STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE , VAUXHALL, New Jersey, 07088

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F0803 SS = F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews and review of pertinent facility documents, it was determined that the facility failed to ensure the development and implementation of menus to consistently provide adequate portions of milk and bread to residents in accordance with the facility's diet manual, policy and national nutritional standards for a four-week cycle menu.	F0803	Tag: F0803 Regulation: Menus Meet Resident Needs / Prepared in Advance / Followed 1. Corrective action taken for the residents affected: No residents were identified to have been affected by this deficient practice. Updated menus were immediately implemented to ensure compliance with dietary guidelines and nutritional adequacy. 2. Identification of other residents who could be affected: All residents have the potential to be affected by this deficient practice. A facility-wide audit of the nutrient menu analysis was completed and found to have met 100% of the nutritional requirements according to the USDA guidelines All residents were reviewed by the Registered Dietitian (RD) for compliance with portion sizes and menu accuracy. Residents with special milk/diet preferences were identified, and appropriate substitutions documented and provided with their meals. 3. Measures/Systemic changes to prevent recurrence: All menus are now reviewed, signed, and dated by the facility RD prior to implementation to verify nutritional adequacy and compliance with the Diet Manual. The Food Service Director (FSD) and RD will review menus quarterly and update as needed (seasonal menu	10/08/2025

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

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

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F0803 SS = F	Continued from page 1 This deficient practice was evidenced by the following: On 8/18/25 at 8:59 AM, during entrance conference it was determined that the facility was licensed for a capacity of 195 beds and had a current census of 189 beds. On 8/18/25 at 10:13 AM, the surveyor toured the kitchen with the U.S. FOIA (b) (6) in the presence of a second surveyor. At the end of the tour, the surveyor requested a copy of the facility's four-week cycle menus (reflects the regular diet) and the extensions (a breakdown of what all the therapeutic and mechanically altered diets received). On 8/19/25 at 12:15 PM, the surveyor observed lunch meal service in the first-floor main dining area. There was no milk on the beverage cart and creamers were offered for coffee. In addition, the main meal did not have a bread indicated on the menu. The alternate meal had serving of garlic bread indicated on the menu. A review of the four-week cycle menus and extensions provided by the facility between 8/18/25 and 8/22/25 reflected four ounces of milk was served at lunch and dinner (instead of required eight ounces). It also reflected that each lunch and dinner had two options on the menu, therefore, of 112 meals developed on the menus, 28 included a bread serving. In addition, the menus provided indicated that 26 of 28 dinner meals crackers would be served; however, this was not indicated on the extensions and therefore also not on residents' dinner meal tickets (this translates to what food service staff place on the resident's tray). A review of a three-week cycle menu provided to the surveyor on 8/25/25 by Registered Dietitian (RD) #2, who stated she approved these menus for nutritional adequacy dated 4/9/25, were not the same as the active menus. Of 84 lunch and dinner meal selections, 61 were different from the active menus provided. on 8/21/25 at 10:06 AM, the surveyor interviewed RD #1, in the presence of a second surveyor. She stated that "corporate" provided the menus and could not speak to who reviewed and approved the menus for nutritional adequacy. On 8/21/25 at 10:37 AM, the U.S. FOIA (b) (6) and the U.S. FOI joined the interview. The U.S. FOIA stated the menus were seasonal and were planned in advance (spring/summer and	F0803	Continued from page 1 changes). All dietary staff were re-educated by the Regional RD on the requirement to: Follow menus as written. Serve correct portion sizes. A new Menu Verification Binder has been created to be readily available and to maintain signed copies of menus, therapeutic extensions, and approvals for one year, The Facility Policy titled "Menu Development" was reviewed by the RD and Administrator and determined no updates or revisions are required at this time. The RD or designee will audit 3 meal services weekly for 12 weeks to ensure compliance with menus, portion sizes, and dietary standards. 4. Monitoring to ensure ongoing compliance: All Findings will be documented and reviewed quarterly at the facility Quality Assessment and Assurance meetings for two consecutive quarters.	

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F0803 SS = F	Continued from page 2 fall/winter). She also stated that “corporate” developed the menus; however, she reviewed the choices with the facility RD’s and U.S. FOI to ensure they would be acceptable to the resident population. The facility preferences were then relayed back to “corporate.” The U.S. FOIA could not speak to who reviewed and approved the menus for nutritional adequacy and stated they were based on the NJ Ex Order 26.4(b)(1). The U.S. FOI also stated that she was unaware as to who reviewed and approved the menus for nutritional adequacy. On 8/22/2025 at 12:51 PM, the surveyor interviewed the U.S. FOIA U.S. FOIA and RD #1, in the presence of the survey team related to menu development and approval. The U.S. FOIA stated that four ounces of milk was served at lunch and dinner since there was a lot of waste and that resident’s were not drinking it. The U.S. FOI stated that many trays were returned to the kitchen with unopened milk. The U.S. FOIA and the U.S. FOI could not speak to whether or not they investigated the reason for the unopened milk (dislike verse staff not opening for residents that needed assistance). The U.S. FOIA acknowledged that the Diet Manual reflected eight ounces of milk should be served at each meal but stated it gets “wasted.” She stated that bread was not served consistently on the menu to avoid serving heavy carbohydrate meals. She acknowledged that the Diet Manual has recommended meal patterns which is not consistently reflected on the facility menus. She also acknowledged that the facility provided a therapeutic NJ Ex Order 26.4(b)(1)) for residents that were diabetic. The U.S. FOIA could not speak to why she was applying that across the board to the entire facility. She added her concern if a resident on a NJ Ex Ord diet was in a room with a resident on a Regular diet, then the NJ Ex Ord diet resident would also ask for bread which would cause a problem for the U.S. FOI She could not speak to why that situation would not require individual education verse enforcing the elimination of a carbohydrate portion (bread) for the entire building. During this interview, the U.S. FOIA stated the facility RD’s approved the menus for nutritional adequacy (which contradicted a previous interview). RD #1 stated that she had not done that and the CRD stated that RD #2 approved the menus, however RD #2 was on vacation. The U.S. FOIA would not state whether or not the menus were based on the Diet Manual. She stated the menus were "based on the needs of the facility; I mean the needs of the residents." The U.S. FOIA and RD #1 were unable to provide the surveyor with the signed menus approved by RD #2. On 8/22/25 at 2:35 PM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)	F0803		

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F0803 SS = F	Continued from page 3 U.S. FOIA (b) (6). The U.S. FOIA (b) acknowledged that the menus were developed by “corporate.” On 8/25/25 at 10:47 AM, the survey team met with the U.S. FOIA (b) He stated RD #2 had returned from vacation and could not speak to why the signed approved facility menus were not readily available. On 8/25/25 at 11:02 AM, the surveyor interviewed RD #2, in the presence of the survey team. She stated that menu development was a team effort between the RD's, the U.S. FOIA and the U.S. FOI but " I am the final word. I sign the menus attesting to nutritional adequacy." She stated the menus were based on the Diet Manual, including portions sizes and the amount of servings required for each food group. She acknowledged a bread was not reflected for every lunch and dinner meal because “we count carbs for the day and bread just seemed extra.” RD #2 provided the surveyor with the menus she signed and attested to have approved for nutritional adequacy. We reviewed the two meals for lunch and dinner offered on cycle week one, day one (Sunday) for the Regular diet. She could not speak to why the main lunch meal did not account for bread yet the lunch alternate meal and both choices for dinner included bread. RD #2 acknowledged that four ounces of milk were served instead of eight ounces per the Diet Manual at lunch and dinner. She further stated that a lot of residents did not want milk, and it was a “corporate decision” to serve four ounces of milk to avoid waste. RD #2 acknowledged that the menus did not reflect the portions for milk and bread in accordance with the Diet Manual. On 8/25/25 at 12:04 PM, RD #2 provided the surveyor a list of residents who disliked whole milk and a list of residents who disliked skim milk. The list did not include substitution’s and did not account for size (fluid ounce) preferences or those who required lactose free milk. The lists provided accounted for 23 residents that disliked both skim and whole milk, 23 out of 189 residents (12.2% of the population). A review of the Diet Manual the facility follows “Diet Manual of Dietetics in Health Care Communities of New Jersey; 8th Edition” dated 2023 and reviewed by the facility on 1/9/25, reflected that the “Regular” diet provided a variety of foods to meet the needs of individuals and is “nutritionally adequate in all nutrient’s when planned according to Dietary Reference Intakes (DRIs) established by Food and Nutrition Board; Institute of Medicine, USDA Dietary Guidelines for Americans 2020-2025.” The “Sample Menu for Regular Diet” included one cup serving of low-fat milk at each	F0803		

