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
	12020	A. BUILDING: ______ B. WING ______	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND ADULT MEDICAL DAY CARE	**316 MADISON AVENUE PERTH AMBOY, NJ 08861**

(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
M 000	Initial Comments Type of Survey: Monitoring/Follow-up to the 7/25/24 audit survey conducted by the Office of the Inspector General. Census: 90 (1) Session Sample Size: 4 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 235	8:43F-3.3(d)(1) Administration (d) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following: 1. A written statement of the program's philosophy and objectives and the services provided by the facility.	M 235		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/10/25

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M 235	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, it was determined that the facility failed to develop and implement a Policy and Procedure manual. The deficient practice was evidenced by the following: 1. On 7/25/24 during the OIG survey, the surveyors requested the Policy and Procedure manual and an Organization Chart, but the facility did not have them. At the time of this survey, the following policies were requested, but the facility did not have them: -Personnel Records -Maintenance of Personnel Records -Annual Mantoux Tuberculin Tests -Annual History and Physical Examinations -Care of Participants -Infection Control -Communicable Diseases -HouseKeeping Operations -Quality Improvement for Participants Care -Abuse and Neglect 2. On 9/2/25, at 11:33 a.m., the surveyor requested the facility's Policy and Procedure Manual from the Administrator and an Organizational Chart. The surveyor received the Policy and Procedure Manual and was provided with copies of the above requested policies, but not the Organizational Chart.	M 235		

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M 417	Continued From page 2	M 417		
M 417	8:43F-6.3(c) General Services All personnel who require licensure, certification, or authorization to provide care to participants shall be licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the Administrator failed to ensure that updated cardiopulmonary resuscitation (CPR) certifications were maintained in the personnel records for 3 of 4 employees reviewed, Employee #s 1, 3, and 4. This deficient practice was evidenced by the following: On 9/2/25 at 10:35 a.m., the surveyor requested the Administrator to provide the personnel files of four (4) employees for review. At 10:45 a.m., the surveyor reviewed the 4 personnel files and observed that there were not CPR certifications in the file. 1. Employee #1 was NJ Ex Order 26. 4B1 and had no CPR certification in her file. This employee was the Administrator. 2. Employee #3 was NJ Ex Order 26. 4B1 and had no CPR certification in her file. This employee was the Registered Nurse (RN) on duty. 3. Employee #4 was NJ Ex Order 26. 4B1 and had no CPR certification in his file. This employee was a	M 417		

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M 417	Continued From page 3 Driver. At 11:33 a.m., the surveyor interviewed the RN on duty, she stated that she does not have a current CPR certification completed. At 12:15 p.m., the surveyor asked about the employee CPR certifications, the Administrator stated that she does not have a current CPR certification completed. At 2:18 p.m., the surveyor interviewed the Administrator to inquire who was responsible for maintaining the personnel record and CPR certifications, the Administrator stated that she was. The surveyor asked about the incomplete CPR certifications for staff, the Administrator further stated that she will make sure all CPR certifications were completed soon. 4. During the OIG survey on 7/25/24, the surveyors observed that the administrator did not provide information on the following: CPR information for staff, one missing employment application, one blank employment application, two employees with blank reference check forms, one employee did not have NJ Ex Order 26. 4B1 test, missing employees trainings and no employee physicals. Employee names were not not provided for further review. The surveyor reviewed the undated facility policy and procedure titled, "Personnel Record" which indicated, "Policy Statement ...Employee health records shall be maintained for each employee. Employee health records shall be confidential and kept separate from personnel records and shall include documentation of all medical screening test and the results. Policy Interpretation and Implementation [-] Each personnel record will	M 417		

