New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A003	A. BUILDING: _____ B. WING _____	C 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT MILLVILL	1125 VILLAGE DRIVE MILLVILLE, NJ 08332

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Re-Visit with Complaints Complaint #: NJ00189881, NJ00189902, NJ00189916, NJ00190299 Census: 118 Sample Size: 22 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administrator's Responsibilities (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/08/26

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based interview and record review, it was determined that the Administrator failed to ensure the development, implementation and enforcement of the policies titled, "Heat/Cold, and Domestic Hot Water Temperature Monitoring Policy (DHWTMP)" for all 118 residents. This deficient practice was evidenced by the following: On 3/26/26, the Department of Health (DOH) received a Plan of Correction (POC) submitted by the facility's Executive Director (ED), for a survey that was conducted on 2/5/26. The POC indicated, "On 2/6/26, the ED revised the Heat/Cold Temperature Monitoring Policy, to include monitoring procedures, frequency and vendor information." On 04/6/26 at 10:00 a.m., during the entrance conference, the surveyor requested the facilities policy and procedure manual, hallway temperature logs from 2/6/26 through 4/5/26, and the DHWTMP log from 2/6/26 through 4/5/26. The ED provided the surveyor with the facility's policy and procedure manual, which contained an undated policy titled, "Heat/Cold". The policy indicated that the facility's temperature should be maintained between 60 and 82 degrees Fahrenheit. However, according to State regulations, the facility temperature should be kept at a minimum	A 310		

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A 310	Continued From page 2 of 72 degrees Fahrenheit during the day and 68 degrees Fahrenheit at night, when residents were present in the facility. Additionally, the policy did not include temperature monitoring or frequency. The documentation field used to indicate which service provider should be contacted for repairs, was left blank for both the heat and cold sections of the policy. Continued surveyor review of the "Heat/Cold" policy revealed that the policy was not revised as indicated in the facility's POC dated 3/26/26. The policy received on 2/5/26, was the same policy received on 4/6/26. At 3:00 p.m. the surveyor interviewed the ED and again requested the hallway temperature logs and DHWTMP logs. The Surveyor reviewed the DHWTMP log provided by the ED which revealed that water temperatures were taken as follows: On 3/13/26 in rooms NJ Ex Order 26. 4B1 On 2/26/26 in rooms NJ Ex Order 26. 4B1 On 2/11/26 in rooms NJ Ex Order 26. 4B1 On 2/10/26 in rooms NJ Ex Order 26. 4B1 . The Surveyor reviewed the DHWTMP, provided by the ED which revealed that hot water temperatures will be taken in "At least one sink and one shower per resident area or hot water loop, high-use bathing areas, and any fixture associated with complaints or recent repairs." Surveyor record review of the POC provided by the ED on 3/26/26 for the survey conducted on 2/5/26 revealed that the POC documented, "Monitoring to ensure ongoing compliance of	A 310		

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A 310	Continued From page 3 water temperatures will occur as follows: Daily for 7 days: 2/6/2026 through 2/13/2026 by Maintenance Director Weekly for 4 weeks: 2/14/26 through 3/14/26 by the ED. However, there was no further documentation of additional locations, or of daily or weekly water temperature monitoring was provided by the ED. The surveyor reviewed the facility hallway temperature logs provided by the ED which revealed that hallway temperatures were only checked and documented on 3/20 and 3/27/26. Further, surveyor record review of the POC provided by the ED on 3/26/26 for the survey conducted on 2/5/26, revealed that the POC documented: Maintenance designee and staff were instructed to complete temperature log each shift. Additionally, the POC documented monitoring to ensure ongoing compliance will occur as follows: Daily for 7 days: 2/6/26 throught 2/13/26 by Maintenance Director and, Weekly for 4 weeks: 2/14/26 through 3/14/26 by the ED. However, there was no further documentation of hallway temperature monitoring was provided by the ED.	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and	A 401		

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A 401	Continued From page 4 assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident's right to live in safe conditions was enforced for 3 of 22 residents reviewed, Resident #s 2, 5 and 6. This deficient practice was evidenced by the following: On 4/6/26 at 9:53 a.m., the surveyor requested the facility's call bell monitoring report, and the Executive Director (ED) stated that she was not able to print the report. The surveyor then inquired how the ED was able to monitor the call bell response times, and the ED stated that she could monitor the response times in the facility's call bell monitoring system. The ED then stated that she would check again to see if she could print the report. At 10:20 a.m., the surveyor interviewed a Licensed Practical Nurse (LPN #1), who stated that the facility's call bell system had not worked on the third and fourth floor since 4/4/26.	A 401		