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F0803 SS = F	Continued from page 4 meal as well as a slice of bread. A review of the facility policy “Menu Development” dated October 2024, reflected that a RD would ensure the menus meet current “Dietary Standards” and that the diet manual should be used as a reference in menu development. It also reflected the menus would be reviewed by the facility team and a copy will be kept on file. Menus would be approved by the facility RD prior to implementation, including any menu changes. In addition, it reflected copies of the current and previous menus would be kept for one year. A review of an undated job description “Clinical Nutrition Director,” reflected assistance in menu development, implementation and approval was part of the position’s responsibilities and duties. NJAC 8:39 – 17.1(b);17.2(a,b);17.4(a(3))	F0803		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and review of	F0812	F0812 Regulation: Food Procurement, Store/Prepare/Serve – Sanitary 1. Corrective action for the residents affected: All damaged, unsanitary, or non-functioning equipment and structural issues in the kitchen including: The walls to the left of the handwashing sink and right of walk-in freezer have been repaired and the metal rack was repaired. The gaskets on both walk-in refrigerators have been replaced. The mixed beverages in the black milk crate in the middle walk-in refrigerator were immediately removed and discarded. The hard plastic shelving in the dry storage area has been raised six inches off the floor. The six lights on the hoods over the cooking area have been repaired. The double stacked convection ovens have been repaired. The single convection oven has been deep cleaned. The double stacked steamer gaskets have been replaced,	10/08/2025

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F0812 SS = F	Continued from page 5 facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly store potentially hazardous foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was observed during two kitchen tours and was evidenced by the following: On 8/18/25 at 10:13 AM, the surveyor toured the kitchen with the U.S. FOIA (b) (6)), in presence of a second surveyor and observed the following: To the left of the handwashing sink, and to the right of the walk-in freezer, there was a damaged wall with a penetration, which the U.S. FOI stated had been that way since she started in NJ Exec Order 26.4b and the U.S. FOIA (b) (6)) was aware. The U.S. FOI stated that there was no formal communication with the U.S. FOIA (it was all verbal either one on one, via phone or at morning meeting. She stated there was no logbook and she did not send emails since the U.S. FOIA did not read his emails. She stated the U.S. FOIA (b) (6)) was aware she had outstanding maintenance concerns. In the middle walk-in refrigerator, there was a wood square propped under the metal rack to the left, due to a missing rack leg. The U.S. FOI acknowledged the wood was not able to be cleaned and sanitized and stated that the U.S. FOIA was aware. In the same walk-in refrigerator, there was a black milk crate stored on the metal rack which had a mix of beverages (four-ounce milks, health shakes, and other fluids mixed together). The U.S. FOI stated they were left from the tray line meal service and that the staff put the leftovers back in the refrigerator for next use. She acknowledged that this practice could lead to an outdated item if the beverages were not sorted through and use by dates checked one by one before the next meal. Both of the kitchen walk-in refrigerators did not have gaskets on the doors. The U.S. FOI stated the U.S. FOIA was aware. In the dry storage area, there was a hard plastic shelving unit that was flush to the ground without a six inch space between the shelf and the floor. The hoods over the cooking equipment had six lights on each side, which did not work, the U.S. FOI stated the U.S. FOIA was aware.	F0812	Continued from page 5 and the double stacked steamer has been deep cleaned. The three-door reach-in refrigerator has been repaired. The two warming boxes have been deep cleaned and gaskets that were in disrepair have been replaced. The faucet on the handwashing sink has been repaired and is no longer leaking. The shared faucet on the two food preparation sinks has been repaired and is now properly functioning with appropriate water temperatures and is no longer leaking. The top reach-in beverage/milk refrigerator has been repaired. The ceiling vent over the ice cream freezer has been thoroughly cleaned. The dish machine room floor tiles that were cracked have been replaced. The walls to either side of the dish machine have been repaired and cleaned. The expired milk identified for resident#1 was immediately discarded by a certified nurse's aide, and no adverse effect was noted to resident #1. Kitchen was deep cleaned and sanitized, including ovens, steamers, hoods, and prep surfaces. 2. Identification of other residents who could be affected: All residents have the ability to be affected by this deficient practice. A facility-wide audit of all food storage areas, refrigerators, freezers, and dry storage area was conducted by the Food Service Director to ensure all food items were within their "use by" date, as well as an A follow up audit of the kitchen/storage area and all kitchen equipment was conducted by the Food Service Director to ensure they were all in a safe sanitary condition. The steamer and warming box gaskets have been received and replaced by the Maintenance Director	

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F0812 SS = F	Continued from page 6 There were double stacked convection ovens that did not work. The U.S. FOI stated the U.S. FOIA was aware. There was a single convection oven that had a heavy buildup of black debris on the bottom and the glass doors had a heavy baked on brown and reddish colored debris. The U.S. FOI acknowledged the same and stated it was cleaned once a month. There was a double stacked steamer. Both unit gaskets were in disrepair. The U.S. FOI stated the U.S. FOIA was aware. The top unit had a buildup of black debris on bottom. The U.S. FOI acknowledged the same. There was a three-door reach in refrigerator that had been out of service since 8/14/25. The U.S. FOI stated the U.S. FOIA was aware. There were two warming boxes (units that keep cooked food hot), both of which gaskets were in disrepair. The warming box to the right had a buildup of food debris on the bottom which the U.S. FOI acknowledged. The handwashing sink in this area had a leaking faucet. The U.S. FOI stated the U.S. FOIA was aware. There were also two food preparation sinks in this area which shared a faucet. The faucet was leaking and the U.S. FOI stated that it only provided “scalding hot” water and that the U.S. FOIA was aware. There was a top reach in beverage/milk refrigerator that had not been working since the previous Friday. The U.S. FOI stated that the U.S. FOIA was aware. There was a ceiling vent over the ice cream freezer that had fuzzy greyish brown debris hanging down over the freezer and racks of clean inverted coffee mugs. The U.S. FOI acknowledged the debris and stated it needed to be cleaned. The dish machine room had multiple missing and cracked floor tiles with still nesting water. There was also a wood block propped under the dish machine table. There were walls to either side of the dish machine in disrepair with penetrations and a build up of back debris on the wall to the right of the dish machine. The U.S. FOI stated the U.S. FOIA was aware of what the surveyor observed. On 8/19/25 at 10:53 AM, a third surveyor interviewed Resident #10, who stated they received expired milk yesterday dated 8/17/25.	F0812	Continued from page 6 3. Measures/Systemic changes to prevent recurrence: A formal written communication system (Kitchen Maintenance Logbook) was implemented by the administrator. All dietary staff are required to record maintenance issues in the log; Maintenance Director/designee must sign off when completed. Maintenance Director or designee will review the Kitchen Maintenance Logbook daily and sign off on completion of all requests. All dietary and maintenance staff have been re-educated by the Administrator on: Food storage standards (no wood or crates, proper shelving). First In First Out and expiration date checks. Daily cleaning and sanitizing requirements. Food Service Director (FSD) or designee will perform daily kitchen maintenance inspections to ensure all equipment is in safe and proper working condition. FSD or designee will conduct daily kitchen sanitation rounds to ensure all kitchen areas are sanitary and free of debris findings will be recorded on a sanitation checklist. FSD or designee will conduct random tray audits of 3 meal services per week times one month and then one tray audit weekly times two months to ensure all food items served are within their “use by” date. The facility Policies Titled “Food Safety and Sanitation” “Kitchen Maintenance” was reviewed by the administrator, FSD and Maintenance Director and determined no revisions or updates were needed at this time. 4. Monitoring to ensure ongoing compliance: All findings will be presented by the Food Service Director and/or Maintenance Director and reviewed quarterly at the facility Quality Assessment and Assurance meetings for two consecutive quarters.	

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F0812 SS = F	Continued from page 7 On 8/22/25 at 9:11 AM, the surveyor interviewed the U.S. FOIA (in presence of the survey team. He stated that there was no formal communication between himself and the U.S. FOI related to maintenance concerns. He stated that the nursing units had logbooks but there was not one for the kitchen. When the surveyor inquired why there was no logbook for the kitchen he stated, 'it's been like that for 14 yrs." He stated that when there was something in the kitchen that required maintenance attention, he would fix it on the spot or would order parts if need be. The U.S. FOIA stated he had no written or formal way of keeping track of any issues brought to his attention from the kitchen or a way to track their resolve. In addition, he stated he was unaware of any maintenance issues in the kitchen prior to the beginning of survey. The U.S. FOIA stated that he replaced 12 loose tiles in the dish machine area of the kitchen two days ago and was notified of that the night before. He also stated that one of the double stack convection ovens had not been working for over a year due to an electrical issue that was unable to be resolved. On 8/22/25 at 9:47 AM, the third surveyor interviewed Resident #10, who stated they received expired eight-ounce fat free milk at breakfast, dated 8/21/25. The resident stated the Certified Nursing Aide (CNA) confirmed the expiration date. On 8/22/25 at 9:55 AM, the third surveyor interviewed the CNA who verified that the date on the unopened milk carton was 8/21/25. She stated that the kitchen was responsible but that everyone should be checking the tray. In addition, she stated that if expired milk was consumed it could make a resident sick. On 8/22/25 at 2:35 PM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) (6)), U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) . The U.S. FOIA (confirmed that there was no formal way of communicating kitchen maintenance issues to the U.S. FOIA (He stated concerns were addressed in morning meeting. On 8/25/25 at 10:47 AM, the survey team met with U.S. FOIA (b) He stated that the maintenance concerns identified in the kitchen during survey were addressed, thereby acknowledging there were maintenance concerns. On 8/25/25 at 11:02 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who has worked at the facility for 12 years (four days a week). She stated she conducted informal kitchen rounds every morning and communicated with the U.S. FOI related to any concerns she identified. The U.S. F stated prior to a two-week vacation from which she had just returned she was only aware of	F0812		

