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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00189007 CENSUS: 99 SAMPLE SIZE: 6 SURVEY DATE: 10/27/2025 - 10/30/2025 The facility is not in substantial compliance with all 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, based on this Complaint Survey. 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 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will 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: 16. The right to be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced	A 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/24/25

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A 389	Continued From page 1 by: Complaint #NJ189007 Based on record review, interview, facility document and policy review, and review of NJ Exec Order 26.4b1 reports, the facility failed to ensure a 1 (Resident #1) of 3 residents reviewed for NJ Exec Order 26.4b1 did NJ Exec Order 26.4b1 the facility without staff knowledge. Specifically, on NJ Exec Order 26.4b1 at an unspecified time, Resident #1 NJ Exec Order the facility through a NJ Exec Order 26.4b1. The facility staff did not identify that the resident was NJ Exec Order 26.4 until a NJ Exec Order 26.4b1 was NJ Exec Order 2 to NJ Exec Order the resident for their scheduled NJ Exec Order 26.4 session at approximately 11:00 AM. Resident #1 was located by the NJ Exec Order 26.4b1 agency at a NJ Exec Order 26.4b1, which was located on the opposite side of a NJ Exec Order 26.4b1 from the facility. It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, harm, impairments, or death to residents. On 10/28/2025, the New Jersey Department of Health determined that the failed practice represented an immediate threat to residents' health and safety. On 10/30/2025 at 04:00 PM, the facility's Executive Director (ED) was verbally informed of the immediacy of the situation involving the resident's NJ Exec Order 26.4b1 Findings included: A facility policy titled, "Missing Resident," effective 06/01/2019, indicated, "1. Any unexplained absence of a resident from the [facility's name] that is in excess of expected return to the Residence, based upon the service and health	A 389		

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care needs of the resident, shall be investigated. 2. Staff who discover a resident is missing will immediately notify the Executive Director/designee. When notified by a staff member that a resident is missing, the Executive Director/designee will notify all staff of the resident's absence, the resident's description, and the last time and place the resident was seen, if possible. If the resident is discovered, the person discovering him/her is to notify the Executive Director who will in turn notify the other personnel. If the resident is not discovered within 10-15 minutes, an organized search is to be initiated. 3. If, after preliminary efforts of all personnel, the missing resident has not been located, the following steps are to be taken: a The Executive Director/or designee (whoever has overall responsibility and is in charge at the facility when the resident is discovered missing) is to take charge of search efforts. This individual is designated the 'Search Director'. b. The Search Director is to be informed of all facts thus far: resident's name, description, areas already searched, etc. [et cetera; and so forth] c. The Search Director will ascertain who in the Residence is available to aid in the search and all available personnel will assemble in the Private Dining Room for further instruction. 4. The Search a. Time is a major factor in finding missing residents. Immediate danger is present when elderly residents, particularly those who are confused, are exposed to street traffic, hazardous terrain, or physical exposure to sun, heat, cold, or inclement weather. It is important that missing residents be discovered soon and that efforts be organized and thorough. 5. If a resident is discovered to be missing at a time when the Executive Director or designee is gone, the search should be directed by the person who is in charge of the Residence in their absence. If

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preliminary search efforts fail to locate the resident (approximately [one-half] hour of sustained search), the Executive Director or designee and police are to be called, regardless of the day or hour. The Executive Director will travel to the Residence and assume responsibility of the search, and notify outside agencies. If neither the Executive Director nor designee can be contacted, the person in charge is to enlist the help of the Security Department and/or the local police."

A facility policy titled, "Resident Elopement," effective 06/01/2019, indicated, "When a resident is identified as missing, all attempts to locate that resident will be made by searching the facility. If the resident cannot be located, an appropriate emergency alert will be initiated to notify all available team members to assist in the search, including all public areas, entrances, facility grounds and parking areas. Photographs of all residents identified as an elopement risk may be posted at the front desk and all units."

A resident demographic record indicated that the facility admitted Resident #1 on NJ Exec Order 26.4b1. According to the resident demographic record, Resident #1 had a medical history that included diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26 [redacted]

Resident #1's initial "Nursing Assessment," dated NJ Exec Order 26.4b1 revealed the resident had NJ Exec Order 26.4b1 [redacted] The Nursing Assessment indicated Resident #1 received prescribed medication for treatment of NJ Exec Order 26.4b1 and could NJ Exec Order 26.4 [redacted] in the facility in familiar surroundings with reminders and guidance from

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care staff. The Nursing Assessment also indicated that Resident #1 was working with NJ Exec Order 26.4 and NJ Exec Order 26.4b1 staff and could NJ Exec Order 26.4b1 and with a NJ Exec Order 26.4b1. The Nursing Assessment revealed Resident #1 was new to the facility and questioned the need to be there, was NJ Exec Order 26.4b1 with NJ Exec Or and/or NJ Exec Order 26.4b1, made statements about leaving or seeking to find someone/something, and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 indicating possible NJ Exec Order 26.4b1 The Nursing Assessment specified that a care plan was in place with interventions of 'NJ Ex Order 26.4(b)(1)," encouraging participation in activities, and an electronic tracking device be applied to a pendant. The Nursing Assessment also indicated that placement on the NJ Exec Order 26.4 care unit was offered, but the family declined. The Nursing Assessment indicated the resident had a history of NJ Exec Or

Resident #1's "Health Care Plan," initiated on NJ Exec Order 26.4b1 and revised on NJ Exec Order 26.4b1, included a problem area that indicated Resident #1 was at risk for NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 . The goal specified that Resident #1 would remain safe within the facility environment. The Health Care Plan directed staff to NJ Exec Order 26.4b1 of the resident, encourage participation in NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 activities to reduce NJ Exec Order 26.4b, and indicated that Resident #1 was to NJ Exec Order 26.4b1 device. Interventions also directed staff to continue NJ Exec Order 26.4b1 and re-evaluate the resident for possible NJ Exec Order 26 to the facility's NJ Exec Order 26.4b1 unit if their NJ Exec Order 26.4b1 or their safety became compromised.