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A 401	Continued From page 5 At 2:22 p.m., the surveyor interviewed the ED, who stated that she was not able to access the call bell monitoring system, so she reached out to the vendor for reports. At 3:05 p.m., the surveyor activated the call bell in Resident #2's bathroom, who resided on the second floor, and observed that the call bell did not work. At 3:19 p.m., a Certified Medication Technician (CMT #2) tested Resident #2's bathroom call bell and confirmed that it did not work. At 3:27 p.m., the surveyor interviewed the ED to inquire if there were any issues with the facility's call bells from 4/4/26 to 4/6/26, and the ED stated "no". On 4/9/26 at 12:45 p.m., the surveyor interviewed CMT #2 to inquire if she documented a maintenance request on the maintenance log, on 4/6/26, when she observed that Resident #2's bathroom call bell did not work. CMT #2 stated that she did not document a maintenance request on the maintenance log but told maintenance verbally. CMT #2 further stated that someone was at the facility at this time to check the call bell. The surveyor reviewed the maintenance log for the second floor, which revealed that the call bell cord in Resident #5's bathroom was detached since [redacted] At 12:48 p.m., the surveyor in the presence of a Certified Nursing Assistant (CNA), observed that the call bell in Resident #5's bathroom did not work and did not have a pull cord attached. The CNA stated that she previously observed that the	A 401		

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A 401	Continued From page 6 pull cord was missing and documented it in the maintenance book. At 12:59 p.m., the surveyor interviewed the Maintenance Director (MD) to inquire how often he reviewed the maintenance logs. The MD stated that he started at the facility NJ Exec Order 26.4b1 [redacted] and that he did not have a chance to review maintenance logs yet. The MD further stated that he was notified by nurses that some call bells did not work and that someone was at the facility to check the call bells. At 2:20 p.m., the surveyor interviewed Resident #6, who resided on the third floor, who stated that the call bell in his/her bedroom had not worked since he/she was admitted to the facility in NJ Ex Order 26. 4B1. Resident #6 stated that staff were aware that his/her call bell did not work and that they did not repair the call bell. Resident #6 stated that he/she was scheduled to move NJ Ex Order 26. [redacted], and that the call bell was part of the reason he/she made the decision. At this time, the surveyor confirmed that the call bell in Resident #6's bathroom did not work. At 3:09 p.m., the surveyor interviewed the ED, who stated that the call bell vendor was at the facility to complete an inspection. The ED stated that the vendor identified four resident apartments that had call bells that did not work. The surveyor reviewed the facility's "Assisted Living Services and Admission Agreement," which indicated, "... E. Emergency Call System. (i) "An electronic "push button" or "pull cord" device will be available in each apartment bathroom and a secondary emergency call device will be in each bedroom ... that will enable the residents to summon assistance in the event of an emergency	A 401		

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A 401	Continued From page 7 ..." The surveyor reviewed the facility's undated policy titled, "Maintenance Work Request," which indicated, "... 1. When a resident staff member or family member recognizes the need for maintenance services, a Maintenance Work Request form will be completed (top portion only) by a resident, a family member or a staff member ... 3. Maintenance personnel will review all Maintenance Work Requests daily and prioritize work to be done ... 4. All maintenance Work Requests will be followed up on within five days of receipt, unless the work needed is of an urgent nature, in which case it will be done immediately ..."	A 401		
A 411	8:36-4.1(a)(27) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 27. The right to receive confidential treatment of information about the resident. Information in the resident's records shall not be released to anyone outside the facility without the resident's approval, unless the resident transfers to another health care facility, or unless the release of the information is required by law, a third-party payment contract, or the Department;	A 411		

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A 411	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure confidential treatment of resident information for all 118 residents. This deficient practice was evidenced by the following: On 4/6/26 at 12:42 p.m., the surveyor interviewed a Certified Medication Tech (CMT #1) to inquire about how she arranged doctor appointments. During this interview, CMT #1 stated that she was not able to document doctor appointments on the Electronic Health Record (EHR) dashboard with her personal login, so she used a login that belonged to a Licensed Practical Nurse (LPN #3). At 1:08 p.m., the surveyor observed a medication pass with CMT #1. CMT #1 stated that she used her personal laptop to administer medications, schedule appointments, and arrange transportation. CMT #1 further stated that the facility provided laptops that took a long time to load, so she used her personal laptop instead. CMT #1 stated that the Executive Director (ED) and the Director of Nursing (DON) told nursing staff "numerous" times that they did not want staff to use their personal devices. The surveyor reviewed a "Security and Confidentiality Agreement," signed by CMT #1 on 12/12/24, which indicated, "... 5. I will not log on to any of [the facility's] computer systems that currently exist or may exist in the future using a password other than my own ... I will not take patient information from the premises of [the facility] in paper or electronic form without first	A 411		