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M 417	Continued From page 4 contain at a minimum:....5. Certification number with effective date and experiation date (if applicable);	M 417		
M 421	8:43F-6.3(e)(1)(i) General Services (e) The facility shall develop and implement a staff orientation plan and a staff training and education plan, including plans for each service and designation of person(s) responsible for ongoing training. 1. All staff shall receive orientation at the time of employment and ongoing in-service training regarding, at a minimum, emergency plans and procedures, the infection prevention and control services, participant rights, and elder abuse. i. The facility shall document ongoing in-service training of all staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide documented evidence of ongoing in-service training regarding emergency plans and procedures, infection prevention and control services, participant rights, and elder abuse for 4	M 421		

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M 421	Continued From page 5 of 4 employees record files reviewed. This deficient practice was evidenced by the following: 1. On 9/2/25 at 10:35 a.m., the surveyor requested the Administrator to provide the personnel files of four (4) employees for review. At 10:45 a.m., the surveyor reviewed 4 personnel files for ongoing in-service trainings, which revealed the following: 1.Employee #1, the Administrator, was NJ Ex Order 26. 4B1 . The employee's last in-service training was on NJ Ex Order 26.4(b) during facility orientation regarding Emergency Plans and Procedures, Infection Prevention and Control Services, Participants Rights, and Elder Abuse. 2. Employee #2, a Registered Nurse, was NJ Ex Order . The surveyor was not able to find any documented evidence on the last in-service training date regarding Emergency Plans and Procedures, Infection Prevention and Control Services, Participants Rights, and Elder Abuse. 3. Employee #3, a Registered Nurse, was NJ Ex Order . The employee's last in-service training was on NJ Ex Order 26.4(b) during facility orientation regarding Emergency Plans and Procedures, Infection Prevention and Control Services, Participants Rights, and Elder Abuse. 4. Employee #4, a driver, was NJ Ex Order 26. 4B1 , the surveyor was not able to find any documentation on the last in-service training date regarding Emergency Plans and Procedures, Infection Prevention and Control Services, Participants Rights, and Elder Abuse. At 2:30 p.m., when the surveyor inquired who was	M 421		

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M 421	Continued From page 6 responsible for providing on-going in-service trainings to staff, the Administrator stated that in-services and trainings were provided by herself. In the same interview, the surveyor asked how often in-service trainings were completed, the Administrator stated that in-service trainings were provided on a yearly basis, and as needed. The surveyor requested a copy of policy and procedures for ongoing in-service trainings for staff from the Administrator. The Administrator was not able to provide the surveyor with a copy of policy and procedure for trainings on Emergency Plans and Procedures, Infection Prevention and Control Services, Participants Rights, and Elder Abuse. 5. During the 7/25/24 OIG survey, the facility did not provide the following to the surveyors: recent trainings of employees on emergency plans and procedures, infection prevention and control services, participant rights and elder abuse and documentation regarding emergency plans and procedures.	M 421		
M 425	8:43F-7.1(a) Nursing Services A registered professional nurse shall be designated in writing as the director of nursing services and shall be on duty at all times when participants are present in the facility. A registered professional nurse shall be designated in writing to act in the director's absence. This REQUIREMENT is not met as evidenced	M 425		

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M 425	Continued From page 7 by: Based on observation, interview and record review, it was determined that the facility failed to ensure the Director of Nursing (DON) was always present at the facility during Participant programming hours and failed to designate in writing the alternate DON to act in the absence of the DON. This deficient practice was evidenced by the following: 1. On 09/2/2025, at 11:15 a.m., the surveyor requested staffing schedules for the month of August and September of 2025 for review from the Adminsitrator. At 11:20 a.m., the surveyor reviewed printed staffing schedules for the month of August 2025, and September 2025, which revealed that there was no listed DON, or alternate DON on the schedules while participants were present at the facility during programming hours. At 11:25 a.m., the surveyor interviewed the Administrator and inquired about the DON, and the alternate DON schedules. The Administrator stated that the Registered Nurse (RN) on duty was the DON. The surveyor asked the Administrator who was the alternate DON. The Administrator stated that the facility did not have an alternate DON. At 11:55 p.m., the surveyor interviewed the RN on duty to inquire about his role as the facility's DON. The RN stated that he was not the DON on record. In the same interview, the RN explained that he was only hired as an RN. The RN further explained that the owner had previously offered him the role as a DON, however the owner declined the RN's request for increased pay, and it was never discussed further.	M 425		