Resident #1's "Service Plan," revealed a 'NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 management" section,

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initiated NJ Exec Order 26.4b1, that specified that the resident had a diagnosis of NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 but at times NJ Exec Order 26.4b1 The Service Plan included a "Health check: NJ Exec Order 26.4b1 section, initiated on NJ Exec Order 26.4b1 that indicated the resident had a diagnosis of NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 but at times NJ Exec Order 26.4b1. The Service Plan interventions directed staff to NJ Exec Order 26.4b1 of the resident, encourage the resident to participate in NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, indicated that the resident was to wear an NJ Exec Order 26.4b1, and directed staff to re-evaluate the resident for possible NJ Exec Order 26.4 to the NJ Exec Order 26.4b1 if their NJ Exec Order 26.4b1 or their safety became compromised.

Resident #1's 'NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1, revealed Resident #1 had a total adjusted score of NJE which indicated the resident had NJ Exec Order 26.4b1

Resident #1's "Nursing Notes," for the timeframe from NJ Exec Order 26.4b1, revealed no documentation that indicated that a NJ Exec Order 26.4 device was NJ Exec Order 26.4b1 Resident #1 nor that the resident had made statements about NJ Exec Order 26.4b1 as indicated by the "Nursing Assessment," "Health Care Plan," and "Service Plan."

A "New Jersey Department of Health Division of Health Facility Survey and Field Operations Long Term Care Assessment and Survey Program/Compliant Unit" "Reportable Event Record/Report," dated NJ Exec Order 26.4b1 revealed that

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the Executive Director reported an NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26.4b1 at 11:00 AM. Per the report, a NJ Exec Order 26.4b1 notified Licensed Practical Nurse (LPN) #18 that she NJ Exec Order 26.4b1 NJ Ex Order 26 Resident #1 for NJ Exec Order 26.4 The report indicated that a "NJ Exec Order 26.4b1" was conducted without success. The report indicated that at 11:15 AM, the facility initiated the NJ Exec Order 26.7 resident protocol and conducted a NJ Exec Order 26.4b1 of the facility and grounds. The report indicated that when the facility was NJ Exec Order 26.4b1 Resident #1 by 11:25 AM, the NJ Exec Order 26.4b1 and the resident's family were contacted. Per the report, the facility staff continued to NJ Exec Order 2 the property and surrounding areas. The report indicated that at 11:40 AM, the facility staff were notified by the NJ Exec Order 26.4b1 that Resident #1 was NJ Exec Order 26.4b1 that was NJ Exec Order 26.4b1 . Per the report, Resident #1 was NJ Exec O and NJ Exec Order 26.4b1 any injuries.

A NJ Exec Order 26.4b1 department "NJ Exec Order 26.4b1" report, dated NJ Exec Order 26.4b1, indicated that a report of a NJ Exec Order 26.4b1 was made on NJ Exec Order 26.4b1 at 11:24 AM via a NJ Exec telephone call and indicated Resident #1 was NJ Exec Order 2 to be NJ Exec Order 26.4

A NJ Exec Order 26.4b1 "NJ Ex Order 26.4 Report for Incident [incident number]," dated NJ Exec Order 26.4b1 at 11:24 AM, revealed that the assigned NJ Ex Order 26 responded to the facility in response to a reported NJ Exec Order 26.4b1. The report indicated that upon arrival, the NJ Exec Order contacted the staff who advised the NJ Exec Order that Resident #1 was NJ Exec Order 26.4 The report indicated that the staff reported Resident #1 was NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 of the building approximately 20 minutes prior, and staff had checked the whole building but was unable to NJ Exec Order 26.4b1. Per the report, at that time,

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the agency received an emergency medical services (EMS) call at the NJ Exec Order 26.4b1 regarding NJ Ex Order 26.4(b)(1) who had NJ Exec Order 26.4b1. The report indicated that the NJ Exec Order responded to the NJ Ex Order 26.4(b)(1) to verify if the patient from the EMS call was the same individual who was listed in the NJ Exec Order 26.4b1, and the NJ Exec Order was able to NJ Exec Order 26.4b1 Resident #1 after staff from the facility arrived at the NJ Exec. The report included a section titled, "Supplement," dated NJ Exec Order 26.4b1 at 11:55 AM, that revealed the following timeline:
-11:26 AM- Identification of Resident #1 as a NJ Exec Order 26.4b1. The report indicated that the resident was NJ Exec Order 26.4b1 at breakfast NJ Exec Order 26.4b1 the doors on the facility were NJ Exec Order 26.4b1 but staff were not aware of any NJ Exec Order 2 that went off.
-11:39 AM- Notification that Resident #1 may have been NJ Exec Order 26.4b1.
-11:53 AM- Resident #1 was identified as the reported NJ Exec Order 26.4b1 and transported to the local hospital via EMS.

Resident #1's hospital record, dated NJ Exec Order 26.4b1 revealed Resident #1 was evaluated for NJ Exec Order 26.4 in the emergency department and was discharged to return to the facility.

During an interview on 10/28/2025 at 2:00 PM, Certified Home Health Aide (CHHA) #23 stated that she was the assigned CHHA for Resident #1 on NJ Exec Order 26.4b1 for the day shift (7:00 AM - 3:00 PM). CHHA #23 stated that Resident #1 wore a NJ Exec Order 26.4b1 with a "NJ Exec Order 26.4b1," and she thought the resident also had a NJ Exec Order 26.4b1 on the NJ Exec Order 26.4 the day of the NJ Exec Order 26.4b1 but was not certain. CHHA #23 stated that she assisted Resident #1 to breakfast area on the morning of NJ Exec Order 26.4b1 between 9:00 AM and 10:00 AM, which was located on the ground floor, and she

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stated that she NJ Exec Order 26.4b the resident "before lunch," NJ Exec Order 26.4b1 in the lounge area on the ground floor. CHHA #23 stated that she thought it was around lunchtime when she heard on a two-way radio that Resident #1 was NJ Exec Order 26.4b but she did not recall the specific time. CHHA #23 further stated that she did not recall if Resident #1 had the NJ Exec Order 26.4b1 with the electronic NJ Exec Order 26.4b1 on when she saw the resident walking in the lounge area of the ground floor before the NJ Exec Order 26.4b1

During an interview on 10/29/2025 at 12:56 PM, Waitress #26 stated that she worked on NJ Exec Order 26.4b1 as a waitress in the dining room. Waitress #26 stated that she saw Resident #1 on NJ Exec Order 26.4b1 at around 9:30 AM NJ Exec Or into the dining room and sit down for breakfast; however, after a few minutes, Resident #1 left the dining room for a few minutes, then returned. Waitress #26 stated that Resident #1 consumed only a small portion of the breakfast meal before leaving at around 9:45 AM and she NJ Exec Order 26.4b1 Resident #1 after 9:45 AM on NJ Exec Order 26.4b1. She stated that she was not certain if Resident #1 had a NJ Exec Order 26.4b on with an NJ Exec Order 26.4b1 the morning of NJ Exec Order 26.4b1.

During an interview on 10/27/2025 at 2:45 PM, the Sales Director (SD) revealed that she observed Resident #1 seated in the activity area of the facility on the ground floor on NJ Exec Order 26.4b1 between 10:15 AM and 10:30 AM. The SD stated that she encouraged Resident #1 to attend a group activity, but Resident #1 NJ Exec Order 26.4b and requested to stay in the activity area and rest.

During a follow-up interview on 10/29/2025 at 12:50 PM, the SD revealed that she was informed by Resident #1's family on NJ Exec Order 26.4b1,

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that the resident's NJ Exec Order 26.4b1 with the NJ Exec Order 26.4 was NJ Exec Order 26.4 The SD stated that she looked but could not locate it, so the NJ Exec Order 26.4 and NJ Exec Order 26.4b1 were replaced. The SD further stated that she was not aware that Resident #1 was assigned an NJ Exec Order 26.4b1 at the time, so she did not report to the ED that the NJ Exec Order 26.4b1 was also NJ Exec Order 26.4

During an interview on 10/28/2025 at 9:03 AM, the NJ Exec Order 26.4b1) stated that on NJ Exec Order 26.4b1 at around 10:30 AM, she looked for Resident #1 in their room and in the dining room on the ground floor to complete a NJ Exec Order 26 evaluation, but she NJ Exec Order 26.4b1 the resident. The NJ Exe stated that when she could not NJ Exec Order Resident #1 by 11:00 AM on NJ Exec Order 26.4b1, she notified LPN #18.

During an interview on 10/27/2025 at 10:24 AM, LPN #18 stated that the NJ Exe notified her at around 11:00 AM on NJ Exec Order 26.4b1 that Resident #1 was NJ Exec Order 26.4b1 or in the dining room. LPN #18 stated that she then NJ Exec Order 2 for the resident in their room and in the dining room, but Resident #1 was NJ Exec Order 26.4b1. LPN #18 stated that the facility implemented the NJ Exec Order 26.4b1 protocol and started a NJ Exec Order 2 for Resident #1. LPN #18 stated that the facility NJ Exec Order 2 was unsuccessful, so the ED, the Director of Nursing (DON), and the NJ Exec Order were notified. LPN #18 stated Resident #1 NJ Exec Order 26.4b1 . LPN #18 stated that she had not previously observed Resident #1 with an NJ Exec Order 26.4b1, nor did the resident have one in place on NJ Exec Order 26.4b1 before the NJ Exec Order 26.4b1 LPN #18 stated that at the time of the NJ Exec Order 26.4b1 it was the responsibility of the ED to place NJ Exec Order 26.4b1 for residents identified as at risk

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A 389	Continued From page 10 for NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 During a telephone interview on 10/28/2025 at 10:38 AM, the Physical Therapist (PT) revealed that she would not recommend that Resident #1 NJ Exec Order 26.4b1 because of the resident's NJ Exec Order 26.4b1 and stated that doing so would be NJ Exec Order 26.4b1 for Resident #1. During an interview on 10/28/2025 at 8:30 AM, NJ Exec Order 26.4b1 #27 revealed that he observed Resident #1 NJ Exec Order 26.4b1 in the NJ Ex Order 26.4b1 of the NJ Exec Order 26.4b1 at around 10:30 AM. He stated that he did not recall the direction Resident #1 came from, but during his first observation of Resident #1, the resident was NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 #27 stated that the resident asked him if they (the resident) could NJ Exec Order 26.4b1 . The NJ Exec Order 26.4b1 stated that he told Resident #1 to NJ Exec Order 26.4b1 in the waiting area. He stated that after about 30 or 45 minutes no one arrived to NJ Exec Order 26.4b1 Resident #1 NJ Ex Order 26.4b1 so he asked the resident to provide the name and phone number of the person the resident was expecting. He stated that the resident could not provide that information, so he notified his supervisor and then contacted the NJ Exec Order 26.4b1 around 11:15 AM or 11:30 AM. NJ Exec Order 26.4b1 #27 stated that the NJ Exec Order 26.4b1 arrived at the NJ Exec Order 26.4b1 soon afterwards and Resident #1 was taken by ambulance to the ED. During a telephone interview on 10/29/2025 at 9:51 AM, the Medical Director (MD) revealed that he assessed Resident #1 in the facility for the first time on NJ Exec Order 26.4b1 He stated Resident #1 was appropriate for assisted living care. He stated that Resident #1 was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and to the NJ Exec Order 26.4b1 but not to NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 He stated that	A 389		

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he was notified that Resident #1 NJ Exec Order 2 from the facility on NJ Exec Order 26.4b1. The MD stated that the area around the NJ Exec Order 26.4b1 and felt that although Resident #1 was NJ Exec Order 26.4b1 the resident would not be NJ Exec O to NJ Exec Or NJ Exec Orde to the NJ Exec Order 26.4b1, due to their NJ Exec Order 26.4b1. The MD stated that when Resident #1 returned from the ED, the resident was re-admitted to the NJ Exec Order 26.4b1 unit due to the NJ Exec Order 26.4b1 which was more appropriate for the resident.

During an interview on 10/27/2025 at 10:00 AM, the DON stated that she was not in the facility on NJ Exec Order 26.4b1 but she was notified by telephone by LPN #18 at around 11:00 AM that Resident #1 was NJ Exec Order 26.4b The DON stated that LPN #18 advised her that the facility staff implemented the NJ Exec Order 26.4b1 policy, conducted a NJ Exec Order 2 for the resident for 10 minutes, and were still NJ Exec Order 26 for the resident at the time of the call. The DON stated that the resident had NJ Exec Order 26.4b1 from the facility before, nor did the family report a history of NJ Exec Order 26.4b1 prior to admission. The DON stated that at baseline, Resident #1 required some NJ Exec Order 26.4b1 to know what to do. The DON stated that it would take 'NJ Exec Order 26.4b1 from the facility. The DON further stated that Resident #1 was transferred to the ED and assessed NJ Exec Order 26.4b1, returned to the facility at NJ Exec Order 26.4b1 and was re-admitted to the NJ Exec Order 26.4b1 unit because of the NJ Exec Order 26.4b1

During an interview on 10/29/2025 at 1:15 PM, the DON revealed that she expected the NJ Exec Order 26.4b1 risk goals to be met for any resident identified as at risk for NJ Exec Order 26.4b1 so that the resident did not NJ Exec Order The DON stated that

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	13A010	A. BUILDING: _____ B. WING _____	C 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS, THE	289 GORDONS CORNER ROAD MANALAPAN, NJ 07726

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A 389	Continued From page 12	A 389		

staff should be aware if a resident was at risk for NJ Exec Order 26.4b1 and be able to identify signs and symptoms of NJ Exec Order 26.4b1, and report to the nurse if the NJ Exec Order 26.4b1 was identified. She stated that Resident #1 did not display NJ Exec Order 26.4b1 prior to NJ Exec Order 26.4b1 and per the family, the resident had not exhibited NJ Exec at home. The DON further stated that when she updated the Nursing Assessment, Care Plan, and Service Plan on NJ Exec Order 26.4b1 regarding Resident #1's NJ Exec Order 26.4b1, which was documented as NJ Exec Order 26.4b1 indicative of NJ Exec Order 26.4b1, it was based on communication from the ED, and she may have misinterpreted the question regarding body language indicating NJ Exec Order 26.4b1.

During an interview on 10/28/2025 at 2:30 PM, the ED stated that at the time of Resident #1's NJ Exec Order 26.4b1 it was his responsibility to apply NJ Exec Order 26.4b1 to residents who had a service plan that included that intervention. He stated that he initially applied a NJ Exec Order 26.4b1 for Resident #1 on NJ Exec Order 26.4b1, but because Resident #1 repeatedly removed the NJ Exec Order 26.4b1, he did not continue to apply the device daily. He stated that the intervention for implementing a NJ Exec Order 26.4 was a result of the family telling him that Resident #1 NJ Exec Order 26.4b1 He stated that he did not document the conversation in the medical record, but he should have. He further stated that at the time, it was not the facility's practice to document the application of a NJ Exec Order 26.4b1 or to assign staff to routinely monitor if the NJ Exec Order 26.4b1 was in place. He stated that he could track the devices with his phone, and he did so periodically. He further stated that on NJ Exec Order 26.4b1,

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A 389	Continued From page 13 Resident #1 did not have a [redacted] in place when they [redacted] from the facility. He stated that when the resident [redacted] the resident was re-admitted to the [redacted] unit. During an interview on 10/29/2025 at 11:44 AM, the ED stated that he acknowledged that the area around the [redacted] where Resident #1 [redacted] and was not [redacted] for the resident to [redacted] because the resident required [redacted] He stated that due to the resident's [redacted], he expected staff to [redacted] or [redacted] Resident #1 to/from [redacted] or [redacted] and expected staff to [redacted] the resident and encourage participation in the events of the day.	A 389		
A 775	8:36-7.5(a) Resident Assessments and Care Plans (a) The facility or program shall arrange for health care services to be provided to residents as needed, in accordance with assessments and with the health service plan. The administrator shall develop a system to identify the residents receiving health care services. This REQUIREMENT is not met as evidenced by: Complaint #NJ189007 Based on a facility policy review, record review, facility document review, and interview, the facility failed to implement the use of an [redacted] according to interventions specified in a "Nursing Assessment," "Health	A 775		

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Care Plan, and "Service Plan" for 1 (Resident #1) of 3 residents reviewed for NJ Exec Order 26.4b1 Specifically, Resident #1 NJ Exec Order the facility on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted] staff knowledge. Resident #1 did not have a NJ Exec Order 26.4b1 in place at the time of the NJ Exec Order 26.4b1 The deficiency resulted staff being NJ Exec Order 26.4b1 Resident #1 without the assistance of the NJ Exec Order 26.4b1 [redacted]

It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, harm, impairments, or death to residents.

On 10/28/2025, the New Jersey Department of Health determined that the failed practice represented an immediate threat to residents' health and safety. On 10/30/2025 at 04:00 PM, the facility's Executive Director (ED) was verbally informed of the immediacy of the situation involving the resident's NJ Exec Order 26.4b1

Findings included:

A facility policy titled, "General and Healthcare Service Plans," dated 06/01/2019, indicated the "Policy" was "A plan to ensure appropriate resident care, based on assessed needs shall be developed when appropriate." The policy revealed the "Procedure" included, "1. Each resident shall be assessed by a nurse to determine if the resident needs general and/or health care services. The initial nursing assessment shall not be required if a licensed physician specifies in writing, within 30 days prior to admission, that the resident has no health care service needs and is appropriate for an assisted living residence or a comprehensive personal

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A 775	Continued From page 15 care home." A resident demographic record indicated that the facility admitted Resident #1 on NJ Exec Order 26.4b1 According to the resident demographic record, Resident #1 had a medical history that included diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26 [redacted] Resident #1's initial "Nursing Assessment," dated NJ Exec Order 26.4b1 revealed the resident had NJ Exec Order 26.4b1 [redacted] The Nursing Assessment indicated Resident #1 received prescribed medication for treatment of NJ Exec Order 26.4b1 and could NJ Exec Order 26.4 [redacted] in the facility in NJ Exec Order 26 surroundings with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 from care staff. The Nursing Assessment also indicated that Resident #1 was working with NJ Exec Order 26.4 and NJ Exec Order 26.4b1 staff and could NJ Exec Order 26.4b1 and with a NJ Exec Order 26.4b1 The Nursing Assessment revealed Resident #1 was NJ Exec O to the facility and NJ Exec Order 26.4b1 [redacted], wasNJ Exec Order 26.4b1 with NJ Exec Or [redacted] and/or NJ Exec Order 26.4b1 diagnosis, made NJ Exec Order 26.4b1 or NJ Exec Order 26 to NJ Exec [redacted] and displayed NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 indicating possible NJ Exec Order 26.4b1 The Nursing Assessment specified that a care plan was in place with interventions of NJ Exec Order 26.4b1," encouraging participation in activities, and an NJ Exec Order 26.4b1 be applied to a NJ Exec Order 26.4b1 The Nursing Assessment also indicated that placement on the NJ Exec Order 26.4 [redacted] was offered, but the family NJ Exec Order 26.4b1 The Nursing Assessment indicated the resident had a history of NJ Exec Or Resident #1's "Health Care Plan," initiated on	A 775		

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NJ Exec Order 26.4b1, included a problem area that indicated Resident #1 was at risk for NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1. The goal specified that Resident #1 would NJ Exec Order 26.4b1 the facility environment. The Health Care Plan directed staff to NJ Exec Order 26.4b1 of the resident, encourage participation in NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, and indicated that Resident #1 was to NJ Exec Order 26.4b1 Interventions also directed staff to continue NJ Exec Order 26.4b1 and re-evaluate the resident for possible NJ Exec Order 26.4 to the facility's NJ Exec Order 26.4b1 if their NJ Exec Order 26.4b1 or their safety became compromised.

Resident #1's "Service Plan," revealed a "NJ Exec Order 26.4b1" section, initiated NJ Exec Order 26.4b1 that specified that the resident had a diagnosis of NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 but at times NJ Exec Order 26.4b1. The Service Plan included a "Health check: NJ Exec Order 26.4b1 section, initiated on NJ Exec Order 26.4b1, that indicated the resident had a diagnosis of NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 but at times NJ Exec Order 26.4b1. The Service Plan interventions directed staff to NJ Exec Order 26.4b1 of the resident, encourage the resident to participate in NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 indicated that the resident was to NJ Exec Order 26.4b1, and directed staff to re-evaluate the resident for NJ Exec Order 26.4b1 if their NJ Exec Order 26.4b1 or their safety became compromised.

Resident #1's "NJ Exec Order 26.4b1," dated NJ Exec Order 26.4b1, revealed Resident #1 had a total adjusted score of NJ E which indicated the resident had NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1.

A "New Jersey Department of Health Division of Health Facility Survey and Field Operations Long Term Care Assessment and Survey Program/Compliant Unit" "Reportable Event Record/Report," dated NJ Exec Order 26.4b1 revealed that the ED reported an NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26.4b1 11:00 AM. Per the report, a NJ Exec Order 26.4b1 notified Licensed Practical Nurse (LPN) #18 that she could NJ Exec Order 26.4b1 Resident #1 for NJ Exec Order 26.4 The report indicated that a NJ Exec Order was conducted without success. The report indicated that at 11:15 AM, the facility initiated the NJ Exec Order 26.4b1 and conducted a NJ Exec Order 26.4b1 of the facility and NJ Ex Order 26.4(b)(1 The report indicated that when the facility was NJ Exec Order 26.4b1 Resident #1 by 11:25 AM, the NJ Exec Order 26.4b1 and the resident's family were contacted. Per the report, the facility staff continued to NJ Exec Order 2 the property and surrounding areas. The report indicated that at 11:40 AM, the facility staff were notified by the NJ Exec Order 26.4b1 that Resident #1 was located at a NJ Exec Order 26.4b1 that was directly across the NJ Exec Order 26.4b1 . Per the report, Resident #1 was NJ Exec O and NJ Exec Order 26.4b1 any injuries.

During an interview on 10/28/2025 at 2:00 PM, Certified Home Health Aide (CHHA) #23 stated that she was the assigned CHHA for Resident #1 on NJ Exec Order 26.4b1 for the day shift (7:00 AM - 3:00 PM). CHHA #23 stated that Resident #1 wore a NJ Exec Order 26.4b1 with a "NJ Exec Order 26.4b1," and she thought the resident also had a NJ Exec Order 26.4b1 on the NJ Exec Order 26.4 the day of the NJ Exec Order 26.4b1 but was not certain. CHHA #23 stated that she assisted Resident #1 to breakfast area on the morning of NJ Exec Order 26.4b1 between 9:00 AM and 10:00 AM,

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A 775	Continued From page 18	A 775		

which was located on the ground floor, and she stated that she NJ Exec Order 26.4b the resident "before lunch," NJ Exec Order 26.4 around in the lounge area on the ground floor. CHHA #23 stated that she thought it was around lunchtime when she heard on a two-way radio that Resident #1 was NJ Exec Order 26.4b but she did not recall the specific time. CHHA #23 further stated that she did not recall if Resident #1 had the NJ Exec Order 26.4b1 with the electronic NJ Exec Order 26.4b1 on when she saw the resident walking in the lounge area of the ground floor before the NJ Exec Order 26.4b1

During an interview on 10/29/2025 at 12:56 PM, Waitress #26 stated that she worked on NJ Exec Order 26.4b1 as a waitress in the dining room. Waitress #26 stated that she saw Resident #1 on NJ Exec Order 26.4b1 at around 9:30 AM walk into the dining room and sit down for breakfast; however, after a few minutes, Resident #1 left the dining room for a few minutes, then returned. Waitress #26 stated that Resident #1 consumed only a small portion of the breakfast meal before leaving at around 9:45 AM and she NJ Exec Order 26.4b1 Resident #1 after 9:45 AM on NJ Exec Order 26.4b1. She stated that she was not certain if Resident #1 had a NJ Exec Order 26.4b on with an NJ Exec Order 26.4b1 the morning of NJ Exec Order 26.4b1.

During an interview on 10/29/2025 at 12:50 PM, the Sales Director (SD) revealed that she was informed by Resident #1's family on NJ Exec Order 26.4b1 , that the resident's NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b was NJ Exec Order 26.4b The SD stated that she looked but NJ Exec Order 26.4b1, so the NJ Exec Order 26.4b and NJ Exec Order 26.4b1 were replaced. The SD further stated that she was not aware that Resident #1 was assigned an NJ Exec Order 26.4b1 at the time, so she did not report to the ED that the NJ Exec Order 26.4b1 was also missing.

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A 775	Continued From page 19 During an interview on 10/27/2025 at 10:24 AM, LPN #18 stated that the [NJ Exec] notified her at around 11:00 AM on [NJ Exec Order 26.4b1] that Resident #1 was [NJ Exec Order 26.4b1] in their room or in the dining room. LPN #18 stated that she then [NJ Exec Order 2] for the resident in their room and in the dining room, but Resident #1 was [NJ Exec Order 26.4b1]. LPN #18 stated that the facility implemented the [NJ Exec Order 26.4b1] protocol and started a [NJ Exec Order 2] for Resident #1. LPN #18 stated that the [NJ Exec Order 26.4b1] was unsuccessful, so the ED, the Director of Nursing (DON), and the [NJ Exec Order] were notified. LPN #18 stated Resident #1 was not [NJ Exec Order 26.4b1]. LPN #18 stated that she had not previously observed Resident #1 with an [NJ Exec Order 26.4b1], nor did the resident have one in place on [NJ Exec Order 26.4b1] before the [NJ Exec Order 26.4b1] LPN #18 stated that at the time of the [NJ Exec Order 26.4b1] it was the responsibility of the ED to place [NJ Exec Order 26.4b1] for residents identified as at risk for [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1] During an interview on 10/29/2025 at 1:15 PM, the DON revealed that she expected the [NJ Exec Order 26.4b1] goals to be met for any resident identified as at risk for [NJ Exec Order 26.4b1] so that the resident did not [NJ Exec Order] The DON stated that staff should be aware if a resident was at risk for [NJ Exec Order 26.4b1] and be able to identify signs and symptoms of [NJ Exec Order 26.4b1], and report to the nurse if the [NJ Exec Order 26.4b] was identified. She stated that Resident #1 did not display [NJ Exec Order 26.4b1] prior to [NJ Exec Order 26.4b1] and per the family, the resident had not exhibited [NJ Exec] The DON further stated that when she updated the Nursing Assessment, Care Plan, and Service Plan on [NJ Exec Order 26.4b1] regarding	A 775		

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Resident #1's NJ Exec Order 26.4b1, which was documented as communicating a NJ Exec Order 26.4b1 [redacted], it was based on communication from the ED, and she may have misinterpreted the question regarding NJ Exec Ord [redacted].