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A 411	Continued From page 9 receiving permission from the privacy officer ..." At 3:27 p.m., the surveyor interviewed the ED to inquire if staff were allowed to use their personal devices to access confidential resident information. The ED stated that it was not ideal for staff to use personal devices to access the facility's electronic medical record or schedule appointments and transportation. On 4/9/26 at 12:07 p.m., the surveyor interviewed LPN #3 to inquire if she shared her personal EHR login with CMT #1. LPN #3 stated that she did not remember sharing her EHR login with CMT #1. LPN #3 stated that the facility made changes that required all staff to have their own logins to access the desktop computers located at the nursing station. LPN #3 explained that some staff had issues with their desktop login, including CMT #1. LPN #3 stated that she allowed CMT #1 to use her desktop login to access the desktop computer at the nursing station and that CMT #1 would use her own EHR login. Further, LPN #3 stated that her login credentials for the desktop computer were the same credentials used to access the EHR. LPN #3 stated that she did not give CMT #1 permission to use her login credentials to access the EHR dashboard. The surveyor reviewed a "Security and Confidentiality Agreement," signed by LPN #3 on 4/17/25, which indicated, "... 6. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as a name tag. I will not allow anyone, including other employees, to use my password to log on to the computer ..." At 12:53 p.m., the surveyor interviewed the ED to inquire if she gave CMT #1 permission to use her	A 411		

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A 411	Continued From page 10 personal device to access confidential resident information, and the ED stated "no". The surveyor reviewed the facility's undated policy titled, "Resident Rights," which indicated, "... Every resident shall have the right to confidentiality in the treatment of personal, social, financial and medical records ..." The surveyor reviewed the facility's undated policy titled, "Privacy Practices," which indicated "... It is the policy of [this facility] to protect the privacy of individual resident health information ... 5. I will not log on to any of the Provider's computer systems that currently exist or may exist in the future using a password other than my own. 6. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as a name tag ... I will not take patient information from the premises of the Provider in paper or electronic form without first receiving permission from the Privacy officer ..."	A 411		
A 749	8:36-7.3(a) General and Health Service Plans (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.	A 749		

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A 749	Continued From page 11 This REQUIREMENT is not met as evidenced by: Complaint # : NJ00190299 Based on interview, record review, and review of pertinent facility documents, the facility failed to ensure the Service Plan (SP) was updated to reflect the resident's current needs following NJ Ex Order 26. 4B1 of 22 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 4/6/26, the surveyor reviewed the Medical Record (MR) for Resident #2, which revealed a move-in date of NJ Ex Order 26. 4B1 and diagnoses that NJ Ex Order 26. 4B1 [redacted]. The surveyor reviewed the Service Plan (SP), revised NJ Exec Order 26.4b1; however, the SP did not include documented interventions to address the resident's continued [redacted] and did not reflect all documented [redacted]. The SP did not reflect all documented [redacted], including [redacted] on NJ Exec Order 26.4b1 [redacted] At 11:25 a.m., the surveyor interviewed Certified Medical Assistant (CMA #1), who stated that she was not aware that Resident #2 had NJ Ex Order 26. 4B1, but she checked on him/her every 2 hours and was not aware of any other interventions. CMA #1 stated that she checked on Resident #2 every 2 hours, which was not consistent with the SP intervention to check at least every 1 hour. At 11:35 a.m., the surveyor interviewed a	A 749		

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A 749	Continued From page 12 Licensed Practical Nurse (LPN), who stated that she was not aware if Resident #2 was a [redacted] risk and that she was assigned to a different assignment; however, if she was covering that area, she could see it on a facility document titled "Nurse Notes." The Nurse Notes did not include documentation identifying Resident #2 as a [redacted] or outlining related interventions. At 11:45 a.m., the surveyor interviewed a Certified Nursing Assistant (CNA #2), who stated that Resident #2 had a history of [redacted] and had [redacted], and she was not aware of any other interventions. CNA #2 stated that Resident #2 had 2-hour checks for safety, which was not consistent with the SP intervention to check at least every 1 hour. At 1:08 p.m., the surveyor interviewed the Director of Nursing (DON), who stated that she was aware that Resident #2 had [redacted] and that if a resident had a [redacted] she was notified by the LPN, the family and physician were notified, and she completed a [redacted] evaluation and documentation. The DON stated that the SP was updated after each incident; however, she was not aware of the last time the SP was updated. At 3:28 p.m., the surveyor interviewed the Executive Director (ED) and asked about the procedure followed if a resident has a [redacted], and the ED stated that an [redacted] report is completed, and the DON does a [redacted] Assessment. The ED further stated she was not aware if interventions were completed as it is the DON's responsibility. The surveyor review of an undated facility policy titled, "Assisted Living E-130," revealed:	A 749		