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M 425	Continued From page 8 During continued interview, the surveyor interviewed the Administrator regarding the facility not having a DON or an alternate DON listed in the writing, the Administrator stated that she thought the RN on duty was the DON. The surveyor reviewed the Hours of Programming submitted by the Administrator which revealed hours are 7: 30 a.m. - 3:30 p.m., Monday thru Friday, with names of RNs on duty. The surveyor did not observe any name listed for the DON, or the alternate DON on the facility's list of programming hours schedule. 2. On 7/25/24 OIG survey, the surveyors observed that the facility failed to ensure the following positions were made available to provide services for Participants at the facility: Alternate Administrator, Alternate DON, Designated Cordinator for Quality Improvement Program and Infection Control Designated Staff. The surveyor reviewed the undated facility policy titled, "Designation of Director of Nursing Services" which revealed, "...A registered professional nurse shall be designated in writing as the director of Nursing Services and shall be on duty at all times when participants are present in the facility... A registered professional nurse, shall be designated in writing to act in the director's absence."	M 425		
M 579	8:43F-12.2(a) Social Work Services The facility shall arrange for the provision of social work services to participants who require them, in accordance with N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G.	M 579		

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M 579	Continued From page 9	M 579		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to ensure that a Licensed or Certified Social Worker (SW) was available to participants to provide services as needed. This deficient practice was evidenced by the following:

1. On 9/2/25 at 11:15 a.m., during interview with the Administrator the surveyor asked about the facility's SW and Participant's SW schedules. The Administrator confirmed that she was the facility's SW and gave a verbal schedule of SW hours. The surveyor asked if there was an assistant Administrator, for the days and times that Administrator was acting as a SW, the Administrator informed the surveyor that the facility did not have an Assistant Administrator.

At 11:20 a.m., upon review of the printed staffing list provided by the Administrator for the month of August 2025, the surveyor noted that there was no SW listed on the staffing schedule. The surveyor also reviewed printed staffing schedules for the month of September 2025, which revealed that there were no listed SW hours for participants, or an Assistant Administrator on the schedule to provide services to participants from August and September 2025.

The surveyor observed that the facility did not have a Licensed or Certified SW available to provide services to Participants during the month of August and September 2025.

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M 579	Continued From page 10 The Administrator was not able to provide a policy for SW services to the surveyor. 2. On 7/25/24 OIG survey, the surveyors observed that the facility failed to ensure the following positions were made available to provide services for Participants at the facility: Alternate Administrator, Alternate DON, Designated Cordinator for Quality Improvement Program and Infection Control Designated Staff. The surveyor reviewed an undated facility policy titled, "Appointment of an Assistant Administrator" which revealed, "...The facility shall appoint an Assistant Administrator who shall be designated in writing to act on behalf of the Administrator and shall be on duty at all times when participants are present in the facility..."	M 579		
M 653	8:43F-14.11(a)(1-3)(i-ii),(4-7) Physical Plant Requirements (a) The construction, equipment, and installation of food service facilities shall meet the requirements of the functional program. Services may consist of an on-site conventional food preparation system, a convenience food service system, a catering service or an appropriate combination thereof. The following facilities shall be provided to implement the food service selected: 1. A control station for receiving food supplies; 2. Storage facilities for food supply, including cold storage items;	M 653		

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M 653	Continued From page 11 3. Food preparation facilities as follows: i. A conventional food preparation system with space and equipment for preparing, cooking and baking; and ii. A convenience food system, such as frozen prepared meals, bulk packaged entrees, individually packaged portions, and contractual commissary services with space and equipment for thawing, portioning, cooking, and/or baking; 4. Handwashing facility(ies), located in the food preparation area; 5. Warewashing space, which shall be located in the kitchen or an alcove separate from the food preparation and serving area; 6. Waste storage facility(ies), which shall be located in a separate room easily accessible to the outside for direct waste pickup or disposal; and 7. Office(s) or desk space(s) for dietitian(s) or the food service manager.	M 653		