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F0812 SS = F	Continued from page 8 a three-door reach in refrigerator not working. She stated that there was a logbook in the kitchen to record and track maintenance needs. On 8/25/2025 at 12:04 PM, the U.S. F reapproached the surveyor in the presence of the survey team and stated she was mistaken, and that there was no logbook in the kitchen for maintenance concerns. The U.S. F stated concerns were communicated verbally and at the morning meetings. A review of the facility policy “Food Safety and Sanitation” with a reviewed date of 2024, reflected the facility would provide safe, nutritious meals in compliance with federal, state and local regulations. It also reflected food would be clean, wholesome and free of spoilage and stock would be rotated using the “first in, first out (FIFO)” method. A review of an undated facility policy “Kitchen Maintenance,” reflected food preparation areas should be maintained in a clean, safe and sanitary condition, to prevent food borne illness, accidents and equipment failure. It also reflected the following: “Daily Maintenance,” included wash and sanitize kitchen equipment used during food preparation. It also included “check expiration dates.” “Weekly Maintenance,” included “deep clean ovens.” “Monthly Maintenance,” included inspect all kitchen equipment for proper function and safety; perform preventative maintenance on equipment as per manufacturer’s instructions; and check sinks for leaks. “Documentation,” included to keep “equipment maintenance records.” A review of an undated facility job description for “Maintenance Director,” included the US FOIA (was responsible for planning, organizing, implementing, and overseeing the total maintenance and repair program of the facility. This included the building, equipment, systems and grounds to ensure the health, safety, comfort and well-being of residents, staff and visitors. This also included routine inspections were completed, documented and corrected. NJAC 8:39-17.1(a);17.2(g);31.2(b,c,e)	F0812		
F0925 SS = F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)	F0925	Tag: F925 Regulation: Maintain an effective pest control program	10/08/2025

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F0925 SS = F	Continued from page 9 §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and review of pertinent facility documents, it was determined that the facility failed to implement an effective pest control program in the kitchen. This deficient practice was evidenced by the following: On 8/18/25 at 10:13 AM, the surveyor toured the kitchen with the U.S. FOIA (b) (6)), in presence of a second surveyor. The surveyors observed a live bug walking up a white tiled wall above a stainless-steel table which had food preparation equipment on it, uncovered. The U.S. FOI observed the bug as well and stated, "we have a pest control problem here; it was like this when I got here; maintenance is aware; we have a company [name redacted] that comes every Tuesday." The surveyors then observed two live bugs walking on the floor, in the dry storeroom. There were also two glue traps of the floor of the storeroom filled with bugs. During the remainder of the kitchen tour, the surveyors observed damaged walls with penetrations as well as still nesting water where multiple floor tiles were missing in the dish machine area. On 8/22/25 at 9:11 AM, the surveyor interviewed the U.S. FOIA (b) (6)), in the presence of the survey team. He stated that he had no involvement with pest control and that the U.S. FOIA (b) (6) was responsible to oversee the pest control program. The U.S. FOIA acknowledged there was pest control problem in the kitchen and added there was a logbook in the kitchen where staff were responsible to note pest sighting (date and location). He further stated that the exterminator would then check those books and treat the targeted areas. The U.S. FOIA stated the exterminator scheduled a “bombing” (Bug bombs, also known as foggers or extermination bombs, are canisters of insecticide that disperse a large volume of insect-killing mist when activated. They are used to treat widespread infestations by filling an entire room or area with insecticide) for the kitchen Monday night.	F0925	Continued from page 9 so that the facility is free of pests and rodents. 1. Corrective action taken for residents affected: No residents were identified to have been affected by the deficient practice. Pest control company was immediately contacted and made aware of the findings. Exterminator was onsite the next morning and conducted heavy treatment for all areas where the pest sightings were noted. The kitchen, dry storage, and dishwashing areas were deep cleaned and sanitized following treatment. Damaged walls, missing floor tiles, and areas of standing water in the dishwashing area were immediately repaired and sealed to eliminate pest harborage areas. 2. Identification of other residents who could be affected: All residents have the potential to be affected by this deficient practice. A facility-wide inspection of all food preparation and storage areas was completed, and no additional pest activity was noted outside of those identified areas. Per the exterminator recommendation, an intensive after-hours cleanout treatment (Bombing) was conducted on 8/26/2025. 3. Measures/systemic changes to prevent recurrence: Food Service Director/designee will perform daily kitchen rounds to check for pest activity and proper sanitation. Pest Control Logbooks: Revised pest sighting logbooks have been placed in all food service and storage areas. All dietary staff were in-serviced by Environmental Service Director regarding mandatory documentation of pest sightings (date, time, location, type of pest). Exterminator Communication: The contracted exterminator will review pest logs at every weekly visit and as	

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F0925 SS = F	Continued from page 10 On 8/22/25 at 9:25 AM, the surveyor interviewed the U.S. FOIA in the presence of the survey team. She stated that she communicated with the exterminator on a regular basis to ensure areas throughout the building where pests were identified would be treated until irradicated. She acknowledged the kitchen had a pest control problem and added the exterminator treated every week. The U.S. FOIA identified a pest management [name redacted] log sheet and acknowledged that the exterminator wrote “no reports” in the kitchen each week for June through 8/19/25. She stated that the kitchen staff should have been filling that out when they see a pest in the kitchen to identify the pest and location. She added the sheet is a form of communication to the exterminator, so they would know the areas to treat. The U.S. FOIA stated about a year or two ago there was an “infestation,” and the exterminating company had to “bomb” the kitchen because the exterminator brought to the facility’s attention that this larger scale treatment had to be done to contain the problem. She could not speak to why pest control in the kitchen was an ongoing problem; however, she did add that it was damp in the kitchen and “roaches like moisture.” On 8/22/25 at 2:19 PM, the surveyor interviewed the U.S. FOIA in presence of survey team and reviewed the original pest control form for the kitchen. She acknowledged that the kitchen staff were not utilizing the logbook to identify pest sightings for the exterminator. In addition, she could not speak to why the exterminator filled out the “staff observations” column as “no reports.” On 8/22/25 at 2:35 PM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) . The surveyor presented the above concerns. On 8/25/25 at 10:47 AM, the U.S. FOIA (met with the survey team. He stated that the kitchen would be “bombed” Tuesday night after the kitchen closed. The U.S. FOIA (further stated that after the last exterminator visit on 8/19/25 (the day after survey started), the exterminator advised that they “needed something stronger.” He stated he was made aware of the pests in the kitchen a few months ago, but he “thought it was taken care of.” 8/25/25 at 11:02 AM, the surveyor interviewed the U.S. FOIA (b) (6)), in the presence of the survey team. The U.S. F stated she worked four days a week and “walked through” the kitchen each morning and would	F0925	Continued from page 10 needed visit and document actions taken. Reports will be submitted to the Administrator weekly. Environmental Director will review pest control logs weekly X 3 months to ensure all staff entries are complete and exterminator follow-up is documented. Administrator will review exterminator service reports and pest sighting logs weekly times 1 month and then monthly times 2 months. The facility Policy titled “Pest control Program” was reviewed by Administrator and Director of Environmental Services and determined that no revisions or updates were necessary at this time. 4. Monitoring to ensure ongoing compliance: All findings will be presented by the Environmental Director and reviewed quarterly at the facility Quality Assessment and Assurance meeting for two consecutive quarters.	

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F0925 SS = F	Continued from page 11 report any concerns to the U.S. FOIA She stated that she was made aware of a pest control problem in the kitchen a few weeks ago. The U.S. F further stated there was a pest control logbook in the kitchen to identify the date and location of pest sightings so the exterminator would know areas to treat. A review of the [name redacted] “Pest Management” logbook dated 6/2/25 through 8/19/25 (12 entries), reflected “no reports” of pest observations in the kitchen. A review of [name redacted] “Pest Management Service Inspection Report’s” dated 6/1/25 through 8/19/25 (12 reports) included a report dated 6/1/25 which reflected, “Treated the kitchen for roach activity,” reports dated 7/29/25 and 8/5/25 did not include treatment for the kitchen. On 8/19/25, the report included “Conducted heavy treatment in the kitchen.” A review of an email sent from the [name redacted] Pest Control company to the U.S. FOIA T dated 8/20/25 at 11:47 AM, reflected “We would like to schedule an after-hours intensive cleanout for your kitchen.” A review of the facility policy “Pest Control” dated as reviewed 2024, reflected if pests were seen in the kitchen, the food service manager or appropriate staff should be informed, describing where and when the pest was seen and documented in the log. “Appropriate action will be taken to eliminate any reported pest situation in the department.” It also reflected the contractor would complete preventative spray treatments and if the problem persisted, the exterminator would use a chemical bomb to “destroy the pests.” In addition, the policy reflected the extermination company must establish an ongoing preventative program to limit the possible return of such pests. NJAC 8:39 – 31.5(a)	F0925		
F0584 SS = D	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-	F0584	Tag: F584 Safe/Clean/Comfortable/Homelike Environment 1. Corrective action for residents affected: Resident #131’s dresser was immediately removed and replaced. Residents room was inspected and found free of any other hazards. 2. Identification of other residents who could be affected:	10/08/2025