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A 749	Continued From page 13 Procedure Title: Assistance/Service Plan ... Procedure: ... 6. "Any Personal Care services needed will be indicated on the assistance/service plan..." The surveyor review of an undated facility policy titled, "Fall Risk Evaluation I-102," revealed: Procedure Title: Fall Risk Evaluation ... Procedure: ... 7. "Residents who score as a 'high' risk for falls will have fall risk addressed in the Assessment and Service Plan and aide care plan..." The surveyor review of an undated facility policy titled, "Post Fall Evaluation I-103," revealed: Procedure Title: Post Fall Evaluation ... Procedure: ... 3. "If interventions are indicated on Post Fall Evaluation the aide care plan and service plan are updated accordingly..."	A 749		
A 783	8:36-7.5(e) Provision of Health Care Services (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing. This REQUIREMENT is not met as evidenced by:	A 783		

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	06A003	A. BUILDING: _____ B. WING _____	C 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT MILLVILL	1125 VILLAGE DRIVE MILLVILLE, NJ 08332

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A 783	Continued From page 14 Complaint #: NJ00190299 Based on interview and record review, it was determined that the facility failed to ensure that residents had an NJ Ex Order 26. 4B1 examination with certification completed by a physician documented in their Medical Record (MR) for 3 of 22 residents reviewed, Resident #s 1, 2, and 3. This deficient practice was evidenced by the following: On 4/6/26, the surveyor reviewed the MRs of Resident #1 and Resident #2 and was not able to locate NJ Ex Order 26. 4B1 examinations with certifications. In addition, the surveyor reviewed the MR of Resident #3 and was not able to locate a physician certification. At 3:27 p.m., the surveyor interviewed the Executive Director (ED) and requested the NJ Ex Order 26. 4B1 examinations with NJ Ex Order 26. 4B1 certifications for Resident #s 1 and 2, and the physician certification for Resident #3. On 4/9/26 at 9:06 a.m., the Director of Nursing (DON) provided the surveyor with Resident #1's NJ Ex Order 26. 4B1 examination, completed on NJ Ex Order 26., which indicated that the document was generated on NJ Ex Order 26., the day after the surveyor's initial survey visit. The DON also provided the surveyor with physician certifications for Residents #s 1 and 3, which revealed that they were ordered on NJ Ex Order 26. 4B. The DON did not provide the surveyor with an NJ Ex Order 26. 4B1 examination with NJ Ex Order 26. 4B1 certification for Resident #2. At 11:39 a.m., the surveyor interviewed the DON to inquire the reason Resident #s 1 and 2 did not have an NJ Ex Order 26. 4B1 examination with	A 783		

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A 783	Continued From page 15 certification documented in their MR. The DON stated that she started at the facility in NJ Ex Order 26. 4B1 and that she could not speak as to why the previous nursing staff did not have them. The DON further stated that she requested Resident #1 and Resident #2's NJ Ex Order 26. 4B1 examination with certification from their providers on NJ Ex Order 26. . Additionally, at the time of survey, there was no policy provided regarding Annual Physical Examination and Physician Certification.	A 783		
A 935	8:36-11.4(b) Administration of medications (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that medication was accurately administered in accordance with prescriber orders, facility policy, and State regulations for NJ of 6 residents	A 935		

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A 935	Continued From page 16 (Resident #4) reviewed and an additional 16 residents reviewed for medication administration. This deficient practice was evidenced by the following: 1. On 4/6/26 at 10:20 a.m., the surveyor conducted a medication pass observation with a Licensed Practical Nurse (LPN #1). LPN #1 stated that she had to administer 8:00 a.m. medications late because the internet on the third and fourth floors was down and not restored until 10:00 a.m. LPN #1 further stated that the Director of Nursing (DON) notified the Nurse Practitioner (NP), who stated that it was okay to administer 8:00 a.m. medications late. LPN #1 then stated that she planned to hold some 12:00 p.m. medications because she did not want to administer the doses too close together. The surveyor asked LPN #1 if she received an order from the NP to hold any 12:00 p.m. medications, and the LPN stated "no". At 10:40 a.m., the surveyor interviewed LPN #2, who stated that the internet on the third and fourth floor was down in the morning and that the internet had not worked since 4/5/26. LPN #2 further stated that she administered all scheduled morning medications and then went to the first floor to document the medications as administered. LPN #2 stated that she knew which medications to administer to each resident because she wrote "AM" and/or "PM" on the medication packaging and wrote the insulin doses down. The surveyor asked LPN #2 how she was able to determine if there were any medication and/or dosage changes without referring to the Medication Administration Record (MAR). LPN #2 stated, "I know it sounds [redacted] LPN #2 then stated that she reviewed all resident MARs on the first floor, went to the fourth floor to administer all	A 935		

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A 935	Continued From page 17	A 935		

resident medications, and then went back to the first floor to document the administration of resident medications.

The surveyor reviewed the MARs of 16 residents, Resident #s 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 and 22 on LPN #2's assignment, which confirmed that they received 8:00 a.m. medications from LPN #2.

