacted] assessments for R20 and R21 were requested. The [redacted] assessment for R21 was not provided. During an interview on 02/26/25 at 2:01 PM the U.S. FOIA (b)(6) confirmed that there were no additional [redacted] statements and confirmed CNA4's name was missing from the document. 2. Review of the "Reportable Event Record/Report" form dated [redacted] revealed the event occurred on [redacted] at 6:30 AM and was classified as NJ Exec Order 26.4b1 The description of the event read, "Nurse reported to [redacted] that during 6 am med [medication] pass on [redacted], CNA [CNA5] observed a NJ Exec Order 26.4b1 between the two residents [R20 and R22]. [R20] has [redacted] and [R22] had v NJ Exec Order 26.4b1 [R22] was transported to hospital for evaluation and returned with no new orders. [R20] was escorted to [redacted] with [redacted] and returned with no new orders. Physician and family members contacted and made aware. [redacted] applied to [R20] as primary intervention for [redacted] ..." Review of the undated "CNA Statement" provided by the facility revealed CNA5 documented, "I was doing my rounds and I asked where was his/her [redacted] [R20] was, and he/she (sic) was just here. Walked out of the room, heard talking so I went in the room and [R20] was [redacted] (sic) [R22] with his/her [redacted] [R22's] [redacted] This was the only [redacted] statement associated with the [redacted] There was no name, signature, or date on the statement by CNA5. A request was made on 02/25/25 to the U.S. FOIA (b)(6) for any additional [redacted] statements for the reportable event that occurred on [redacted] None were provided. There was no [redacted] statement from the nurse involved in the [redacted] and there were no statements taken from the residents involved (R20 and R22). Review of the undated "Investigation Summary" provided by the facility revealed, there were no statements from the residents describing what happened; it is unknown how it was determined that R22 may have NJ Exec Order 26.4b1 R20 to NJ Exec Order 26.4b1 . The	F0610		04/10/2025

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F0610 SS = D	Continued from page 33 NJ Exec Order statement CNA5 did not document this. In addition, the "Investigation Summary" did not indicate whether NJ Exec Ord occurred. During an interview on 02/26/25 at 2:04 PM, the U.S. FOIA verified there were no additional NJ Exec Order statements for the NJ Exec Order occurring on [redacted] Even though CNA5 observed R20 with his/her NJ Exec Ord on R22's NJ Exec O and R22 sustained NJ Exec Order 26.4b1 rom the NJ Exec Order 26 during an interview on 02/27/25 at 7:03 PM, the U.S. FOIA was asked if the NJ Exec Ord was NJ Exec Order 26.4b1 as this was not documented on the "Investigation Summary." The U.S. FOIA stated he was not sure if NJ Exec Ord was NJ Exec Order 26.4b1 3. Review of the "Reportable Event Record/Report" form dated NJ Exec Order 26 provided by the facility revealed the NJ Exec Order was classified as NJ Exec Order 26.4b1 that occurred on [redacted] at 5:45 PM and was reported to the state on NJ Exec Order 26 at 7:40 PM by the U.S. FOIA The "Reportable Event Record/Report" revealed the NJ Exec Order occurred in R24's bedroom and it was reported to the U.S. FOIA that R20 NJ Exec Order 26.4b into R24's bedroom. Staff intervened and attempted to NJ Exec Order R20 out of the room. R20 became NJ Exec Order 26.4b and a NJ Exec Order 26.4b1 started between the residents. Both residents were NJ Exec Order 26.4b1 and Emergency Medical Services (EMS) was called. R24 was transported to the hospital for evaluation and returned on NJ Exec Order 26 with no new orders or NJ Exec Order EMS was requested to send R20 to NJ Exec Or but they NJ Exec Order 2 Review of LPN15's "Employee Statement" revealed the NJ Exec Order occurred at 5:30 PM as follows, "Resident [R20] was last seen in hallway going to dayroom for dinner. Was notified by aide that resident [R20] was in [R24's room] following a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Resident [R20] became NJ Exec Order 26.4b1 with staff upon entry. NJ Exec Order 26.4b1 resulted in [R24] being NJ Exec Orde and sent to the hospital with NJ Exec Order 26.4b1 to the back of his/her NJ Exec Ord This was the only Exec Order statement in the Reportable Event file dated [redacted] There was no NJ Exec Order statement by CNA6 who was involved/assigned per the facility's undated/untitled	F0610		04/10/2025

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F0610 SS = D	Continued from page 34 document of staff who were working. Nowhere in the file was CNA6's name documented. There was no documentation in the Reportable Event file dated [redacted] of R24's [redacted] statement. Review of R24's admission "MDS" with an ARD of [redacted] in the EMR under the "MDS" tab revealed R24 was [redacted] in cognition with a BIMS score of [redacted] out of 15. During an interview on 02/27/25 at 6:39 PM, the [redacted] stated he had spoken with R24 on the phone after the [redacted] occurring on [redacted] The [redacted] stated R24 reported to him that R20 [redacted] into his/her [redacted] and the staff [redacted] R20 [redacted] The [redacted] stated R24 told [redacted] R20 [redacted] him/her [redacted] The [redacted] confirmed all documents including [redacted] statements for the [redacted] was provided and there was no additional information to provide. N.J.A.C. 8:39-9.4	F0610		04/10/2025
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F0761	Corrective Action: Licensed Practical Nurse (LPN) 6 was educated on 2/27/25 by the Director of Nursing on the facility policy regarding keeping the medication and Treatment cart locked and secure. LPN # 6 Educated by the DON regarding protecting private health information by closing electronic medical records when left unattended in an area accessible to the public. No residents were affected form the deficient practice Identification of at-Risk Residents: All residents have the potential to be affected by the deficient practice. Systemic change: DON initiated a re-education in-service on 3/10/2025 for staff nurses on the following: The facility policy and the importance of keeping medication and treatment carts securely locked at all times when not in use and view. Protecting private health information by locking electronic medical records when left attended in an area accessible to the public. Quality Assurance (QA): DON/designee will do random audits of all medication, Treatment carts	04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2025

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F0761 SS = D	Continued from page 35 be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to ensure that one of two medication carts on [redacted] Hall was secure when staff were not present. This had the potential to affect all residents on that hall who could have accessed the cart. Findings include: Review of the facilities policy titled, "Security of Medication Cart," revised August 2024 revealed, medication carts must be secured during medication pass to prevent unauthorized entry. During an observation on 02/26/25 at 6:07 AM revealed a medication cart sitting in the front of the nurse's station outside the hallway down from resident rooms [redacted] and [redacted] was not locked and the computer screen was also open and upright revealing 14 resident names. There was one certified nurse's aide walking down the hallway. During an interview on 02/26/25 at 6:11 AM Licensed Practical Nurse (LPN) 6 walked up from another hallway and stated she knew the cart was unlocked. She said there were no families visiting or residents up during the 11 PM to 7 AM shift so she wasn't as careful with locking the cart as she was during the morning or evening shifts. However, she agreed the medication cart should be locked regardless of what shift it was. During an interview on 02/26/25 at 5:10 PM the [redacted] stated he would defer to the facility policy. He stated the cart should have been locked unless a nurse was at the cart. He also expected nursing staff to ensure they ensure privacy and HIPPA to maintain the privacy of the resident information. N.J.A.C. 8:39-29.4(h)	F0761	Continued from page 35 weekly for 4 weeks and biweekly 8 weeks to ensure medication /treatment carts are securely locked when not in use and in view. The DON/designee will do a random audit of all electronic medical records daily for 4 weeks, weekly for 8 weeks to ensure protection of private health information is not left unattended in area accessible to the public. Any issues from these audits will be addressed immediately and the results from the audit will be reviewed by the QAPI and Quality Assurance (QA) Committee monthly for one quarter. The QA committee will determine if further actions are needed and necessary adjustment to the corrective action.	04/10/2025
F0727	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F0727	Corrective action: On 3/10/2025 the Administrator educated [redacted]	04/10/2025

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F0727	Continued from page 36 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on review of Nurse Staffing Report sheets, it was determined on 2/26/2025 that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 2 days of 15 weeks reviewed. This deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for the weeks of 05/14/2023 to 05/20/2023, 06/25/2023 to 07/01/2023, 08/27/2023 to 09/02/2023, 11/12/2023 to 11/18/2023, 02/25/2024 to 03/02/2024, 07/14/2024 to 07/20/2024, 07/28/2024 to 08/03/2024, 08/04/2024 to 08/10/2024, 09/29/2024 to 10/05/2024, 11/03/2024 to 11/09/2024, 11/10/2024 to 11/16/2024, 12/01/2024 to 12/07/2024, 01/26/2025 to 02/01/2025, 02/09/2025 to 02/15/2025, 02/16/2025 to 02/22/2025 The facility provided no RN staffing for residents over 24 hours on 12/01/2024 and 01/26/2025. The surveyor reviewed the facility's policy titled "Staffing" updated 2/2023 which indicated, "Our facility provided sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment."	F0727	Continued from page 36 U.S. FOIA (b)(6) that an RN must be scheduled for a minimum of eight (8) hours per day. No residents were affected by this deficient practice. Resident At Risk: All residents have the potential to be affected by this practice. Systematic Change: Facility implemented a daily staffing meeting Monday - Friday to ensure that RN Coverage requirements are being met for every day. The daily staffing meeting is attended by Administrator, Scheduler and DON or Designated Nurse Manager. Quality Assurance: Scheduler or designated on call Nursing Manager will audit daily for four weeks to ensure that an RN is scheduled for eight hours per day to meet requirements; in the event of a call off the RN on call will cover the hours in facility. Ongoing audits will be conducted weekly for one quarter. The audits will be reported to the QAPI Committee for tracking and recommendations. Additional audits will be determined by the QAPI Committee.	04/10/2025

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F0727	Continued from page 37 N.J.A.C. 8:39-25.2(h)	F0727		04/10/2025

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S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of pertinent facility documentation, on 02/26/2025, it was determined that the facility failed to ensure staffing ratios were met for 15 weeks reviewed. This deficient practice had the potential to affect all residents. The deficient practice was evidenced by the following: Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 15 weeks of AAS-11 staffing, the facility was deficient as follows: For the week of Complaint staffing from 05/14/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows:	S0560	No residents were affected by this deficient practice. Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. All residents have the potential to be affected by the deficient practice. The facility Administrator has put in place a bonus structure to help increase the levels of staffing accordance to census. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials, and referral bonuses are being utilized to become more competitive in the marketplace. In addition, the Director of Nursing or designee will meet with the Staffing Coordinator to ensure appropriate staffing. The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. Findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI committee quarterly until compliance is met.	04/10/2025

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

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S0560	Continued from page 1 -05/14/23 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. For the week of Complaint staffing from 06/25/2023 to 07/01/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -06/30/23 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. For the week of Complaint staffing from 08/27/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -08/27/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. For the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -11/12/23 had 11 CNAs for 122 residents on the day shift, required at least 15 CNAs. -11/18/23 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. For the week of Complaint staffing from 02/25/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -02/25/24 had 12 CNAs for 124 residents on the day shift, required at least 15 CNAs. For the 2 weeks of Complaint staffing from 07/28/2024 to 08/10/2024, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -07/28/24 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs.	S0560		04/10/2025

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S0560	Continued from page 2 -07/29/24 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -08/02/24 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -08/02/24 had 8 total staff for 123 residents on the overnight shift, required at least 9 total staff. -08/03/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -08/04/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -08/05/24 had 7 total staff for 121 residents on the overnight shift, required at least 9 total staff. -08/07/24 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -08/10/24 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. For the week of Complaint staffing from 09/29/2024 to 10/05/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -09/29/24 had 15 CNAs for 134 residents on the day shift, required at least 17 CNAs. For the week of Complaint staffing from 01/26/2025 to 02/01/2025, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -01/26/25 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -01/31/25 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. For the 2 weeks of Complaint staffing from	S0560		04/10/2025

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S0560	Continued from page 3 02/09/2025 to 02/22/2025, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -02/10/25 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs.	S0560		04/10/2025