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F0584 SS = D	Continued from page 12 §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 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 and review of facility documents, it was determined the facility failed to maintain a comfortable and homelike environment for the residents (Resident #131). This deficient practice was identified on 1of 5 nursing units reviewed for environment and was evidenced by the following: On 8/18/2025 at 11:29 AM, the surveyor observed Resident #131, in the day room. The surveyor observed the resident's room and noted the resident's dresser, with the 3rd drawer down broken. The surveyor observed nails sticking out of the inside of the drawer.	F0584	Continued from page 12 All residents have the potential to be affected by this deficient practice. A facility-wide audit of all resident rooms and furnishings was immediately initiated and completed. All identified issues were corrected through repair or replacement to ensure resident safety and a proper homelike environment. 3. Measures/Systemic changes to prevent recurrence: All staff re-educated by the Maintenance Director or Assistant Maintenance Director (AMD) or Licensed Nursing Home Administrator (LHNA) on proper reporting procedure for broken/unsafe furniture and to log Maintenance concerns immediately. Maintenance Director or AMD or LHNA will review maintenance log on each unit daily Maintenance Director or AMD or LHNA will complete random weekly audits of 5 rooms times 2 months to ensure all rooms are free of hazards. Facility Policy Titled "Home Like Environment" was reviewed by Administrator and Maintenance Director and determined that no revisions or updates were necessary at this time. 4. Monitoring to ensure ongoing compliance: The Maintenance Director will present the results of these audits quarterly at the Facility Quality Assessment and Assurance meeting for two consecutive quarters.	

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F0584 SS = D	Continued from page 13 On 8/19/2025 at 10:29 AM, the surveyor observed Resident # 131, in a reclining chair, next to their bed. The resident's eyes were closed. The surveyor again noted the dresser with the broken drawer. On 8/20/2025 at 8:50 AM, the surveyor observed Resident # 131, in a reclining chair, in front of the dresser. The resident NJ Exec Order 26.4b1 to the surveyor's questions. The surveyor again noted the dresser with the broken drawer. The surveyor reviewed the electronic medical record for Resident #131. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)). A review of the Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4, revealed the resident had a Brief Interview for Mental Status of NJ E out of 15, indicating the resident was NJ Ex Order 26.4(b)(1) . Further review of the MDS, revealed the resident was NJ Ex Order 26.4(b)(for NJ Ex Order 26.4(b)(1) . On 8/21/2025 at 8:30 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated she was asked to come in today since the U.S. FOIA (b) (6) would not be in. She stated if something was in disrepair or needed to be fixed it would go into the maintenance logbook at the nurse's station. She walked with the surveyor to Resident # 131's room and observed the broken drawer. LPN #1 walked into the room and looked at the drawer. She asked the Certified Nursing Aide (CNA) #1, who was performing Resident #131's care in the room, about the drawer. CNA #1 stated he "hadn't noticed it." She acknowledged that it should have been noticed and entered in the maintenance log. LPN # 1 showed the maintenance logbook to the surveyor, which was at the nurse's station. She reviewed, the book with the surveyor, from 6/20/25 and acknowledged that the drawer was not listed there. On 8/21/2025 at 8:45 AM, the surveyor interviewed the U.S. FOIA (b) (6) , who stated the first thing he did in the morning was to check all the maintenance	F0584		

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F0584 SS = D	Continued from page 14 log books on the units. He added he also checked with the supervisor to see if there were any issues that were not documented in the books. The U.S. FO stated if something was in the book, it would be addressed right then and there. The surveyor showed the U.S. FO the picture of Resident #131's broken drawer and he acknowledged the nails sticking out of the wood. He stated he would have expected to be called right away to come fix it. The U.S. FO stated he would have addressed it right away, but he had no idea that it was broken. He stated a broken drawer would be addressed right away by removing and replacing the dresser. On 8/21/2025 at 9:02 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated if they (staff) noticed it (something broken), it should be in the maintenance book. The surveyor showed the U.S. FOIA (the picture of the broken drawer and he acknowledged it should have been noticed especially because the nails were sticking out. The U.S. FOIA (stated, "It should have been addressed right away." He stated the staff had already made him aware of the surveyor's findings. On 8/22/2025 at 2:35 PM in the presence of the survey team, the surveyor made the U.S. FOIA (b) (6) , the U.S. FOIA (b) the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) aware of the above findings. NJAC 8:39-4.1(a)	F0584		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #172's NJ Ex Order 26.4(b)(1) was immediately adjusted to the correct setting per resident's NJ Ex Order 2 Resident #172's NJ Ex Order 26 were assessed by the NJ Ex Order nurse practitioner, and all NJ Ex Order 26 were noted to be improving or resolved on 8/20/25 and 8/27/2025. Licensed Practical Nurse (LPN) #1, Registered Nurse (RN) #1 and Certified Nurse Assistant (CNA) #1 were immediately re-educated by the Director of Nursing (DON) on how to determine the correct setting for a LAL mattress per resident's weight. How will you identify other residents having the potential to be affected by the same deficient practice	10/08/2025

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F0686 SS = D	Continued from page 15 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that an NJ Ex Order 26.4(b)(1)) was accurately set in accordance with the resident's NJ Ex Order for one (1) of one (1) resident reviewed for NJ Ex Order 26.4(b)(1) Resident #172. This deficient practice was evidenced as follows: On 8/19/2025 at 10:39 AM, the surveyor interviewed Resident #172, who was in bed. The surveyor observed an NJ Ex Order 26.4(b)(1) at the foot of the resident's bed. The setting on the NJ Ex Orde was set at approximately NJ Ex Or The resident stated, 'NJ Ex Order 26.4(b)(1) On 8/20/2025 at 8:45 AM, the surveyor observed the resident in bed with the NJ Ex Order 26.4(b)(1) set at approximately NJ Ex O The survey met with resident's nurse to attempt to do a NJ Ex Order care observation, but the nurse stated the NJ Ex Order care was done this morning by the NJ Ex Order care team. The surveyor reviewed the electronic medical record (EMR) for Resident #172. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)). A review of the quarterly Minimum Data Set, an assessment tool dated NJ Ex Order 26.4 , revealed the resident had a Brief Interview for Mental Status of NJ E out of 15, indicating the resident was NJ Ex Order 26.4(b)(1) . A review of the individual comprehensive care plan revealed a focus of has hx (history) of refusing NJ Ex Order 26.4(b)(1) , refusing to NJ Ex Order 26.4(b)(1) . Date Initiated: NJ Ex Order 26.4(b)(1) . Further review, revealed a focus of at risk for NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) Hx: NJ Ex O	F0686	Continued from page 15 and what corrective action will be taken? All residents who reside in the facility and have physician's orders for a LAL mattress have the potential to be affected by the deficient practice. A comprehensive audit of all residents who utilize LAL mattresses was conducted on 8/22/2025 to ensure that all settings were correct according to the resident's current weight. No additional inconsistencies in the LAL mattress settings were found. What measures will be put in place or what systemic changes will be put in place to ensure the deficient practice does not recur? The DON or designee has re-educated the current nursing staff on the manufacturer's recommendation for LAL mattress settings by using the resident weight that is recorded in the resident's electronic health record. The physician's orders in the electronic health record for LAL mattresses have been updated to state "refer to resident's current weight for setting". 4.How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place? The DON or designee will conduct weekly random audits of 10 residents who utilize a LAL mattress x 4 weeks, then monthly x 3 months to ensure that LAL mattresses are set correctly per resident weight. The results of these audits will be reviewed at the facility Quarterly Quality Assurance Meeting x 2 quarters to determine the need for improvement and/or continued monitoring to ensure the deficient practice does not recur.	

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F0686 SS = D	Continued from page 16 NJ Ex Order 26.4(b)(1) revision on: NJ Ex Order 26.4(b)(1) with an intervention that included utilize NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), revision on NJ Ex Order 26.4(b). A review of the Order Summary Report revealed a physician's order (PO) for NJ Ex Order 26.4(b)(1) on bed for NJ Ex Order 26.4 prevention every shift for NJ Ex Order 26.4(Prevention Check setting and function on NJ Ex Order 26.4(b)(1) Start Date NJ Ex Order 26.4(b)(at 1500 (3PM). A review of the Treatment Administration Record (TAR) for NJ Ex Order 26.4(b)(1) revealed the above PO had been signed as completed for day shift on NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b)(1) On 8/22/2025 at 10:07 AM, the surveyor observed with Licensed Practical Nurse (LPN) #1, Registered Nurse (RN) #1, and Certified Nursing Assistant (CNA #1). At the beginning of the observation, LPN #1 had bumped the NJ Ex Order 26.4(b)(1) and knocked it off the bed. The nurse picked the NJ Ex Orde up and placed it back on the bed. The surveyor observed the setting remained on approximately NJ Exec the same setting as the prior observations. After the NJ Ex Order 2 care observation was completed, the surveyor questioned the NJ Ex Order 26.4(b)(1). Both RN #1 and LPN #1, confirmed the NJ Exec Order 26.4b1 setting was at NJ Exec On 8/22/2025 at 10:33 AM, the surveyor interviewed CNA #1, who stated the NJ Ex Order 26.4(b)(1) was set by resident's NJ Ex Order and the nurses checked it. On 8/22/2025 at 10:35 AM, the surveyor interviewed LPN#1, who stated she rounded with the NJ Ex Order care team. The surveyor asked about the NJ Ex Order 26.4(b)(1) setting of NJ Ex O LPN#1 stated it probably got messed up when the NJ Ex Orde fell. The surveyor made her aware of the above observations and that the settings had been the same prior to the NJ Ex Orde falling. She stated the NJ Ex Orde should be set close to the resident's NJ Ex Order 2 She checked the electronic medical record in the presence of the surveyor and verified the resident's NJ Ex Order was NJ Ex O. She stated the higher setting would make the mattress too hard. LPN #1 stated the reason it was important to have the settings set to the resident's NJ Ex Order was for NJ Ex Order 26.4(b)(1), "so it (the NJ Ex Order 26.4(b) could adjust to the NJ Ex Order 26 On 8/22/2025 at 10:45 AM, the surveyor interviewed CNA #2, who stated, "We check to make sure there is air in there if not, we call maintenance." On 8/22/2025 at 11:17 AM, the surveyor interviewed	F0686		

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F0686 SS = D	Continued from page 17 RN#1, who was Resident #127s assigned nurse. RN #1 stated she makes sure the [NJ Ex Order 26.4(b)(1)] was working but she was not checking the settings. RN #1 reviewed the TAR in the presence of the surveyor and acknowledged she had signed the above-mentioned PO as being completed but then confirmed she signed that “it was working.” On 8/22/2025 at 11:21 AM, the surveyor interviewed the [U.S. FOIA (b) (6)], who stated the purpose of an [NJ Ex Order 26.4(b)(1)] was prevention of [NJ Ex Order 26.4(b)(1)]. She stated maintenance applied the air mattress and sets it. The [U.S. FOIA] stated maintenance would ask for the [NJ Ex Order 26] and set the [NJ Ex Order]. She added it was between the nurses and the unit managers to check that the [NJ Ex Order] setting was correct. On 8/22/2025 at 1:27 PM, the [U.S. FOIA (] in the presence of another surveyor, confirmed that the facility does not have a policy on the [NJ Ex Order 26.4(b)(1)] settings. She stated the setting should be adjusted to the resident’s [NJ Ex Order] due to [NJ Ex Order] distribution and added we are in servicing all the nurses on checking the settings. On 8/22/2025 at 2:35 PM in the presence of the survey team, the surveyor made the [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)] and the [U.S. FOIA] were made aware of the above findings. A review of the facility’s policy, “Homelike Environment Policy” revised 1/1/2025, revealed Policy: The facility is committed to creating and maintaining a homelike environment by: Ensuring the environment is free from odors, clutter, and hazards while maintaining a warm and inviting atmosphere. Procedures: 3. Maintenance Services: Maintenance staff will ensure all resident rooms and common areas are kept in good repair, with no hazards such as loose flooring, exposed wiring, or broken furniture. 6. Staff Training: Housekeeping and maintenance staff will be trained in infection prevention, safety…with emphasis on respecting resident preferences and maintaining a homelike environment. NJAC 8:39-25.2 (c), 27.1(e)	F0686		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F0755	F0755 Pharmacy Srvs/Procedures/Pharmacist/Records What corrective action will be accomplished for residents identified to have been affected?	10/08/2025

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F0755 SS = D	Continued from page 18 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a medication was administered according to the physician orders (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in one (1) of six (6) residents (Resident #202) observed during the medication observation pass. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching,	F0755	Continued from page 18 Resident #202's physician orders for [redacted] and [redacted] were immediately updated with a place for the nurse to plot the [redacted] and/or [redacted] on the resident's electronic medication administration record (e-MAR). Registered Nurse (RN) #1 was immediately educated to add the necessary documentation to the physician order if it is missing from the e-MAR. How will you identify other residents who could be affected? All residents who have physician orders for Hydralazine, Norvasc and Metoprolol with parameters for pulse and/or blood pressure have the potential to be affected by the deficient practice. A comprehensive review of current residents who have physician orders for Hydralazine, Norvasc and Metoprolol with parameters has been conducted to ensure there is a place on the resident's e-MAR to plot the pulse and/or blood pressure. No other residents were found to have been affected. What measures/systemic changes will be put in place to prevent recurrence? The Assistant Director of Nursing (ADON) has re-educated all licensed nursing staff on the procedure for updating the physician orders for residents who receive Hydralazine, Norvasc and Metoprolol with pulse and/or blood pressure parameters if it is missing on the e-MAR. The facility policy for "Medication Administration" was reviewed by the Director of Nursing (DON) and the Administrator and determined no revisions or updates were necessary at this time. The DON or designee will review 5 resident charts per week x 3 months that have new physician orders for Hydralazine, Norvasc and Metoprolol with parameters for pulse and/or blood pressure to ensure that there is a place on the resident's e-MAR to document the necessary vital signs. This review will occur monthly.	

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F0755 SS = D	Continued from page 19 health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 8/19/25 at 8:54 AM, during the medication administration observation, the surveyor observed Registered Nurse (RN#1) enter the room of Resident #202. The surveyor observed RN#1 informing Resident #202 that she would be taking the resident's vitals and would then be administering the resident's medications. RN #1 was observed taking the resident's vitals which were NJ Ex Order 26.4(b)(1) . On 08/19/25 at 8:57 AM, the surveyor observed RN#1 preparing to administer five (5) medications to Resident #202 which included NJ Ex Order 26.4(b)(1) tablet (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) tablets (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) tablet (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) tablet (NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) tablet (NJ Ex Order 26.4(b)(1)). After RN#1 finished preparing the resident's medication she was observed entering the resident's room and administering Resident #202's medications. After RN#1 finished administering Resident #202's medications, the surveyor observed RN#1 signing off the Electronic Medication Administration Record (e-MAR) but did not observe her entering the vitals for the NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), or NJ Ex Order 26.4 tablets. After completing medication administration observation, the surveyor did record review which revealed that the resident had parameter orders for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 which included a hold order if the NJ Ex Order 26.4(b)(1)	F0755	Continued from page 19 How will the corrective action be monitored to ensure the deficient practice does not recur, i.e. What quality assurance program will be put in place? The DON or designee will conduct weekly random audits x 4 weeks, then monthly audits x 2 months of residents who have physician orders with pulse and/or blood pressure parameters for Hydralazine, Norvasc and Metoprolol to ensure there is a place on the e-MAR for the nurse to document the necessary vital sign(s). The results of these audits will be reviewed at the Quarterly Quality Assurance Meeting x 2 quarters to determine the need for improvement and/or continued monitoring to ensure the deficient practice does not recur.	

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F0755 SS = D	Continued from page 20 NJ Ex Order 26.4(b)(1)) or the NJ Ex Order 26.4(b)(1) a certain level. A review of the full medical record revealed no documentation of the resident's NJ Ex Orde which included the NJ Ex Or A review of the Admission Record (an admission summary) reflected that Resident #16 was admitted to the facility with diagnoses that included but not limited to;NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)). A review of the NJ Ex Order 26.4(b)(1) Order Summary Report (OSR) revealed the following PO's) dated NJ Ex Order 26.4: NJ Ex Order 26.4(b)(1) , give 1 tablet by mouth two times a day NJ Ex Order 26.4(b)(1)) hold NJ Ex Order 26.4(b)(1) per policy. May cause NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , give 1 tablet by mouth two times a day NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) per policy. Take with or immediately after meals. May cause NJ Ex Order 26.4(b) May cause NJ Ex Order 26.4(b)(1). 3.NJ Ex Order 26.4(b)(1)), give 1 tablet by mouth two times a day NJ Ex Order 26.4(b)(1) and NJ Ex Ord per policy. May cause NJ Ex Order 26.4(b)(1) . Avoid NJ Ex Order 26.4(b) A review of the NJ Ex Order 26.4(b)(1) e-MAR revealed the following POs dated NJ Ex Order 26. 1.NJ Ex Order 26.4(b)(1) , give 1 tablet by mouth two times a day NJ Ex Order 26.4(b)(1) per policy. May cause NJ Ex Order 26.4(b)(1) with an administration time of 0900 (09:00 AM) and 1700 (5:00 PM). A further review of the e-MAR revealed that nurses were not plotting the NJ Ex 2.NJ Ex Order 26.4(b)(1) , give 1 tablet by mouth two times a day NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) per policy. Take with or immediately after meals. May cause NJ Ex Order 26.4(b) May cause NJ Ex Order 26.4(b)(1) with an administration time of	F0755		

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F0755 SS = D	Continued from page 21 0900 (9:00 AM) and 1700 (05:00 PM). A further review of the e-MAR revealed that nurses were not plotting the [redacted] [redacted]), give 1 tablet by mouth two times a day [redacted] and [redacted] per policy. May cause [redacted] Avoid [redacted] with an administration time of 0900 (9:00 AM) and 1700 (05:00 PM). A further review of the e-MAR revealed that nurses were not plotting the [redacted] On 8/19/25 at 11:00 AM, the surveyor interviewed RN#1, who stated that she would take the resident's vitals which included the [redacted] and [redacted] and will write it down on a piece of paper. RN#1 acknowledge that she does not enter the vitals into the electronic medical record. In the presence of the surveyor, RN#1 reviewed Resident #202's e-MAR and acknowledged that the resident had three medication that required parameters which included [redacted], [redacted] and [redacted] and that the e-MAR contained no place to document the resident's vitals. She further acknowledges that medications that have perimeters should contained a place to plot the [redacted] and [redacted] She stated that all three medications did not contain a place to plot the [redacted] and [redacted] On 08/19/25 at 1:00 PM, the surveyor discussed the above concerns with the facility administration team that consisted of the [redacted]) and the [redacted]. There was no additional information provided. A review of the facility's policy for "Medication Administration" that was dated 11/2024 and was provided by the Regional Director of Nursing revealed the following: The policy does not mentioned perimeters but mentions to review the eMAR and notified the physician if something was questionable. "If an order for a medication is unusual (such a large dose more than two tablets will be required), question the order. Check the physician order sheet (POS) against the eMAR. Compare the eMAR to the label on the drug container. Call the physician or pharmacist with any concerns."	F0755		

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F0755 SS = D	Continued from page 22 NJAC 8:39-11.2 (b), 29.2 (d)	F0755		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 8/19/25, the surveyor observed four (4) nurses administer medications to six (6) residents. There were 27 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.41%. The deficient practice was identified for two (2) of six (6) residents, (Resident #55 and #74), that were administered medications by two (2) of four (4) nurses that were observed. The deficient practices were evidenced by the following: 1). On 8/19/25 at 8:32 AM, during the medication administration observation, the surveyor observed Licensed Practical Nurse (LPN#1) entered the room of Resident #55. The surveyor observed LPN#1 informing Resident #55 that she would be administering the resident's medications. The surveyor observed the resident who was in their bed and was observed eating breakfast. On 08/19/25 at 8:35 AM, the surveyor observed LPN#1 preparing to administer five (5) medications to Resident #16, which included NJ Ex Order 26.4(b)(1)), one (1) tablet NJ Ex Order 26.4(b)(1)), one (1) tablet of NJ Ex Order 26.4(b)(, three (3) tablets of NJ Ex Order 26.4(b)(1)), and one (1) tablet of NJ Ex Order 26.4(b)(1) . While preparing the resident's medications the surveyor observed LPN#1 reviewing the resident's Electronic Medication Administration Record (e-MAR), the surveyor	F0759	F0759 Free of Medication Error Rates 5 Percent or More What corrective action will be accomplished for residents identified to have been affected? Resident #55 was assessed and indicated no NJ Ex Order 26.4(b)(1) related to the administration of the medication NJ Ex Order 26.4(b)(1) being given without NJ Ex Order 26.4(b)(1) per the manufacturer's recommendation. Licensed Practical Nurse #1 was immediately re-educated by the Assistant Director of Nursing (ADON) to check the electronic medication administration record (e-MAR) instructions prior to administering medications. Resident #74 was assessed and found to have no complaints of NJ Ex Order 26.4(b)(1) and was not given the NJ Ex Order 26.4(b)(1) tablet that Registered Nurse (RN) #1 obtained from the medication cart instead of the correct NJ Ex Order 26.4(b)(1) tablet that was ordered by the physician. RN #1 was immediately re-educated by the ADON on the difference between chewable aspirin tablets and aspirin with enteric coating (EC) tablets and to always check the medication three times: 1. before removing from cart 2. before pouring it and 3. after pouring it (prior to administering to the resident). How will you identify other residents who could be affected? All residents in the facility who have a physician order for potassium chloride solution and/or aspirin EC tablets have the potential to be affected by the deficient practice. A review of current residents who have physician orders for potassium chloride solution and/or aspirin EC tablets was conducted, and none had any complaints of GI irritation. What measures/systemic changes will be put in place to prevent recurrence?	10/08/2025

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F0759 SS = D	Continued from page 23 noticed that LPN#1 did not click and read the full directions for NJ Ex Order 26.4(b)(1) (ERROR #1). LPN#1 told the surveyor that the resident received their NJ Ex Order 26.4(b)(1), the surveyor then observed LPN #1 entered the resident's room and administered the resident's medication including NJ Ex Order 26.4(b)(1). The resident was observed drinking approximately NJ Exec Order 26.4b1 after being administered their NJ Ex Order 26.4(b)(1). A review of the Admission Record (an admission summary) reflected that Resident #55 was admitted to the facility with diagnoses that included but not limited to; NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) ." A review of the annual Minimum Data Set, an assessment tool used to facilitate the of care, dated NJ Ex Order 26.4(b reflected that the resident's NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) score was NJ E out of 15, which indicated that the resident's NJ Exec Order 26 was NJ Ex Orde A review of the NJ Ex Order 26.4(b)(1) Order Summary Report (OSR) revealed a Physician's Order dated NJ Ex Order 26.4 , for NJ Ex Order 26.4(b)(1) , give NJ E mouth two times a day for NJ Ex Order 26.4(b)(1) every NJ Ex Orde with at least NJ Exec Order 26.4b1 Administer with or after meals. A review of the NJ Ex Order 26.4(b)(1) e-MAR revealed a Physician's Order dated NJ Ex Order 26.4 , for NJ Ex Order 26.4(b)(by mouth two times a day for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) with at least NJ Exec Order 26.4b1) of NJ Exec O Administer with or after meals with an administration time of 0900 (09:00 AM) and 1700 (05:00 PM). A review of the Manufacturer's Specifications for NJ Ex Order 26.4(b)(1) revealed the following: -NJ Ex Order 26.4(b)(1): Pour the measured NJ Ex Orde dose into a glass with NJ Ex Order 26.4(b)(1) can also help NJ Ex Order 26.4(b)(1)	F0759	Continued from page 23 LPN #1 and RN #1 have both had a successful medication pass observation conducted by the ADON without any medication errors. All licensed nursing staff have been re-educated by the ADON to check the medication administration instructions and verify each medication three times: 1. When obtaining the medication, 2. During the medication preparation, 3. At the bedside prior to administration. The licensed nursing staff have also been educated by the ADON on the need to dilute potassium chloride solution before administering it to prevent GI irritation and the importance of ensuring that when aspirin EC tablet is ordered by the physician it is also to prevent GI irritation and chewable aspirin tablet is not an acceptable substitute. The facility policy for "Medication Administration" was reviewed by the Director of Nursing (DON) and the Administrator and determined the policy required it to be clarified to check the medications 3 times as follows: 1. before removing from cart 2. before pouring it and 3. after pouring it (prior to administering to the resident). How will the corrective action be monitored to ensure the deficient practice does not recur, i.e. What quality assurance program will be put in place? The DON or designee will conduct 5 random medication pass observations with licensed nurses weekly x 4 weeks, then monthly x 2 months for residents who receive potassium chloride solution and/or aspirin EC tablets to ensure the residents receive the correct medication and they are administered according to the manufacturer's instructions. The results of these audits will be reviewed at the Quarterly Quality Assurance Meeting x 2 quarters to determine the need for improvement and/or continued monitoring to ensure the deficient practice does not recur.	

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F0759 SS = D	Continued from page 24 On 8/19/25 at 11:00 AM, the surveyor interviewed Resident #55 who acknowledge that they always received their NJ Ex Order 26.4(b)(in a little medicine cup and that it was never administered NJ Ex Order in a cup of water. Resident #55 stated that they never experience any NJ Ex Order 26.4(b)(1) taking the medication NJ Ex Order 26.4(b)(1) On 8/19/25 at 11:20 AM, the surveyor in the presence of LPN #1, reviewed Resident #55's e-MAR. LPN#1 reviewed the directions for Resident #55's NJ Ex Order 26.4(b)(1) and acknowledged that there was an order to NJ Ex Ord the NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1). LPN#1 further acknowledge that she should have NJ Ex Order the medication prior to administering the medication. 2. On 8/19/25 at 09:16 AM, during the medication administration observation, the surveyor observed Registered Nurse (RN#1) entered the room of Resident #74. The surveyor observed RN#1 identify Resident #74 and then observed RN#1 taking the resident's vitals. RN#1 then informed Resident #74 that she would be administering the resident's medications. On 08/19/25 at 9:20 AM, the surveyor observed LPN#1 preparing to administer five (5) medications to Resident #74, which included one tablet of NJ Ex Order 26.4(b)), one tablet of NJ Ex Order 26.4(b)(1)), one tablet of NJ Ex Order 26.4(b)(1)) ERROR #2, NJ Ex Order 26.4) and NJ Ex Order 26.4(b)(1)). The surveyor observed RN#1, after preparing the above medications, fill a cup with approximately NJ Exec Order 26.4b1 and was observed her walking into Resident #74's room. Once RN#1 entered the room, she was stopped by the surveyor, just prior to administering the resident's medications. The surveyor asked the nurse to leave the resident's room with the resident's medications. The surveyor, in the presence of RN#1, reviewed the resident's e-MAR. At that time, RN#1 acknowledge that the resident had an order for NJ Ex Order 26.4(b)(1) . She further acknowledges that she picked the wrong form of NJ Ex Order 26 When the surveyor asked her why NJ Ex Order 26.4(b)(1) was different from NJ Ex Order 26.4(b)(1) , RN#1 was not able to tell the surveyor the difference between the two NJ Ex Order 26.4(	F0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

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F0759 SS = D	Continued from page 25 A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to [redacted].	F0759		
	A review of the Annual Minimum Data Set, an assessment tool used to facilitate the management of care dated [redacted], reflected that the resident's [redacted] skills for [redacted] score was [redacted] out of 15, which indicated that the resident' had [redacted]			
	A review of the [redacted] OSR revealed a PO dated [redacted], for [redacted]. Do not crush/chew. Give with plenty of water. Monitor for [redacted].			
	A review of the [redacted] e-MAR revealed a PO dated [redacted] for [redacted]. Do not crush/chew. Give with plenty of water. Monitor for sign of [redacted] with an administration time of 0900 (9:00 AM).			
	On 8/19/25 at 1:10 PM, the surveyor presented the above concerns to the [redacted] and the [redacted].			
	No further information was provided.			
	A review of the facility's policy for "Medication Administration" that was dated 11/2024 and was provided by the Regional Director of Nursing revealed the following:			
	“Under Medication Pass:”			
	“Read medication name, dosage, and timing.”			
	“Read labels on all medications three times: before removing from cart/before pouring it/ and after pouring it.”			

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F0759 SS = D	Continued from page 26 NJAC 8:39-11.2(b), 29.2(a)(d)	F0759		
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 be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly secure medications in one (1) of four (4) medication carts observed during Medication Administration Pass. This deficient practice was evidenced by the following: On 8/19/25 at 09:16 AM, during the medication administration observation, the surveyor observed Registered Nurse (RN#1) enter the room of Resident #74. The surveyor observed RN#1 identify Resident #74 and then observed RN#1 taking the resident's vitals. RN#1 then informed Resident #74 that she would be administering the resident's medications. On 08/19/25 at 9:20 AM, the surveyor observed LPN#1 preparing to administer five (5) medications to Resident #74, which included NJ Ex Order 26.4(b)(1)	F0761	F0761 Label/Store Drugs and Biologicals What corrective action will be accomplished for residents identified to have been affected? Registered Nurse (RN) #1 was immediately re-educated on the facility policy titled "Medication Storge" which states "Keep the medication cart visible or locked at all times while passing medications." Resident #74 had NJ Ex Order 26.4(b)(1) due to RN #1 not locking the medication cart while entering the room to administer medications. How will you identify other residents who could be affected? All residents who reside in the facility have the potential to be affected by the deficient practice. No other medication carts were found to be unlocked. What measures/systemic changes will be put in place to prevent recurrence? The Director of Nursing (DON) or designee has re-educated current licensed nursing staff of the facility policy titled "Medication Storage" dated 11/2024 which states "Keep the med cart visible or locked at all times while passing medications." The facility policy for "Medication Storage" was reviewed by the Director of Nursing (DON) and the Administrator and determined no revisions or updates were necessary at this time. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e. What quality assurance program will be put in place? The DON or designee will conduct daily audits/observations x 4 weeks, then weekly x 2 months on all units to ensure that medication carts are locked when not visible during the med pass.	10/08/2025

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F0761 SS = D	Continued from page 27 ([redacted] NJ Ex Order 26.4(b)(1) [redacted]), [redacted] NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted] and [redacted] NJ Ex Order 26.4(b)(1) [redacted]). The surveyor observed RN#1, after preparing the above medications, fill a cup with approximately 120 ml of water. The surveyor observed RN #1 walk into Resident #74's room without locking the medication cart. The surveyor observed no residents in the vicinity of the medication cart. Once RN#1 entered the room, the surveyor stopped her just prior to administering the resident's medications. The surveyor asked the nurse to leave the resident's room with the resident's medications. The surveyor stopped RN#1 because she was going to administer the wrong form of [redacted] NJ Ex Order 2 [redacted]). At that time, the surveyor asked RN#1 if her medication cart was locked, in which she replied "no". RN#1 acknowledged that she should have locked the medication prior to leaving the medication cart and entering the resident's room. On 8/19/25 at 1:00 PM, the surveyor presented the above concerns to the [redacted] U.S. FOIA (b) (6) [redacted]) and the [redacted] U.S. FOIA (b) (6) [redacted]). No further information was provided. A review of the facility's policy for "Medication Storage" that was dated 12/2024 and was provided by the [redacted] U.S. FOIA (b) (6) [redacted] indicated the following: "A. with the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy." A review of the facility's policy for "Medication Administration" that was dated 11/2024 and was provided by the [redacted] U.S. FOIA (b) (6) [redacted] indicated the following: "Keep the med cart visible or locked at all times while passing medications." NJAC: 8:39-29.4 (a) (h) (d)	F0761	Continued from page 27 The results of these audits will be reviewed at the Quarterly Quality Assurance Meeting x 2 quarters to determine the need for improvement and/or continued monitoring to ensure the deficient practice does not recur.	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	F880 Infection Prevention and Control How will corrective action be accomplished for those	10/08/2025

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F0880 SS = D	Continued from page 28 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with	F0880	Continued from page 28 individual residents found to be affected by the deficient practice? Resident # 202 had NJ Ex Order 26.4(b)(1) due to the deficient practice. Resident #202 no longer resides in the facility and has been discharged NJ Ex Orde on NJ Ex Order 26.4(b). Registered Nurse (RN) #1 was immediately re-educated by the U.S. FOIA (b) (6)) on the facility policy and procedure of proper Handwashing/Hand Hygiene and disinfecting blood pressure (BP) monitor before and after use. A return demonstration of handwashing/hand hygiene and disinfecting the BP monitor was completed correctly by RN #1. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who reside in the facility have the potential to be affected by the deficient hand hygiene and disinfecting the BP monitor practice. Observations of RN #1 were conducted on hand washing and disinfecting the BP monitor when entering and exiting resident rooms was completed per policy. No other residents were found to be affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur? The Infection Preventionist (IP) or designee will in-service current licensed nursing staff on the facility policy and procedure on hand washing/hand hygiene and disinfecting the BP monitor when entering and exiting resident rooms according to the CDC and facility policy and procedure. The IP or designee will conduct competencies/observations of current licensed nursing staff on correct hand washing/hand hygiene and disinfecting the BP monitor when entering and exiting resident rooms. The IP or designee will conduct random weekly audits x 4 weeks, then monthly x 2 to ensure Nurses are washing their hands and disinfecting the vital signs machine when entering and exiting the residents' rooms per	

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F0880 SS = D	Continued from page 29 residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and a review of pertinent medical records, it was determined that the facility failed to minimize the potential spread of infection to residents during medication administration for 1of 4 nurses observed during medication pass on 1 of 4 nursing units. This deficient practice was evidenced by the following. On 08/19/25 at 8:34 AM, during medication administration observation the surveyor observed a Registered Nurse (RN#1) taking Resident #202's NJ Ex Orde [redacted] with a NJ Ex Order 26.4(b)(1). After taking Resident #202's NJ Ex the nurse was observed taking the NJ Ex Order 26.4(b)(1) [redacted]) and placing it next to her medication cart. RN#1 was then observed preparing Resident #202's medications (no observation of performing hand hygiene) and was then observed entering the resident's room. The surveyor observed RN#1 lifting the resident's NJ Ex Order 26.4(b)(1) with a NJ Ex O [redacted], which was next to the resident's bed. RN#1 was then observed handling Resident #202's NJ Ex Order 2 and placing it behind the resident's NJ Ex Orde After administering Resident #202's medications the surveyor observed RN#1 returning to her medication cart, without performing hand hygiene and signing off Resident #202's Electronic Medication Administration Record (e-MAR). After signing off the e-MAR for Resident #202's, the	F0880	Continued from page 29 facility policy. The facility policies for "Medication Administration", "Hand Washing/Hand Hygiene", and "Cleaning and Disinfecting Equipment Between Residents" was reviewed by the Director of Nursing (DON) and the Administrator and determined no revisions or updates were necessary at this time. 4.How will the facility monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place? The IP or designee will conduct 5 random weekly audits x 4 weeks, then monthly x 2 months to ensure licensed nursing staff are performing proper hand washing/hand hygiene and disinfecting the BP monitor when entering and exiting the residents' rooms per facility policy. The results of these audits will be presented at the Quarterly Quality Assurance Performance Improvement (QAPI) Committee Meeting for 2 consecutive quarters to monitor this deficient practice to ensure compliance. The committee will then determine the need for continuation thereafter.	

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F0880 SS = D	Continued from page 30 surveyor observed RN#1, without performing hand hygiene or disinfecting the NJ Ex Order 26.4(b)(1), take NJ Ex Order 26.4(b)(1) and enter Resident #74's room. The surveyor stopped RN#1 just before she was going to take Resident #74's BP. The surveyor asked RN#1 to step out of the resident's room with the NJ Ex Order 26.4(b)(1) At that time, the surveyor interviewed RN#1, who acknowledge that she did not perform hand hygiene or disinfect the NJ Ex Order 26.4(b)(1). RN#1 further stated that she should have disinfected the NJ Ex Order 26.4(b)(1) after taking Resident 202's vitals and that she should have performed hand hygiene after administering Resident #202's medications. The surveyor then observed RN#1 wash her hands. RN#1 was observed putting on the faucet, wetting her hands, applying soap, and then scrubbing her hands for 5 seconds away from the stream of water and then rinsing her hands with the stream of water. At that time, the surveyor asked RN#1, how many seconds should she scrub her hands away from a stream of water, the RN#1 stated for "20 second". The surveyor then asked RN#1 if she scrubbed her hands away from a stream of water for 20 seconds, RN#1 stated "No". On 8/19/25 at 1:00 PM, the surveyor presented the above concerns to the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6). No further information was provided. A review of the facility's policy titled "Medication Administration" with a review date of 11/2024 and was provided by the Regional Director of Nursing revealed the following: "Wash hands before and after resident contact. An alcohol-based commercial may be substituted." A review of the facility's policy titled "Hand Washing/Hand Hygiene" with a review date of 04/28/25 and was provided by the Regional Director of Nursing revealed the following: "7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-microbial) and water for the following situations: c. Before preparing or handling medications." Under Washing Hands:	F0880		

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F0880 SS = D	Continued from page 31 "1. Vigorously later hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under moderate stream of running water, at comfortable temperature. Hot water is unnecessarily rough on hands." A review of the facility's policy titled "Cleaning and Disinfecting Equipment Between Residents." with a review date of 4/15/25 and was provided by the Regional Director of Nursing revealed the following: "To provide maximum safety and prevent transmission of pathogenic microorganisms from one resident to another, this facility will ensure that measures are in place to clean and disinfect all equipment that come in contact with the resident prior to the use of another resident." NJAC 8:39-19.4 (a)(1), (m)	F0880		
F0000	INITIAL COMMENTS Complaint #s: 410474, 410477, 410484 Standard Survey: 08/18/2025 to 08/25/2025 Census:189 Sample Size: 35 + 3 closed records The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F0000		10/08/2025

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S0560	Mandatory Access to Care 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 interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 10 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The survey team requested staffing for the weeks from 8/3/25 – 8/9/25 and 8/10/25 – 8/16/25. For the 2 weeks of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows:	S0560	S560- How will corrective action be accomplished for those individual residents found to be affected by the deficient practice? There were no residents identified to have been affected by the deficient practice of not meeting the NJ staffing requirements during the 7:00Am-3:00PM shifts on the dates of 8/3/25, 8/4/25, 8/5/25, 8/6/25, 8/9/25, 8/10/25, 8/11/25, 8/12/25, 8/13/25, and 8/16/25. A review of the care provided on the day shift of those dates identified, revealed no complaints or grievances related to care that were reported on these dates on the day shift. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur? The Staffing Coordinator has been re-educated by the Licensed Nursing Home Administrator (LHNA) on the State of New Jersey Staffing requirement as follows: One CNA per 8 residents on the 7-3 shift, one direct care staff per 10 residents on 3-11 shift and one direct care staff per 14 residents on 11-7 shift. The following measures have been put into place to prevent the deficient practice from recurring. 1. Advertising / job postings for Certified Nursing Assistants (CNAS) have been posted on multiple hiring platforms. 2. Incentives such as bonuses are offered to CNAS to	10/08/2025

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

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S0560	Continued from page 1 -08/03/25 had 23 CNAs for 189 residents on the day shift, required at least 24 CNAs. -08/04/25 had 23 CNAs for 189 residents on the day shift, required at least 24 CNAs. -08/05/25 had 23 CNAs for 189 residents on the day shift, required at least 24 CNAs. -08/06/25 had 23 CNAs for 189 residents on the day shift, required at least 24 CNAs. -08/09/25 had 20 CNAs for 191 residents on the day shift, required at least 24 CNAs. -08/10/25 had 20 CNAs for 191 residents on the day shift, required at least 24 CNAs. -08/11/25 had 23 CNAs for 190 residents on the day shift, required at least 24 CNAs. -08/12/25 had 23 CNAs for 190 residents on the day shift, required at least 24 CNAs. -08/13/25 had 22 CNAs for 190 residents on the day shift, required at least 24 CNAs. -08/16/25 had 21 CNAs for 188 residents on the day shift, required at least 23 CNAs. On 8/22/2025 at 10:44 AM, the surveyor interviewed the Staffing Coordinator who stated she knew the staffing ratios and that she was able to meet them most times. Review of facility provided policy "Staffing Policy" reviewed 12/2024, included: Goal: South Mountain's goal is to provide adequate staffing to meet needed care and services for our resident population. Our nursing staff's goal is to assure resident safety and attain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual care plans. Definitions: Direct care staff member means any registered professional nurse, licensed practical nurse, or certified nurse aid who is acting in accordance with the individual's authorized scope of	S0560	Continued from page 1 pick up vacant shifts. 3. If unable to fill a shift with its in-house employees, agencies will be utilized by the Staffing Coordinator or designee to fill those open shifts. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place? The LHNA will review the staffing schedule weekly times three months to monitor the staffing ratio. The findings will be presented and reviewed at facility Quality Assessment and Assurance meeting for two consecutive quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062023	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

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S0560	Continued from page 2 practice. Policy: Certified nursing assistants will be available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan and with the following ratios:One certified nurse aide to every eight residents for the day shiftOne direct care staff member to every ten residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct care staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties.One direct care staff member to every fourteen residents for the night shift, provided that each direct staff member shall be signed in to work as a certified nurse aide and perform certified nurse aide duties.Upon expansion of the resident census, South Mountain will increase the direct care staffing ratios within a period of nine consecutive shifts from the date of the expansion of the resident census. South Mountain Healthcare and Rehabilitation Center will continue to monitor staffing compliance.	S0560		
S0000	Initial Comments Survey Date:8/18/2025 to 8/25/2025 Census: 195 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S0000		10/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/18/2025 in relation to the 8/25/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062023	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/18/2025 in relation to the 8/25/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315283	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

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K0372 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and that smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6.2. This deficient practice had the potential to affect all 189 residents and was evidenced by the following: Observations on 08/21/25 from 11:45 AM until 4:00 PM of the facility's smoke barriers, revealed the 1 North Hallway near room 144 had two wires penetrating a one inch in diameter unsealed opening on both sides of the smoke barrier; and 18 category (CAT) 5 wires penetrating a two inch in diameter unsealed opening on both sides of the smoke barrier. Continued observations on the 1 South Hallway near room 113 revealed five CAT 5 wires penetrating a one inch in diameter unsealed opening on both sides of the smoke barrier. Observation of the 2 North Hallway smoke barrier doors near room 248 revealed a one inch in diameter hole above the smoke barrier door.	K0372	Tag: K0372 1. Corrective action taken for residents affected: All identified penetrations in the 1 North Hallway, 1 South Hallway, and 2 North Hallway smoke barriers were immediately sealed by Maintenance Director with approved firestop material to restore the smoke barrier's integrity. No residents were found to have been affected by this deficient practice. 2. Identification of other residents who could be affected: All residents have the potential to be affected by this deficient practice. A facility-wide inspection of all smoke barriers and penetrations was completed by the Maintenance Director, and any additional penetrations identified were sealed with approved firestop materials. 3. Measures/systemic changes to prevent recurrence: Staff Education: Maintenance staff were in-serviced by Administrator on Life Safety Code requirements for smoke barriers, proper sealing procedures, and the prohibition of unsealed penetrations. Maintenance Director/designee will perform monthly audits times 3 months of all smoke barriers to ensure no unsealed penetration exists. Findings will be documented and reported to the Administrator. Any penetration found will be immediately sealed with approved firestop material.	10/08/2025

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K0372 SS = F	Continued from page 1 During an interview at the time of observations, the U.S. FOIA (b) (6) confirmed the above penetrations in the smoke barriers. NJAC 8:39-31.2(e)	K0372	Continued from page 1 4. Monitoring to ensure ongoing compliance: All findings of the smoke barrier audit will be presented and reviewed quarterly at facility QA meeting for two consecutive quarters.	
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 08/21/25 and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. South Mountain HC is a two-story building built in 1987. It is composed of Type II unprotected construction. The facility is divided into eight - smoke zones. The generator powers approximately 65% of the building per the US FOIA (b)(6). The current occupied beds are 189 of 195.	K0000		10/08/2025

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 08/21/25. The facility was found to be in compliance with 42 CFR 483.73.	E0000		10/08/2025

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/19/25 in relation to the 8/25/25 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/19/2025 in relation to the 8/25/2025 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness	E0000		

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