2. At 11:56 a.m., the surveyor conducted a medication pass observation with a Certified Medical Tech (CMT #1). The surveyor observed CMT #1 attempt to administer [redacted] (used to treat [redacted]) to Resident #4. The surveyor reviewed Resident #4's MAR, which revealed that the resident's [redacted] was ordered to be administered at 2:00 p.m. At this time, the surveyor asked CMT #1 if she was going to administer the [redacted] to Resident #4, and the CMT stated "yes". The surveyor asked CMT #1 to review Resident #4's MAR to confirm the scheduled administration time. CMT #1 then stated, "It used to be scheduled for 1:00 p.m., now it's 2:00 p.m., it must have changed."

The surveyor interviewed the DON and the Executive Director (ED) to inquire about the internet outage on the third and fourth floors.

At 12:20 p.m., the DON stated that LPN #1 notified her of the internet outage on 4/6/26 at 8:00 a.m. The DON stated that she instructed LPN #1 to go to the side of the building that did have internet to print all the MARs for the third and fourth floors and then administer medications. The surveyor inquired if the DON instructed LPN #2 to use the printed MARs, and the DON stated that she did not. The DON further

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A 935	Continued From page 18	A 935		

stated that she notified the NP that the internet did not work, and that the NP instructed staff to continue with medication administration. The DON stated that facility protocol for an internet outage was for nursing staff to print paper MARs and document medication administration manually.

At 3:27 p.m., the ED stated that she was notified on 4/6/26, between 7:30 a.m. and 8:00 a.m., that the internet was down. The ED stated that the internet was restored between 10:00 a.m. and 10:30 a.m. The ED stated that facility protocol for an internet outage was for nursing staff to use a hotspot to print paper MARs and complete paper documentation. At this time, the surveyor asked the ED about the facility's medication administration process. The ED stated that nursing staff would verify the right resident and right medications, administer the medication, and then document. The ED stated that medication administration documentation would be completed right after medications were administered to a resident. The ED also stated that medications were to be administered one hour before or one hour after scheduled administration times.

The surveyor reviewed the facility's undated policy titled, "Medication Administration," which indicated, "Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication ... Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare

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A 935	Continued From page 19 the medication and dosage schedule on the resident's MAR with the medication label ... Medications are administered in accordance with written orders of the prescriber ... Verify medication is correct (3) times before administering the medication. a. When pulling medication package from med cart b. When dose is prepared c. Before dose is administered ... Medications are administered within 60 minutes of scheduled time ... Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center ... The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given ..."	A 935		
A1231	8:36-17.5(a)(1) Heating and Air Conditioning ((a) The heating and air conditioning system shall be adequate to maintain the required temperature in all areas used by residents. Residents may have individually controlled thermostats in residential units in order to maintain temperatures at their own comfort level. 1. During the heating season, the temperature in the facility shall be kept at a minimum of 72 degrees Fahrenheit (22 degrees Celsius) during the day ("day" means the time between sunrise and sunset) and 68 degrees Fahrenheit (20 degrees Celsius) at night, when residents are in the facility.	A1231		

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A1231	Continued From page 20 This REQUIREMENT is not met as evidenced by: Complaint # NJ 00189881 Based on observation and interview, it was determined that the facility failed to ensure that the heating and air conditioning system was adequate to maintain the required temperature in all areas used by residents in accordance with N.J.A.C. 8:36-17.5(a)1. [During the heating season, the temperature in the facility shall be kept at a minimum of 72 degrees Fahrenheit (22 degrees Celsius) during the day]. This deficient practice was evidenced by the following: On 4/6/26 at 10:30 a.m., during surveyor tour with the Director of Maintenance (DOM), the surveyor observed that the thermostat near the Heating, Ventilation, Air Conditioning (HVAC) unit on the second floor of Building [redacted] had a reading of 67 degrees Fahrenheit. Additionally, the corridor containing resident rooms [redacted] was not provided with a temperature monitoring device to ensure that temperatures remained within the required range. During surveyor interview with the DOM regarding the above concerns, the DOM confirmed that the thermostat had a reading of 67 degrees Fahrenheit and acknowledged that the resident room corridor did not contain a temperature monitoring device.	A1231		
A1249	8:36-17.7 Building and Grounds Maintenance	A1249		

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A1249	Continued From page 21 The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the building emergency exits lights were functioning for all [redacted] residents. This deficient practice was evidenced by the following: On 4/6/26 at 10:50 a.m., during surveyor tour with the Director of Maintenance (DOM), the surveyor observed that 6 emergency exit lights were not illuminated on the second floor of Building [redacted]. Additionally, 8 of 8 illuminated exit signs that were tested to ensure that they would stay lit and visible during a power outage did not stay lit when the test button was pressed. During surveyor interview with the DOM regarding the above concerns, the DOM confirmed that 6 emergency exit lights were not illuminated and acknowledged that 8 illuminated exit signs did not	A1249		

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A1249	Continued From page 22 stay lit when tested.	A1249		

New Standard Senior Living at Millville
1125 Village Drive Millville, NJ 08332
856-469-8192

Plan of Correction: May 8, 2026, Revised 5/21/26

A310 8:36-3.4(a)(1) Administrator's Responsibilities: failed to ensure the development, implementation and enforcement of the policies titled, "Heat/Cold, and Domestic Hot Water Temperature Monitoring Policy.