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M 653	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a control station for receiving food supplies and storage for food supply for Participants. The deficient practice was evidenced by the following: 1. On 9/2/25 at 10:20 a.m., during the tour with the Registered Nurse, the surveyor observed a box of fresh apples on the other side of the quiet room and boxes of soap detergents in the same area. At 11:15 a.m., the surveyor asked about the box of apples and soap detergents storage in the same location, the Administrator stated that she was not aware that the box of apple and detergents were stored in the same location. 2. On 7/25/24 OIG survey, the surveyors observed food with refrigeration requirement were not refrigerated, and also observed food was stored with bleach.	M 653		
M 689	8:43F-14.17(f)(g) Physical Plant Requirements (f) Drills of emergency plans shall be conducted at least four times a year and documented, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The four drills shall include at least one drill for emergencies due to fire. (g) The facility shall conduct at least one drill per year for emergencies due to another type of disaster, such as storm, flood, other natural disaster, bomb threat, or nuclear accident. All staff shall participate in at least one drill annually,	M 689		

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M 689	Continued From page 13 and program participants may take part in drills. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to conduct emergency drills between the years of 2023 through 2025. This deficient practice was evidenced by the following: 1. On 9/2/25 at 9:50 a.m., the surveyor requested a copy of 2023 through 2025 fire drills and other emergency drills for review from the Administrator. At 1:30 p.m., the surveyor reviewed the facility's emergency preparedness binder, but there was no documented evidence of any documentation for fire drills, or other emergency drills conducted between the years of 2023, through 2025. At 1:35 p.m., the surveyor interviewed the Administrator regarding the facility's emergency drills, and any other drills conducted in the past years and current, the Administrator confirmed that there were no formal fire drilsl or other emergency drills conducted between 2023 and 2025. 2. During the 7/25/24 OIG survey, the surveyors observed that the facility did not have any records of emergency drills between 2023 or 2024.	M 689		

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M 691	Continued From page 14	M 691		
M 691	8:43F-14.17(h) Physical Plant Requirements Fire extinguishers shall be examined annually and maintained in accordance with manufacturers' and National Fire Protection Association (NFPA) requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observation, and record review, it was determined that the facility failed to inspect and maintain fire extinguishers annually as required by National Fire Protection Association (NFPA). This deficient practice was evidenced by the following: 1. On 9/2/25 at 10:30 a.m., the surveyor toured the facility to inspect the fire extinguishers. The surveyor observed 7 of 7 fire extinguishers had a label which indicated that revealed the fire extinguishers were last inspected in April of 2025. At 1:30 p.m., the surveyor reviewed the facility's emergency preparedness binder. However, the surveyor did not observe any documented evidence when the fire extinguishers were last inspected. 2. On the 7/25/24 survey, the surveyors toured	M 691		

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
	12020	A. BUILDING: ____ B. WING ____	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND ADULT MEDICAL DAY CARE	**316 MADISON AVENUE PERTH AMBOY, NJ 08861**

(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
M 691	Continued From page 15 the facility and observed a fire extinguisher near the participants activity room that had not been examined in over a year, with a label that indicated the fire extinguisher was last inspected in June of 2023.	M 691		
M 765	8:43F-16.1(b)(1-4) Infection Control, Santation, Housekeeping (b) The administrator shall designate a person who shall be responsible for the direction, provision, and quality of infection prevention and control services. The designated person shall: 1. Have education, training and completed course work or experience in infection control or epidemiology; 2. Be responsible for developing and maintaining written objectives for infection prevention and control services; 3. Be responsible for developing a policy and procedure manual for infection prevention and control services; and 4. Be responsible for developing an organizational plan and a quality improvement program for infection prevention and control services.	M 765		

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M 765	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to designate an Infection Preventionist to implement the facility's Infection Control Program who was responsible for the direction, provision, and quality of infection prevention and control services. This deficient practice was evidenced by the following: 1. On 9/2/25 at 1:38 p.m., the surveyor interviewed the Administrator to inquire if the facility had an infection prevention program and an infection preventionist who was responsible for infection prevention and control services. The Administrator stated that "that would me". In the same interview, the Administrator stated that the facility did not have an infection prevention program or an infection preventionist and she conducted all infection control trainings for staff. The surveyor asked the Administrator when was the last infection control training conducted. The Administrator stated that she had not conducted any trainings since the beginning of 2024. At 1:41 p.m., the surveyor interviewed the Registered Nurse (RN) on duty to inquire who was responsible for infection control trainings for staff. The RN stated that he was not aware of who conducted trainings for staff. In the same interview, the RN confirmed that he had not received any training on infection control since he was hired. 2. On the 7/25/24 OIG survey, the surveyors observed that the facility failed to ensure the following position was available to provide services to the participants at the facility: Infection Control Designated Staff.	M 765		

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	12020	A. BUILDING: ___ B. WING ___	09/02/2025

NAME OF PROVIDER OR SUPPLIER: **GRACELAND ADULT MEDICAL DAY CARE**

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M 765	Continued From page 17 The surveyor reviewed the undated facility's policy titled, "Infection Control Program," which indicated, "The facility has established an Infection Control Committee to ensure a safe and sanitary environment by preventing the development and dissemination of infectious or communicable diseases among participants and employees ... The Administrator is responsible for the development and implementation of the Infection Control Program and the Director of Health Services is designated responsibility for coordinating the direction, provision and quality of the program ..." Cross Reference Tag: 8:43F-16.1(a) (b) M0763, M0765	M 765		
M 813	8:43F-16.7(a)(1-23) Infection Control, Santation, Housekeeping (a) The following housekeeping, sanitation, and safety conditions shall be met: 1. The facility and its contents shall be free of dirt, debris, and insect and rodent harborages; 2. Nonskid wax shall be used on all waxed floors; 3. All rooms shall be ventilated to help prevent condensation, mold growth, and noxious odors; 4. All participant areas shall be free of noxious odors; 5. Throw rugs or scatter rugs shall not be	M 813		

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M 813	Continued From page 18 used in the facility; 6. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Equipment shall be kept covered to protect from contamination and accessible for cleaning and inspection. Broken or worn items shall be repaired, replaced, or removed promptly; 7. All equipment shall have unobstructed space provided for operation; 8. All equipment and materials necessary for cleaning, disinfecting, and sterilizing shall be provided; 9. Thermometers which are accurate to within three degrees Fahrenheit shall be maintained in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration; 10. Pesticides shall be applied in accordance with N.J.A.C. 7:30; 11. Articles in storage shall be elevated from the floor and away from walls; 12. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room that is used for no other purpose; 13. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement;	M 813		

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M 813	Continued From page 19 14. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in closed metal cabinets or containers; 15. Unobstructed aisles shall be provided in storage areas; 16. A program shall be maintained to keep rodents, flies, roaches, andother vermin out of the facility; 17. Toilet tissue, soap dispenser, paper towels or air dryers, and waste receptacles shall be provided in each bathroom at all times; 18. All solid or liquid waste that is not regulated medical waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey Department of Environmental Protection and the New Jersey Department of Health and Senior Services. Solid waste shall be stored in insect-proof, rodent-proof, and fire-proof, non-absorbent, watertight containers with tight-fitting covers and collected from storage areas regularly, so as to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24; 19. Garbage compactors shall be located on an impervious pad that is graded to a drain. The drain shall be unobstructed and connected to the sanitary sewage	M 813		

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M 813	Continued From page 20	M 813		

disposal system;

20. Plastic bags shall be used for solid waste removal. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal;

21. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof;

22. Wastebaskets and ashtrays shall be made of noncombustible materials;

23. Latex foam pillows shall be prohibited.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined that the facility failed to ensure sanitary and safe environment for all participants. This deficient practice was evidenced by the following:

1. On 9/2/25 at 10:00 a.m., the surveyor toured the facility with the Registered Nurse (RN) and observed the following items that required repairs, removal, and cleaning and sanitation:

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M 813	Continued From page 21 a) 2 water fountains in the hallway, that were filled with dust, debris, and stained. The surveyor pushed both handles to activate the water fountain. However, the surveyor observed that there was no water dispensed from the water fountains. b) 2 water coolers located at the end of hallway. The surveyor activated the handle and observed that both water coolers was not in working condition. The surveyor asked the RN how long the coolers had not been in use, the RN stated that both the fountains and the water coolers had not been in use since he was hired. c) At 10:25 a.m., during the tour of the facility, the surveyor observed several boxes stacked on the floor in quiet room. Also, on the other side of the quiet room, the surveyor observed several boxes stacked on the floor which contained fresh fruits (apples), juice boxes, soap detergent, and boxes of foam cups. d) During the tour of the facility, the surveyor observed 4 ceiling tiles towards bathroom which had water leaked stained with holes and 3 ceiling tiles missing in the hallway near the participants activity room. e) At 11:15 a.m., the surveyor interviewed the Administrator regarding the stained and missing ceiling tiles, cluttered and obstructed participant quiet room, and the water coolers not working in the facility, the Administrator stated that she was not aware of the items that needed repairs, and she was not aware that items in the participants quite room were obstructed with stacked of boxes. The Administrator further stated that, she was not aware that the storage closet was	M 813		

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M 813	Continued From page 22 cluttered with boxes. f) At 1:45 p.m., the surveyor inquired about who is responsible for the cleaning of storage spaces and maintenance of equipment, the Administrator confirmed that the storage cleaning should be done by staff, and the facility did not have an assigned staff person for maintenance. The surveyor asked the Administrator for the facility's cleaning schedules and requested the Policy and Procedure manual for housekeeping and maintenance. The surveyor reviewed the undated facility policy and procedure titled, "Quality Improvement Program" which revealed that "...Purpose: To ensure periodic evaluation of environment services, periodic evaluation of sanitation, and ongoing maintenance of physical plant and equipment..." 2. On 7/25/24 during the OIG survey, the surveyors observed the following: the storage areas were very full with items falling over, unable to walk into a closet used for storage was obstructed by boxes, the quiet room furniture was obstructed by storage boxes, missing ceiling tiles, water damage on ceiling tiles, an exit obstructed by a cardboard shelter, bleach left out in one of the bathrooms, bleach left in one of the quiet rooms and the entrance to the basement was unlocked.	M 813		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
12020		12/4/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND ADULT MEDICAL DAY CARE	316 MADISON AVENUE PERTH AMBOY, NJ 08861

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 M0235 Reg. # 8:43F-3.3(d)(1) LSC	Correction Completed 12/01/2025	ID Prefix M0417 Reg. # 8:43F-6.3(c) LSC	Correction Completed 12/01/2025	ID Prefix M0421 Reg. # 8:43F-6.3(e)(1)(i) LSC	Correction Completed 12/01/2025
ID Prefix M0425 Reg. # 8:43F-7.1(a) LSC	Correction Completed 12/01/2025	ID Prefix M0579 Reg. # 8:43F-12.2(a) LSC	Correction Completed 12/01/2025	ID Prefix M0653 Reg. # 8:43F-14.11(a)(1-3)(i-ii),(4-7) LSC	Correction Completed 12/01/2025
ID Prefix M0689 Reg. # 8:43F-14.17(f)(g) LSC	Correction Completed 12/01/2025	ID Prefix M0691 Reg. # 8:43F-14.17(h) LSC	Correction Completed 12/01/2025	ID Prefix M0765 Reg. # 8:43F-16.1(b)(1-4) LSC	Correction Completed 12/01/2025
ID Prefix M0813 Reg. # 8:43F-16.7(a)(1-23) LSC	Correction Completed 12/01/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
9/2/2025	