During an interview on 10/28/2025 at 2:30 PM, the ED stated that at the time of Resident #1's NJ Exec Order 26.4b1 it was his responsibility to apply NJ Exec Order 26.4b1 to residents who had a service plan that included that intervention. He stated that he initially applied a NJ Exec Order 26.4b1 for Resident #1 on NJ Exec Order 26.4b1 but because Resident #1 repeatedly removed the NJ Exec Order 26.4b1, he did not continue to NJ Ex Order 26.4(b)(1) daily. He stated that the intervention for implementing a NJ Exec Order 26.4 [redacted] was a result of the family telling him that Resident #1 NJ Exec Order 26.4b1 [redacted] He stated that he did not document the conversation in the medical record, but he should have. He further stated that at the time, it was not the facility's practice to document the application of a NJ Exec Order 26.4b1 or to assign staff to routinely monitor if the NJ Exec Order 26.4b1 was in place. He stated that he could NJ Exec Ord the devices with his phone, and he did so periodically. He further stated that on NJ Exec Order 26.4b1, Resident #1 did not have a NJ Exec Order 26.4b1 in place when they NJ Exec Order 2 from the facility.

POC #2 received 1/6/26
acceptable

VILLAS
A Healthy Living Community

Meridian Living at Manalapan, LLC, DBA The Villas
Plan of Correction

Name of Facility: Meridian Living at Manalapan LLC, dba The Villas
Address of Facility: 289 Gordons Corner Road, Manalapan, NJ 07726
License number: 13A010
Inspection date(s): 10/30/2025
Name and Title of Legal Entity Representative Signing the Plan of Correction: Kenneth Keegan, Executive Director
Signature of Representative:
Date of Submission: 1/6/26

A389 8:36-4.1(a)(16) Residents Rights

Plan of Correction:

- **The corrective actions accomplished for the residents affected by the deficient practice:**
- Resident#1 [NJ Exec Order 26.4b1] to the community o [NJ Exec Order 26.4b1] at approximately 6:00pm to our [NJ Exec Order 26.4b1] On [NJ Exec Order 26.4b1] the RN Wellness Director updated the residents' service plan. The following sections were updated:
- [NJ Exec Order 26.4b1]
  "Resident has a diagnosis of [NJ Exec Order 26.4b1] and is [NJ Exec Order 26.4b1] Resident [NJ Exec Order 26.4b1] [NJ Exec Order 26] as subsequently moved to the [NJ Exec Order 26.4b1] [NJ Exec Order 2] unit. Care staff and nursing staff will provide [NJ Exec Order 26.4b1] and engagement in meaningful activities to r [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1]
- [NJ Exec Order 26.4b1]
  "Round on resident throughout the night to ensure safety while on the [NJ Exec Order 26.4b1] unit."
- [NJ Exec Order 26.4b1] **Section:**
  Resident identified as an [NJ Exec Order 26.4b1] risk following [NJ Exec Order 26.4b1]
  Interventions implemented:
  - Transfer to secured [NJ Exec Order 26.4b1]
  - Increased staff [NJ Exec Order 26.4b1]

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- NJ Exec Order 26.4b1 ctivities
- NJ Exec Order 26.4b1
- Encouragement of regular family visitation

- **ADLs Updated:**
  Assistance required fo NJ Exec Order 26.4b1 care as needed, and NJ Exec Order 26.4b1 care.
- **Meals:**
  All meals to be eaten within the NJ Exec Order 26.4b1
- **Medication Administration:**
  Medications to be administered by NJ Exec Order 26.4b1 CMAs or nursing staff.
- NJ Exec Order 26.4b1 **eeds:**
  Resident requires NJ Exec Order 26.4b1 and staff NJ Exec Order 26.4b1 meals and activities from NJ Exec Order 26 re staff and on the NJ Exec Orde unit.

- The RN Wellness Director(designee) communicated this apartment change and updated service plan to all care staff and the attending physician.
- Resident #1 is no longer a resident of the community.

- **How we will identify other residents having the potential to be affected by the same deficient practice:**
- All residents have the potential to be affected by the deficient practice. On 10/9/2025 the RN Wellness Director, Nursing Leadership and Executive Director reviewed the elopement risk assessment of each resident.
- On 10/9/25 all residents identified at risk for elopement had their service plans reviewed/updated by the RN Wellness Director. The RN Wellness Director and Executive Director ensured a tracking device was in place and functioning on each resident. Any residents who are non-compliant with their health service plan will be relocated to the secure memory care unit.

- **Measures put in place or systemic changes made to ensure that the deficient practice will not recur:**
- A root cause analysis was conducted by the IDC team to identify the underlying cause of the deficient practice. It was determined the monitoring process for the electronic tracking devices was lacking. Therefore, a new monitoring process was initiated on 10/9/2025 which confirms the presence

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of the electronic tracking devices, each shift while awake, and is documented on the Medication Administration Record (MAR).

- The nurses and medication technicians are responsible for completing this documentation each shift, while the resident is awake, on the MAR. All nursing staff were educated on the new monitoring process on 10/14/2025 by the RN Wellness Director and the nursing leadership team.
- The Executive Director revised the Wanderguard Policy on 10/31/25 to include the use and monitoring of the electronic tracking devices. All team members were educated on the revised Wanderguard Policy by the Executive Director on 10/31/25.

- All exit doors in the community are alarmed. In addition, the Wanderguard system was upgraded to include a Wanderguard monitor at the rear patio door (in addition to the front door). All assisted living residents at risk for elopement have wanderguard bracelets placed on their body (in addition to electronic tracking devices). The Wanderguard policy was reviewed and updated by the RN Wellness Director and Executive Director. All wander protection systems will be checked daily for placement every shift while awake, per policy. All Wanderguard bracelets and doors will be checked weekly by the Executive Director (or designee) for function, per policy. All staff were in-serviced by the Executive Director on the updated Wanderguard policy.

- **How the corrective actions will be monitored to ensure the deficient practice will not recur:**
- The Executive Director or designee will conduct weekly audits of 5 residents' wander protection systems (Electronic Tracking devices and Wanderguard bracelets), weekly for 3 months, monthly for 1 year. These audits will check placement, function and documentation of these devices. The results will be reported to the Quality Assurance Committee.

Date of Completion: **December 31, 2025** Accepted

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A775 8:36-7.5(a) Resident Assessments and Care Plans

Plan of Correction:

- **The corrective actions accomplished for the residents affected by the deficient practice:**
- Resident#1 NJ Exec Order 26.4b1 at approximately 6:00pm to the NJ Exec Order 26.4b1 unit. Upon return to the facility, resident #1 was assessed and the service plan was updated by the RN Wellness Director. The revised service plan included:

- NJ Exec Order 26.4b1 **Section:**
  "Resident has a diagnosis of NJ Exec Order 26.4b1 Resident NJ Exec Order 26.4b1 was subsequently moved to the NJ Exec Order 26.4b1 unit. Care staff and nursing staff will provide NJ Exec Order 26.4b1 in meaningful activities to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1
- NJ Exec Order 26.4b1
  "Round on resident throughout the night to ensure safety while on the NJ Exec Order 26.4b1 unit."
- NJ Exec Order 26.4b1 **Section:**
  Resident identified as an NJ Exec Order 26.4b1 risk following NJ Exec Order 26.4b1
  Interventions implemented:
  a. Transfer to secured NJ Exec Order 26.4b1 unit
  b. Increased staff NJ Exec Order 26.4b1
  c. NJ Exec Order 26.4b1 activities
  d. NJ Exec Order 26.4b1
  e. Encouragement of regular family visitation
- **ADLs Updated:**
  Assistance required for NJ Exec Order 26.4b1 care as needed, and NJ Exec Order 26.4b1 care.
- **Meals:**
  All meals to be eaten within the NJ Exec Order 26.4b1 unit.
- **Medication Administration:**
  Medications to be administered by NJ Exec Order 26.4b1 CMAs or nursing staff.

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- **[redacted] Needs:**
  Resident requires [redacted] and staff [redacted] to meals and activities from [redacted] care staff and on the [redacted] unit.

- **Change of Apartment**

- **[redacted] Book Updated**

- The resident's family, care staff, and attending physician were notified of the updated plan of care. Resident #1 is no longer a resident of the community.

- **How we will identify other residents having the potential to be affected by the same deficient practice:**
- All residents with a Nursing Assessment, Health Service Plan or Service Plan indicating the use of an electronic tracking device, have the potential to be affected by the deficient practice. On 10/9/25 the RN Wellness Director, nursing team and Executive Director reviewed the Assessments and Service Plans for all residents using an electronic tracking device. On 10/9/25 these residents were checked by the Executive Director to confirm they have an electronic tracking device in place.

- **Measures put in place or systemic changes made to ensure that the deficient practice will not recur:**
- A root cause analysis was conducted on 10/9/25 by the facility interdisciplinary team to identify the underlying cause of the deficient practice. It was determined through the root-cause analysis, there was a failure to follow the service plan based on nursing assessment due to lack of communication.
- On 10/9/25 a new system on service plan communication was put in place to ensure compliance as follows:
- The RN Wellness Director/designee will communicate updates/changes to the residents' health service plan and general service plan to the department heads during the clinical morning meeting.
- Clinical huddles will be conducted daily to communicate updates/changes on the health care plan/service plan of residents with electronic tracking devices to the staff.
- A list of residents (with their photo) who use an electronic tracking device will be maintained by the receptionist.

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• Any residents with new electronic tracking devices will be listed on the 24 hour report. • On 10/31/25 the Executive Director/designee educated all team members on the updated Wanderguard Policy. This education included use of electronic tracking devices, communication in clinical meetings and huddles, and the list of residents using Wander Protection equipment at the reception desk.
• **How the corrective actions will be monitored to ensure the deficient practice will not recur:** • The Executive Director or designee will conduct weekly audits of the electronic tracking devices on 5 residents for compliance to the health service plan for 3 months and monthly for 1 year. These audits will check placement, function and documentation of these devices. The results will be reported to the Quality Assurance Committee.

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13A010 Y1	A. Building B. Wing Y2	1/9/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS, THE	289 GORDONS CORNER ROAD MANALAPAN, NJ 07726

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 A0389 Reg. # 8:36-4.1(a)(16) LSC	Correction Completed 12/31/2025	ID Prefix A0775 Reg. # 8:36-7.5(a) LSC	Correction Completed 12/31/2025	ID Prefix Reg. # LSC	Correction Completed
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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 10/30/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: J0P212

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13A010 Y1	A. Building B. Wing Y2	1/9/2026 Y3

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