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?

   The Heat /Cold and Domestic Hot Water Temperature policy has been retired and removed from the policy manual on 5/7/26.

   A new policy, entitled Air Temperature Policy, has been developed and approved by the Executive Director on 5/6/26. The new policy includes the requirements of the central heating system maintaining a minimum of 72 degrees Fahrenheit during the day and 68 degrees Fahrenheit at night. The frequency of temperature monitoring, no less than weekly, is included in the policy. The policy has been added to the facility's policy manual on 5/7/26.

   A new policy entitled Domestic Hot Water Temperature Monitoring Policy has been developed and approved by the Executive Director on 4/6/26. The policy includes maintaining hot water temperatures between 105°F and 120°F and the frequency of monitoring. The routine frequency of water temperature monitoring is no less than weekly. The new policy has been added to the facility's policy manual on 5/7/26.

   The Maintenance Director reviewed the new policies with the Executive Director on 5/6/26 and understands the requirements.

   The Executive Director added Vendor contact information for HVAC and water boiler to the policy addendum on 4/10/26.

2. How the facility will identify other residents having the potential to be affected by the same practice.

   All residents have the potential to be affected

3. What measures will be put into place or systematic changes made, to ensure this deficient practice will not recur

   On 4/27/26, The Executive Director received training by the Regional Director of Clinical Services on ensuring plans of correction are implemented as required.

   The Hot water boiler has been fully functional since March 17, 2026. The Maintenance Director will be responsible for implementing the Domestic Hot water and Air Temperature

policies, and notifying the Executive Director and Vendor, if necessary, when the temperatures are outside of the required range

4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and not recur.

   The maintenance Director will submit the results of the temperature monitoring to the Executive Director each month.

   Completion date 5/15/26

A 401 8:36-4.1(a)(22) Resident Rights: failed to ensure that a resident's right to live in safe conditions

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?

   The Maintenance Director replaced the battery in resident #2's bathroom call bell on 4/6/26 and is working properly
   The Maintenance Director installed a new call bell cord and replaced the battery in resident #5's bathroom on 4/6/26 and is working properly
   The Maintenance Director replaced the battery in resident #6's bathroom call bell on 4/6/26 and is working properly. Resident #6 [redacted].

2. How the facility will identify other residents having the potential to be affected by the same practice.

   All residents have the potential to be affected
   The call bell vendor conducted an audit of the call bell system on 4/6/26. The Maintenance Director rectified the remaining call bell issues by replacing the battery and /or pull cord issues in the units identified in the audit report on 4/13/26.

   There are [redacted] apartments that require full call bell replacement. [redacted] units are unoccupied. The Maintenance Director contacted the vendor on 4/14/26 to obtain the new units. Until the new units arrive and are installed, the [redacted] residents have been provided with ring bells and have placed on hourly checks. The staff was in serviced on the hourly checks by the Director of Nursing and Assistant Director of Nursing on 5/8/26. The Director of Nursing also added a memo in the 24-hour report to remind the staff of the requirements.

   The call bell vendor is scheduled to replace the nonfunctioning units in the [redacted] occupied units on 5/21/26. The non-functioning units were replaced by the call bell vendor on 5/21/26 and are now fully functional.

3. What measures will be put into place or systematic changes made, to ensure this deficient practice will not recur

   The housekeeping staff will be responsible for bringing the maintenance log forms from the nursing stations to the Maintenance Director daily to ensure appropriate follow-up. The in-service service started on 5/1/26 and will continue until all housekeepers have been trained. The final housekeeper completed the training on 5/19/26.

4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

The Maintenance Director or designee will conduct monthly random call bell audits. The Maintenance Director will submit the results of the audits and repairs to the Executive Director monthly.

Revised 5/22/2026

A 411 8:36-4.1(a)(27) Resident Rights: failed to ensure confidential treatment of resident information

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?

   CMT#1 received an Inservice on 4/10/26 by the Director of Nursing (DON) for violation of the security and confidentiality agreement by logging into the EHR using another staff members credentials

   On 4/10/26 the Director of Nursing CMT#1 was in-serviced by the DON regarding not using a personal laptop instead of the facility's approved devices.

   LPN #3 received an Inservice on 4/10/26 by the Director of Nursing for violation of the security and confidentiality agreement by not keeping username and password safe.

   On 5/3/26, CMT#1 EHR access was changed by the Regional Director of Clinical Services to allow editing of the dashboard for appointment and transportation scheduling.

   The nursing staff received training on not using personal devices for accessing EHR information and protecting log-in information from others. The training given by the Executive Director and Director of Nursing started on 4/10/26 and will continue through 5/4/2026. The training was completed by 5/4/26.

   On 5/4/2026, The Executive Director inventoried the facility issued laptops, desktop computers and ancillary equipment to verify all were properly functioning

   The Executive Director in-serviced the staff on April 20, 2026 on Resident Rights

2. How the facility will identify other residents having the potential to be affected by the same practice.

   All residents have the potential to be affected

3. What measures will be put into place or systematic changes made, to ensure this deficient practice will not recur

   Nursing staff have all facility-approved devices needed to access the EHR system. The Director of Nursing enters each staff member's information into the EHR and provides the initial username and password. Each staff member then resets the password. The level of access is automatically set and is based on the position.

4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

During their daily rounds, the Executive Director and Nursing leadership (DON and ADON) will verify staff is using the approved facility devices. Non-compliance will lead to disciplinary action. Nursing leadership was in- serviced on this process by the Regional Director of Clinical Services on 5/10/26.

Completion date: 5/18/2026

A 749 8:36-7.3(a) General and Health Service Plans: failed to ensure the Service Plan (SP) was updated to reflect the resident's current needs following multiple falls

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?

   The RN Director of Nursing (DON) completed a full assessment [redacted] and analyzed Resident#2's [redacted] and updated the [redacted] plan on [redacted] The resident remains in the facility and has not sustained a [redacted] since [redacted]

2. How the facility will identify other residents having the potential to be affected by the same practice.

   All residents have the potential to be affected

   An audit of resident falls for the last 30 days was conducted by the Director of Nursing on 5/5/2026 to verify fall risk interventions have been added to the residents' service plans

3. What measures will be put into place or systematic changes made, to ensure this deficient practice will not recur

   The Director of Nursing or designee will review resident incidents and update service plans during the daily clinical huddle. This fall review and service plan update process started on 5/11/26. The Executive Director will review and sign resident incident reports.
   The effectiveness of fall interventions will be discussed in the monthly clinical team fall meeting

   A resident intervention fall binder containing resident fall prevention interventions will be placed on each floor and updated as needed. The new process will begin on 5/13/2026. The Director of Nursing or designee will update the binder when changes are made.

4 How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

   The DON, or designee will audit the fall report each month to verify the service plan interventions have been addressed in the resident's service plan. The DON will submit the audit findings and plans of correction (if needed) monthly to the Executive Director

Revised Completion date 5/23/2026

A 783 8:36-7.5(e) Provision of Health Care Services: failed to ensure that residents had an annual physical examination with certification completed by a physician documented in their Medical Record

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?

   Resident #1's health care provider sent the certification as appropriate for assisted living on [redacted].
   Resident #3's NJ Ex Order 26. 4B1 certification as appropriate for assisted living was received by the facility on [redacted]

   After several attempts to request the [redacted] exam and certification, the facility received Resident #2's [redacted] exam indicating he/she is NJ Ex Order 26. 4B1 for Assisted Living. The physician did not have any additional nursing orders. Nursing administration has a call scheduled with the resident's emergency contact to discuss placement in a nursing facility. On 5/8/26, the DON and ED spoke with the responsible party to inform he/she of the need for NJ Ex Order 26. 4B1 . Another call was held with the resident's family member and ED, DON on [redacted] to discuss NJ Ex Order 26. 4B1 . Until placement is arranged and resident is [redacted], the DON will continue to closely monitor resident's outcomes of care. The resident's service plan has been updated with increased monitoring.

   An audit of resident's physical exams and certifications for assisted living was completed by the Director of Nursing on 4/16/26 and starting contacting resident providers. On 5/3/26 The Assistant Director of Nursing (ADON) was assigned to continue contacting the residents' health care providers to obtain a copy of the residents' physical examinations and certifications. The ADON is documenting the attempts to obtain a copy of the records in the resident's progress notes. The physicians' certifications will be completed by 6/1/26.

2. How the facility will identify other residents having the potential to be affected by the same practice.

   All residents have the potential to be affected

3. What measures will be put into place or systematic changes made, to ensure this deficient practice will not recur

   The date of each resident's completed annual physician certification will be entered into the facility's EHR system, to track when the next certifications will be due. The Assistant Director of Nursing will be responsible for requesting the required documentation at least one month prior to the due date.

4 How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

The Assistant Director of Nursing will be responsible for reporting the status of resident's physician examinations and certifications each month to the Director of Nursing and Executive Director.

Updated completion date 6/1/2026

A 935 8:36-11.4(b) Administration of medications: failed to ensure that medication was accurately administered in accordance with prescriber orders,

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?

   LPN #1 received an in-service by the DON on 4/7/26 regarding obtaining a health practitioner order to hold meds.

   LPN# 2 received an Inservice by the DON on 4/7/26 regarding administering medications in accordance with standards of practice and using the MAR and signing.

   On 4/8/26 CMT # 1 received Inservice training by the DON on administering medications at the scheduled time

   Med pass observation competencies were completed for by the ADON for LPN #2 and the DON for CMT #2 on 4/21/26

2. How the facility will identify other residents having the potential to be affected by the same practice.

   All residents have the potential to be affected

3. What measures will be put into place or systematic changes made, to ensure this deficient practice will not recur

   Nursing Administration is conducting 2 medication competencies per week for the next eight weeks.
   The facility procured hot spots on 4/8/26. A new internet outage policy was developed and approved by the Executive Director on 4/8/2026. The Director of Nursing initiated training for the nursing staff on 4/10/2026

4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

   Nursing administration (consists of the DON and ADON) will conduct random visual audits to verify that nurses and medication aides are using the MAR when administering medication. Noncompliance will be immediately addressed and reported to the Executive

Director.

6/7/2026

A1231 8:36-17.5(a)(1) Heating and Air Conditioning: failed to ensure that the heating and air conditioning system was adequate to maintain the required temperature in all areas used by residents

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?

   On 4/6/26, the Maintenance Director installed thermostats in the [NJ Ex Order 26. 4B1] corridor.
   On 4/7/26, the Maintenance Director added 19 additional thermostats in other key areas of the facility, including each resident corridor, the common room, dining hall areas, laundry area on [NJ Ex Order 26] buildings on both floors.

   The Maintenance Director adjusted the central heat setting and identified that open windows in building [NJ E] floor 2, near the HVAC unit, contributed to the lower temperature. The windows were closed. On 4/7/26, the maintenance director rechecked the temperature and recorded as 72 degrees.

2. How the facility will identify other residents having the potential to be affected by the same practice.
   All residents have the potential to be affected

3. What measures will be put into place or systematic changes made, to ensure this deficient practice will not recur

   Since 4/7/26 the Maintenance Director has been recording temperatures in the identified corridor daily for 2 weeks, all temperatures have been maintained at 72 degrees or above.

   Effective 5/7/26, weekly temperatures have been recorded by the Maintenance Director in other corridors on the same floor and building. Temperatures were within requirements.

4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

   The Maintenance Director will maintain a weekly log of all air temperature checks, any temperatures outside of requirements will be rectified by the Maintenance Director. The logs will be submitted monthly to the Executive Director.

Completion date: 5/30/26

A1249 8:36-17.7 Building and Grounds Maintenance: failed to ensure that the building emergency exits lights were functioning

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?

   The six (6) Exit signs that were not illuminated were rewired by POE lighting vendor on 4/8/26.
   All exit signs including the eight signs are currently illuminating and are connected to generator power transfer. The facility's electrical contractor is purchasing new exit sighs, which will have enable a battery backup. The instillation will be completed by June 30th, 2026.
   The electrical contractor was notified on 4/7/26.

2. How the facility will identify other residents having the potential to be affected by the same practice.

   All residents have the potential to be affected

3. What measures will be put into place or systematic changes made, to ensure this deficient practice will not recur

   The electrical contractor conducted an audit of all exit signs on 4/30/26. There are 72 exit signs that require a battery backup.
   Starting 5/5/26 and until the battery backup exit lights are installed, when conducting the weekly generator tests, the maintenance director or designee will check 1 floor's exits signs each week to verify the exit signs remain illuminated during generator transfer. The testing has resulted in the signs remaining illuminated during the generator transfer.

   The Exit signs with battery back-up are on order and instillation will begin upon receipt, and installation will be completed by 6/30/26.

4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

   After the new Exit signs have been installed, the Maintenance Director will check 20% of exit lights each month to verify illumination battery back-up is functioning. The audit report will be submitted monthly to the Executive Director.

Completion date: 6/30/2026

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
06A003 Y1	A. Building B. Wing Y2	6/1/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT MILLVILLE	1125 VILLAGE DRIVE MILLVILLE, NJ 08332

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0401	Correction	ID Prefix A0411	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-4.1(a)(27)	Completed
LSC	05/15/2026	LSC	05/22/2026	LSC	05/18/2026
ID Prefix A0749	Correction	ID Prefix A0783	Correction	ID Prefix A0935	Correction
Reg. # 8:36-7.3(a)	Completed	Reg. # 8:36-7.5(e)	Completed	Reg. # 8:36-11.4(b)	Completed
LSC	05/23/2026	LSC	06/01/2026	LSC	06/07/2026
ID Prefix A1231	Correction	ID Prefix A1249	Correction	ID Prefix	Correction
Reg. # 8:36-17.5(a)(1)	Completed	Reg. # 8:36-17.7	Completed	Reg. #	Completed
LSC	05/30/2026	LSC	06/30/2026	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/9/2026

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO