STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	**103 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint ID: 2620240, 2622045, 423030 Survey Date: 10/29/25 Census: 90 Sample: 9 The NJDOH conducted a Complaint survey on 10/29/25 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The survey was officially completed on 11/17/25. Deficiencies were cited for this survey.	F0000		11/26/2025
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure	F0580	Resident #1 had a[redacted] in the facility, the[redacted] did not immediatly inform the the primary physician as well as the responsible party in an appropriate time frame: 1 on 1 Inservice was given on 10/29/2025 by the Director of nursing to notify the residents primary physician and family about the incident[redacted] in proper time frame All residents have the potential to be affected by this deficient practice; however, no other residents were affected by this deficient practice The Administrator and Director of Nursing reviewed the investigation/fall policy on 10/29/2025, and there were no changes made to the policy. The Director of Nursing/ Designee in-service all other nursing staff on investigation and fall policy and procedure on 10/29/2025, The Director of Nursing/ Designee conducted on 10/29/2025 audits on fall protocol of notifying the primary physician and responsible party that happened in the previous day, weekly x4, and monthly x 1, and quarterly x 2. The results of this audit will be submitted to the administrator for review at the quality assurance performance meeting to ensure that this deficient practice will not recur	11/27/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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F0580 SS = D	Continued from page 1 that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: COMPLAINT # 423030 Refer to F0689 Based on interview, review of medical records and other facility documentation, it was determined that the facility failed to notify the U.S. FIOA (B)(6) and the U.S. FOIA (b) (6) about an NJ Ex Order 26 4B1 reported by the resident. This deficient practice was identified for 1 of 2 residents, Resident #1, reviewed for NJ Ex Order 26 4B1 . This deficient practice was evidenced by the following: On 10/28/25 at 9:30 AM, the surveyor requested from the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) all Facility Reported Event (FRE) investigations and a list of residents with NJ Ex O in the NJ Ex Order 26 4B1 .	F0580		

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F0580 SS = D	Continued from page 2 On 10/28/25 at 11:20 AM, the [redacted] provided the FRE investigations for the last [redacted] Resident #1 had [redacted] dated [redacted]. The surveyor reviewed a facility provided investigation dated [redacted] which indicated Resident #1 had an [redacted] for Resident #1 which occurred on [redacted]. The investigation conclusion and incident note revealed the following: On 4/30/25 at 7:15 AM, Resident #1 was seen by a [redacted]) at the bedside. At 7:50 AM, the [redacted] saw the resident and morning care was rendered by the [redacted]) with nothing unusual observed. At 9:30 AM, the [redacted] visited the resident for a [redacted] session in their room and the resident reported to the [redacted] that he/she [redacted] and [redacted] The [redacted] reported this to the resident's assigned [redacted]). The [redacted] went to check the resident. There was [redacted], or [redacted] The [redacted] applied the resident's routine [redacted] to their [redacted] site which was due to be given prior to their outpatient [redacted] treatments. The resident was sent out to their [redacted]. At approximately 3:00 PM, the facility received a call from the [redacted] stating that the resident was observed with [redacted] and was transferred to the emergency room (ER) for further evaluation. A review of the facility's investigation revealed that the [redacted] did not initiate an investigation as per the facility's [redacted] at the time of the resident's [redacted]. Additionally, there was no documentation that the [redacted] was informed at the time that the resident [redacted] A review of the Electronic Health Record (EHR) revealed Resident #1 was not in the facility. The Resident #1's EHR revealed diagnoses which included but were not limited to [redacted]	F0580		

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F0580 SS = D	Continued from page 3 NJ Ex Order 26 4B1 A review of the NJ Ex Order 26 4B1 order summary revealed: A physician's order for NJ Ex Order 26 4B1 on NJ Ex Order 26 4B1 and their NJ Ex Order 26 4B1 for NJ Ex Order 26 4B1 A physician's order for NJ Ex Order 26 4B1 that indicated to apply to the NJ Ex Order 26 4B1 in the NJ Ex Order 26 4B1 A physician's order for NJ Ex Order 26 4B1 NJ Ex Order 26 4B1 . A review of the comprehensive Minimum Data Set (MDS), a facility assessment tool to facilitate the plan of care, dated NJ Ex Order 26 revealed the resident's NJ Ex Order 26 4B1 using a Brief Interview of Mental Status (BIMS) test. Resident #1 scored a NJ Ex Order 26 4B1 which indicated the resident had NJ Ex Order 26 4B1 . On 10/28/25 at 2:40 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated if a resident had a NJ Ex Order 26 4B1 was reported, a NJ Ex Order 26 4B1 and vital signs were completed. The U.S. F explained the U.S. FOIA (b) (6) , the U.S. FOIA (b) (6) , and the U.S. F were to be notified of the incident; and the resident's care plan would be updated; and an incident report started. On 10/29/25 at 12:09 PM, the surveyor interviewed the U.S. FO , who was assigned to care for the resident on NJ Ex Order 26 for the 7AM to 3PM shift. The U.S. FOIA stated she recalled the U.S. FOIA informed her that Resident #1 stated that NJ Ex Order 26 , and she went to check on the resident. The U.S. FO stated that there was no change or NJ Ex Ord with the resident. The U.S. FOIA further explained that she applied NJ Ex Order 26 4B1 to the resident's NJ Ex NJ Ex Order 26.4(b)(1) as ordered and the resident was sent to NJ Ex Order 26 4B1 . The U.S. FOIA stated that the NJ Ex Order 26 4B1 called the facility and reported that the resident had a NJ Ex Order 26 4B1 and was going to the NJ Ex Order 26 4B1 . The U.S. FOI	F0580		

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F0580 SS = D	Continued from page 4 confirmed that she did not report to the supervisor, the resident's U.S. FOIA (b) (6) that Resident #1 NJ Ex Order 26 4B1 to a staff member. The U.S. FOI also confirmed that she did not initiate the facility's NJ Ex Order 26 4B1 protocol. On 10/29/25 at 2:00 PM, the surveyor interviewed the U.S. FOIA (b) who confirmed that he treated Resident #1 in their room for a NJ Ex Order 26 4B1 that day and the resident reported they had NJ Ex Or. The U.S. FOIA (b) further explained Resident #1 couldn't say when the NJ Ex Order 26 4B1 or what happened. The U.S. FOIA (b) stated that the resident NJ Ex Order 26 4B1 On 10/29/25 at 3:10 PM, the surveyor informed the U.S. FOIA (b and the U.S. FOIA (b) (6) regarding the concern that the NJ Ex Order 26 4B and the NJ Ex were not informed at the time that the resident reported NJ Ex Order 26 4B1 to the staff. The U.S. FOIA (b) (6) acknowledged that the U.S. FOIA did not follow the facility's NJ Ex Order 26 4B1. On 10/29/25 at 3:59 PM, the U.S. FOIA (b) (6) met with the surveyor. There was no additional information provided to the surveyor. A review of the undated facility policy titled, "Assessing Falls and Their Causes" which revealed under Steps in the Procedure After a Fall: #5 "Notify the resident's attending physician and family in an appropriate time frame." NJAC 8:39-13.1(c)(d)	F0580		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike	F0584	in the family room there were broken shades on the window which were taken down on 10/29/2025 and maintenance director in serviced the maintenance staff on making sure that work orders are being done in a timely fashion on 10/29/2025 on the ripple 2 entrance to the residents dining room there was broken wood on the frame which was fixed on 10/29/2025 and new corner guards were ordered and replaced on 11/18/2025 and maintenance director in serviced the maintenance staff on making sure that work orders are being done in a timely fashion on 10/29/2025	11/18/2025

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F0584 SS = D	Continued from page 5 environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Complaint #2622045 Based on observation, interview, and record review, it was determined that the facility failed to maintain residents' environment in a safe, clean, comfortable, and homelike surrounding. This deficient practice was identified for 1 of 9 residents reviewed, (Resident #3). The deficient practice was evidenced by the following: On 10/28/25 at 12:25 PM, the surveyor conducted the initial tour in the presence of the U.S. FOIA (b) (6) and observed the following:	F0584	Continued from page 5 in room NJ Ex Or there was a rip in the carpet between the carpet and the bathroom a rim was put down on 10/29/2025 in the entrance to the bathroom there was a sharp piece hanging by the molding which was removed on 10/29/25 and maintenance director in-service the maintenance staff on making sure that work orders are being done in a timely fashion on 10/29/2025 regarding resident #3 in room NJ Ex Orde there were ceiling tiles that were loose and not in its track and the maintenance fixed the ceiling tile on 10/29/2025 and U. S. FOIA (b) (2) in-service the maintenance staff on making sure that work orders are being done in a timely fashion on 10/29/2025 All residents have the potential to be affected by this deficient practice, however no other residents were affected by this deficient practice all nursing staff were in serviced by the maintenance director on 10/29/2025 how to use the maintenance electronic system to place work order and maintenance workers were in-service on preventive maintenance on 10/29/2025 by the maintenance director the maintenance director will review the electronic system 5 days a week for 1 month and there after quarterly x 2 and will do round 5 days a week for 3 months and there after quarterly x 1 to make sure that all issues of maintenance are being put into the electronic system this way they can be fixed right away The results of this audit will be submitted to the administrator and reviewed at the quality assurance performance improvement (QAPI) Meeting for two quarters for review and any further recommendations to ensure that this deficient practice will not reoccur	

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F0584 SS = D	Continued from page 6 1. In the family room, used by residents, near the [redacted] unit, the surveyor observed one broken window blind on the window. The [redacted] stated, “I don’t know how long it’s been like that, but I will have maintenance look at it.” The [redacted] further stated that he made rounds every day. The surveyor requested from the [redacted] for the Homelike Environment policy. 2. At 12:32 PM, on the [redacted] floor, in the main resident dining room entrance, the door’s frame had areas with broken wood on both of its sides. The [redacted] confirmed observation of the damaged door frame and stated he would put in a maintenance work order. 3. In room [redacted], by the bathroom entrance, the carpet was observed torn and frayed; and a sharp plastic piece was broken off the frame of the bathroom entrance. The surveyor and the [redacted] were joined by the [redacted] who stated, she did not notice the environmental concerns. The [redacted] explained that the process for work orders was to let the [redacted] know and they would contact maintenance staff. The [redacted] added that they previously submitted work orders through an electronic system and were currently transitioning to a new system. The [redacted] was not able to provide the surveyor documentation of any work orders entered for the issues observed in the main dining room and Room [redacted] On 10/28/25 at 3:42 PM, the [redacted] stated that they do not have a facility policy for Homelike Environment. 4. On 10/29/25 at 11:00 AM, the surveyor observed Room [redacted] on the [redacted] floor. The surveyor observed two ceiling tiles near the window loose and out of alignment. The surveyor observed Resident #3 lying in the bed and the resident stated that the tiles on the ceiling were loose and have been like that since [redacted]. The resident stated that [redacted] it may [redacted]. On 10/29/25 at 11:15 AM, the [redacted] assigned to Resident #3 accompanied the surveyor to the room to observe the ceiling tiles. The [redacted] confirmed the observation of the broken ceiling tiles and stated, “I’ve never noticed that… I will let maintenance know.”	F0584		

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F0584 SS = D	Continued from page 7 The surveyor reviewed the Resident #3's medical records which revealed diagnoses which included but were not limited to NJ Ex Order 26 4B1 [redacted] A review of a Quarterly Minimum Data Set (MDS), a facility assessment tool that facilitates the plan of care, dated NJ Ex Order 26, revealed the resident's cognition was assessed using a Brief Interview Mental Status (BIMS) score of NJ Ex Order 26 4B1 which indicated the resident NJ Ex Order 26 4B1. At 3:10 PM, the surveyor informed the U.S. FOIA (b) (6) of the observed concerns regarding homelike environment. There was no additional information provided to the surveyor. NJAC 8:39-31.4(a)	F0584		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: COMPLAINT #423030 and #2620240	F0610	The resident#1 was sent out for NJ Ex Order 26 while resident was at NJ Ex Order 26 the facility was notified that resident #1 NJ Ex Order 26 4B1 [redacted] but no investigation was initiated by the nurse who was in charge of the resident the director of nursing gave 1 to 1 inservice to the nurse assigned to resident #1 on initiating investigation and completing incident on NJ Ex Order 26 4B1 [redacted] and resident NJ Ex Order 26 4B1 was done by the rn assigned to resident #1 upon the return from the NJ Ex Order 26.4(b)(1) . the facility was notified that resident #2 had a NJ Ex Order 26 4B1 [redacted] and that a NJ Ex Order 26 4B hit resident #2 and resident #2 had a NJ Ex Order 26 4B1 on the NJ Ex Order 26 4B1 initiated and completed and no findings of NJ Ex Order and NJ Ex Order 2 substantiated but on investigation 72 hour look back statements from all staff interviewed were not obtained the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) was given 1 to 1 Inservice on 10/29/2025 on investigation policy on obtaining written statements from all staff from the 72 hour lookback period All residents have the potential to be affected by this deficient practice; however, there were no other residents affected by this deficient practice Regarding resident #1, the director of nursing/designee in-service all nurses on initiating investigation and completing the incident report on bruising and pain on	11/27/2025

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F0610 SS = D	Continued from page 8 Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to: a) conduct a thorough investigation to address an NJ Ex Order 26 4B1; and b) maintain documentation that a thorough investigation was conducted for an NJ Ex Order 26 4B1. This deficient practice was identified for 2 of 2 residents (Resident #1 and Resident #2), NJ Ex Order 26 4B1. This deficient practice was evidenced by the following: 1. On 10/28/25 at 9:30 AM, the surveyor requested from the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) all Facility Reported Event (FRE) investigations and a list of residents NJ Ex Order 26 4B and NJ Ex Order 26 in the last NJ Ex months. On 10/28/25 at 11:20 AM, the surveyor reviewed the resident's electronic medical record (EMR) which revealed the following: Resident #1 had diagnoses which included but were not limited to NJ Ex Order 26 4B1 . Resident #1 was no longer residing in the facility. A review of the NJ Ex Order 26 4B1 physician's order revealed an order for NJ Ex Order 26 4B1 or NJ Ex Order 26 4B1 and their NJ Ex Order 26 . A review of a comprehensive Minimum Data Set (MDS), a facility assessment tool to facilitate the plan of care, dated NJ Ex Order 26 revealed the resident's NJ Ex Order 26 4B was assessed using a Brief Interview of Mental Status (BIMS) test. Resident #1 scored a NJ Ex Order 26 4B1 which indicated the resident had NJ Ex Order 26 4B1 . A progress note dated 5/23/25 at 3:07 PM, written by Registered Nurse (RN) #1, indicated Resident #1's RR called and reported that the resident was noted at NJ Ex Order 26 4B1 and NJ Ex Order 26 4B1 . The note further revealed that the resident had been seen prior to NJ Ex Order 26 by the physician and a body assessment was done by RN #1 with NJ Ex Order 26 4B1 resident with NJ Ex . On 10/28/25 at 2:40 PM, the surveyor interviewed the U.S. FOIA (b) (6) on the process for new NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4 The U.S. FOIA (b) (6) stated that	F0610	Continued from page 8 10/29/2025, Regarding resident #2, the Director of Nursing/ Designee in-service all nurses on obtaining statements from the 72-hour look back from all staff that are providing care to that resident on NJ Ex Order 26 4B1 regarding resident #1 and #2 Director of Nursing / Designee gave in-service on abuse, neglect, and exploitation on 10/29/2025 Regarding resident #1, the director of nursing / Designee will conduct audits on skin impairment or discoloration and pain that incident protocol will be followed weekly x4 and monthly x 1and quarterly x 2. All findings of the audit will be submitted to the administrator and reviewed at the QAPI meeting to ensure that this deficient practice does not recur Regarding resident #2, the Director of Nursing / Designee will conduct an audit on obtaining written statements on 72-hour look back on all incidents/ accidents weekly x4, monthly x 1, and quarterly x 2. All findings of the audit will be submitted to the administrator and reviewed at the QAPI meeting to ensure that this deficient practice does not recur	

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F0610 SS = D	Continued from page 9 if a resident was reported to have bruising or any new NJ Ex Order 26.4(b)(1) the resident would be assessed; the supervisor, the U.S. FOIA the U.S. FOIA (b) (6), and the U.S. F would be notified; and the resident's care plan would be updated. On 10/28/25 at 4:30 PM, the surveyor requested from the U.S. FOIA any investigation for Resident #1 regarding the NJ Ex Order 26 4B1 reported by the U.S. FO or NJ Ex Order 26. On 10/28/25 at 5:03 PM, the U.S. FOIA informed the surveyor that she could not find any investigation for the report of Resident #1's NJ Ex Order 26 4B1. The U.S. FOIA stated the nursing staff should have called the NJ Ex Order 26 4B1 to follow up and completed a full investigation which was the facility's protocol for any NJ Ex Orde found or reported. On 10/29/25 at 9:00 AM, the U.S. FOIA provided a NJ Ex Order 26.4(b)(1) assessment form for Resident #1 dated NJ Ex Order 26, which was completed by RN#2. The assessment revealed the NJ Ex Orc was completed on 3PM to 11PM shift and documented NJ Ex Order 26 4B1 noted, NJ Ex Order 26 4B1 On 10/29/25 at 12:25 PM, the surveyor interviewed the primary License Practical Nurse (LPN) #1, who the U.S. FOIA confirmed was assigned to Resident #1 on NJ Ex Order 26 during the 7AM to 3PM shift. She stated that she did a NJ Ex Or before the resident NJ Ex Order 26 4B1 and when they NJ Ex Order 26 4B1. LPN #1 stated the resident did not complain of NJ Ex Order 26 4B1 or have any NJ Ex Order 26 4 before leaving and when they arrived back from NJ Ex Order 26. On 10/29/25 at 12:35 PM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who was assigned to Resident #1 on 5/23/25 for the 7AM to 3PM shift. CNA #1 stated the facility's protocol was to report immediately NJ Ex Order 26 4B1 She further stated that the U.S. F called from the NJ Ex Order 2 center to say that Resident #1 had NJ Ex Order 26 4B1. On 10/29/25 at 12:50 PM, the U.S. FOIA informed the surveyor that there were NJ Ex Order 26 4B1 found for Resident #1 for NJ Ex Order 2. On 10/29/25 at 3:10 PM, the surveyor informed the U.S. FOIA (b) and the U.S. FOIA of the concern that there was no investigation completed regarding the U.S. FOIA report that Resident #1 had NJ Ex Order 26 to their NJ Ex Order 2. The U.S. FOIA acknowledged that a thorough investigation should have been completed. 2. On 10/28/25 at 12:56 PM, the surveyor reviewed the	F0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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F0610 SS = D	Continued from page 10 EMR of Resident #2. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1) [redacted]). A quarterly MDS assessment, an assessment tool to facilitate the management of care, with an Assessment Reference Date of NJ Ex Order 26, indicated the facility assessed the resident's cognition using a BIMS test. Resident #2 scored an NJ out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) . A progress note dated NJ Ex Order 26, written by LPN #2 indicated approximately 2:10 PM, one of Resident #2's representative reported to the nurse that the resident was NJ Ex Order 26 4B1 last night. The resident was assessed and had a NJ Ex Order 26 4B1 [redacted] The U.S. FOIA documented "…Area around the NJ Ex Order 26.4(b) appears NJ Ex Order 26.4(b)(1) …" and the U.S. FOIA (b) (6)), the physician, and the U.S. FOIA (b) (6)) were notified. The resident was transferred to the hospital for further evaluation and treatment. A follow up progress note dated NJ Ex Order 26.4(b)(1) the resident was admitted to the hospital with a diagnosis NJ Ex Order 26 4B1 [redacted] The surveyor reviewed the facility provided investigation for the NJ Ex Order 26 incident which included the following: -A summary of the investigation which included interventions and a conclusion. The summary indicated the RR stated Resident #2 told them a NJ Ex Order 26.4(b)(1) [redacted] them. The summary documented "a 72 hour look back was initiated all staff were interviewed". Additionally, two CNAs (CNA #2 and CNA #3) who fit the description of the NJ Ex Order 26.4(b)(1) and were assigned to care for resident during the 72-hour lookback were suspended pending the investigation on NJ Ex Order 26. -A completed AAS-45, a "Reportable Event Record/Report", dated NJ Ex Order 26 to the New Jersey Department of Health (NJDOH) which indicated the incident was called in to the NJDOH by the facility on NJ Ex Order 26 at 4 PM.	F0610		

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F0610 SS = D	Continued from page 11 - The facility's investigation included statements from LPN #2, Registered Nurse/Nurse Supervisor (RN/NS), CNA #2, and interviews with seven residents on the unit regarding care by CNAs. There was no statement by CNA #3 and there were missing statements with the investigation for the 72-hour lookback of the incident as follows: The surveyor did not see a statement from the nurse who cared for the resident on NJ Ex Order 2, 7-3 shift. The surveyor did not see a statement from the nurse who cared for the resident on NJ Ex Order 2, 3-11 shift. The surveyor did not see a statement from the CNA who cared for the resident on NJ Ex Order 26. 7-3 shift. The surveyor did not see a statement from the CNA who cared for the resident on NJ Ex Order 2, 3-11 shift. The surveyor did not see a statement from the CNA who cared for the resident on NJ Ex Order 2, 11-7 shift. The surveyor did not see a statement from the nurse who cared for the resident on NJ Ex Order 26, 3-11 shift. The surveyor did not see a statement from the nurse who cared for the resident on NJ Ex Order 26, 11-7 shift. The surveyor did not see a statement from the CNA who cared for the resident on NJ Ex Order 2, 7-3 shift. The surveyor did not see a statement from the CNA who cared for the resident on NJ Ex Order 2, 3-11 shift. The surveyor did not see a statement from the CNA who cared for the resident on NJ Ex Order 26.4 11-7 shift. The surveyor did not see a statement from the nurse who cared for the resident on NJ Ex Order 26.4 3-11 shift. The surveyor did not see a statement from the CNA who cared for the resident on NJ Ex Order 2, 7-3 shift. The surveyor did not see a statement from the CNA who cared for the resident on NJ Ex Order 26.4 7-3 shift. On 10/28/25 at 12:53 PM, the surveyor interviewed the U.S. FOIA (b) who stated the facility went back 72 hours prior to the incident to interview and obtain statements from the staff who were assigned to the resident. The surveyor informed the U.S. FOIA (b) of the concern that the statement for CNA #3 and additional staff statements	F0610		

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F0610 SS = D	Continued from page 12 was not found with the investigation. The U.S. FOIA (b) stated that they did obtain CNA #3's statement, all staff were interviewed and that there should be written statements. The U.S. FOIA (b) stated he would provide additional information. On 10/29/25 at 9:40 AM, the U.S. FOIA (b) provided a statement by CNA #3. There were no additional statements provided by the U.S. FOIA (b). On 10/29/25 at 1:50 PM, the U.S. FOIA (b) (6) met with the surveyors. The U.S. FOIA (b) and the U.S. FOIA (b) confirmed for a 72-hour lookback, statements from all staff interviewed should be obtained. The U.S. FOIA (b) stated that he did interview all staff but did not obtain written statements from them. There was no additional information provided by the facility's management. The surveyor reviewed the facility's policy titled "Freedom from Abuse Neglect and Exploitation" with a last revised date of October 2022 revealed, "The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation, or mistreatment: Thoroughly investigate the alleged violation." Under Policy Interpretation and Implementation revealed: "…Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations…and providing complete and thorough documentation of the investigation…" NJAC 8:39-4.1(a)(5)	F0610		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Complaint #423030, and #2622045 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that proper NJ Ex Order 26.4(b)(1) care was provided to 1 of 3 residents (Resident #5) reviewed for NJ Ex Order 26.4(b)(1)	F0677	Resident #5 was found to be NJ Ex Order 26 4B1 , even though it was not requested and care planned for the resident. Resident #5 was changed to NJ Ex Order 26.4(b)(1 by the U.S. FOIA (The assistant Director of nursing inserviced the assigned U.S. FOIA on NJ Ex Order 26 4B1 on not using NJ Ex Order 26 4B1 All residents have the potential to be affected by this deficient practice. However, there were no other residents affected by this deficient practice The DON/ Designee inserviced all other nursing staff on not using NJ Ex Order 26, 4B1 . the Don/ Designee inserviced al U.S. FOIA on incontinent care including how to check residents that need to be changed, and how frequently residents are being checked or changed for incontinence on 10/28/2025 and is ongoing Director of nursing/ designee inserviced nurses on updating care plan for all incontinent residents	11/27/2025

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F0677 SS = D	Continued from page 13 This deficient practice was evidenced by the following: On 10/28/25 at 10:46 AM, the surveyor conducted NJ Ex Order 26 4B1 rounds with the U.S. FOIA (b) (6) on randomly selected residents who were NJ Ex Order 26 4B1. Resident #5 was observed resting in their bed covered with blankets. The resident was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) to speak with the surveyor. Resident #5 stated that they were waiting for their assigned U.S. FOIA (b) (6)) to return to provide hygiene care. Resident confirmed they were NJ Ex Order 26 4B1 The surveyor asked Resident #5 when they last received NJ Ex Order 26 4B1 and had their NJ Ex Order 26 4B1 changed. The resident replied, NJ Ex Order 26 4B1 " and could not recall NJ Ex Order 26 4B The surveyor asked the resident if they were NJ Ex Order 26 4B1 . The resident replied not yet, and that the U.S. FOIA was returning to NJ Ex Order 26 4B1. Resident #5 was agreeable for the U.S. FOIA (b) with the surveyor present to check their NJ Ex Order 26 4B1. Upon the U.S. FOIA (b) removing the blanket off the resident, the surveyor and U.S. FOIA (b) observed the resident had on two incontinent briefs. The NJ Ex Order 26.4(b) was NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b) was NJ Ex Order 26.4(b)(1). The NJ Ex Order 2 The U.S. FOIA (b) asked the resident if they requested to NJ Ex Order 26 4B1 The resident stated that the CNAs used the NJ Ex Order 26 4B1, and the resident was ok with it because they don't NJ Ex Order 26.4(b)(1) at times and was worried of NJ Ex Order 26 4B1 . The surveyor asked Resident #5 if the resident initially requested to have the NJ Ex . The resident replied that they did not initially request to have NJ Ex Order 26 4B1 that the U.S. FOIA would NJ Ex Order 26 4B1, and they thought it was ok. After exiting the room, the U.S. FOIA (b) stated that some residents may request to use NJ Ex Order 26 4B1 at a time and would have to check if it was documented in the resident's care plan. The U.S. FOIA (b) provided the U.S. FOIA assignment for the shift which included important information about the residents such as, their assistant needs, NJ Ex Order 26 4B1, and other pertinent information. There was no documentation that indicated Resident #5 preferred or requested the use of NJ Ex Order 26 4B1. On 10/28/25 at 11:03 AM, the surveyor interviewed Resident #5's assigned U.S. FOIA who stated that at the start of the shift, after receiving her assignment, she	F0677	Continued from page 13 that wishes to use double incontinent briefs after the residents are educated on risks and benefits on use of double incontinent briefs on 10/28/2025 : administrator and Director of nursing reviewed the incontinent care policy and procedure and updated adding the no double incontinent unless requested by resident on 10/30/2025 The DON /designee will conduct audit on 5 incontinent residents on the use of double incontinent briefs per week for 4 weeks and then 10 incontinent resident x 1 month and then quarterly x 2 of 10 incontinent residents all findings the results of this audit will be submitted to the Administrator and reviewed at the quality assurance performance meeting to ensure that this defiecieant practice will not reoccur	

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F0677 SS = D	Continued from page 14 would round to check on assigned residents to make sure they were ok and if they were soiled, she would come back to clean them. The surveyor asked the U.S. FOIA how often she rounded on assigned residents to check if residents needed NJ Ex Order 26 4B1 The U.S. FOIA replied two to three times on the shift. The surveyor asked the U.S. FOIA about Resident #5. The U.S. FOIA confirmed she was the resident's assigned U.S. FOIA and that on morning rounds the resident was checked and didn't need any assistance. The U.S. FOIA further explained she answered the resident's call light at approximately 10:38 AM. The U.S. FOIA stated that Resident #5 thought they had the NJ Ex Order 26.4(b)(1) , but it NJ Ex Order 26.4(b)(and the U.S. FOIA told the resident that she would return to provide hygiene care as she was taking care of another resident. The surveyor asked the U.S. FOIA if she checked the resident's NJ Ex Order 26.4(b)(1) at that time. The U.S. FOIA replied that she did. The surveyor asked the U.S. FOIA how she checked the resident's NJ Ex Ord The U.S. FOIA replied that she felt the outside of the NJ Ex Order 26 4B1 . The U.S. FOIA further explained that she knew the resident was NJ Ex from the NJ Ex Order 2 of the NJ Ex Order 26 4B1 because if they were NJ Ex Order 26 4B1 The surveyor asked the U.S. FOIA about the use of NJ Ex . The U.S. FOIA replied that staff were supposed to use NJ Ex Order 26 4B1 but the residents could NJ Ex Order 26 4B1 . The U.S. FOIA further explained some residents have special requests and Resident #5 liked to NJ Ex Ord a NJ Ex Order 26 4B1 . On 10/28/25 at 11:45 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #5. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26 4B1 . A quarterly Minimum Data Set (MDS) assessment, an assessment tool to facilitate the management of care, with an Assessment Reference Date of NJ Ex Order 26 4 indicated the facility assessed the resident's NJ Ex Order 26 4B1 using a Brief Interview Mental Status (BIMS) test. Resident #5 scored a NJ Ex Order 26 4B1 , which indicated the resident was NJ Ex Order 26 4B1 . A BIMS Assessment dated NJ Ex Order 26 4B revealed Resident #5	F0677		

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F0677 SS = D	Continued from page 15 scored a NJ Ex Order 26 4B1, indicating the resident was NJ Ex Order 26 4B1 A care plan with a focus area on NJ Ex Order 26 4B1, last revised on NJ Ex Order 26 4, included the intervention "Check the resident as per protocol and as required for NJ Ex Order 26.4(b)(1) There was no intervention documented that the resident preferred or requested NJ Ex [redacted] A care plan with a focus area on NJ Ex Order 26 4B1, last revised on NJ Ex Order 26 4 included interventions: "Check resident every two hours and NJ Ex Order 26.4(b)(1) as needed"; and 'NJ Ex Order 26 4B1 [redacted], and initiate toileting schedule if indicated". There was no intervention documented that the resident preferred or requested NJ Ex Order 26 4B1. A care plan with a focus area on NJ Ex Order 26.4(b)(1) [redacted] performance deficit, last revised on NJ Ex Order 26.4, included interventions: "The resident is NJ Ex Order 26.4(b)(1) on 1 staff to provide NJ Ex Order 26.4(b)(1)"; "The resident is NJ Ex Order 26.4(b)(1) on 1 staff for NJ Ex Order 26.4(b) "The resident requires NJ Ex Order 26.4(b)(1) by 1 staff with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) and "The resident is NJ Ex Order 26.4(b)(1) on staff for NJ Ex Order 26.4". Additional review of the resident's medical record including the care plan revealed no documentation that the resident preferred or requested the use of NJ Ex [redacted] On 10/28/25 at 12:25 PM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] regarding NJ Ex Order 26 4B1 The U.S. FOIA stated staff were expected to round on residents at least every two hours and check if NJ Ex Order 26 4B1 or NJ Ex Order 26 was needed. The U.S. FOIA stated more than NJ Ex Order 26 4B1 should not be applied to the resident unless the resident requested it. The U.S. FOIA continued to explain that if the resident requested or preferred NJ Ex Order 26 4B1 the resident should be educated on the risks for NJ Ex Order 26.4(b) NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1). The U.S. FOIA stated if the resident still wished to use NJ Ex Order 26 4B1 it should be documented in their care plan regarding their preference. The surveyor informed the U.S. FOIA of the above concerns for Resident #5's NJ Ex Order 26.4(b)(1) during rounds with the U.S. FOIA (b) (6) the interview with the U.S. FOIA, and that no documentation was found to indicate that the resident requested to use NJ Ex Order 26 4B1. The U.S. FOIA acknowledged the NJ Ex Order 26 4B1 concerns. On 10/29/25 at 4:59 PM, the surveyor informed the	F0677		

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F0677 SS = D	Continued from page 16 U.S. FOIA (b) (6) and the U.S. FOIA about the concern related with Resident #5's NJ Ex Order 26 4B1 There was no additional information provided by the facility's administration. A review of an undated policy titled "Incontinent Care" revealed, "It is the policy of [facility name] that incontinent residents will be maintained clean and dry". A review of the facility's policy titled "Care planning" with an effective date of 11/1/19 revealed under Policy: "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient." Under Procedure of the policy revealed: "…5. Care plans will be updated on an ongoing basis as changes in the patient occur…" A review of an undated facility provided policy and procedure titled "Incontinence Care" revealed: "Take all incontinent residents to the bathroom or put on the bedpan before and after meals and at least every two hours between meals." The policy did not address use of incontinent brief. NJAC 8:39- 27.2 (h)	F0677		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: COMPLAINT # 423030 Based on interview, review of medical records and other	F0689	Resident #1 had a fall in the facility which the resident notified the U.S. FOIA who notified the LPN, but the LPN did not initiate an investigation on fall, and did not inform the primary physician as well as the responsible party: 1 on 1 Inservice was given to the U.S. FOIA by the director of nursing All residents have the potential to be affected by this deficient practice, however no other residents were affected by this deficient practice The Administrator and DON reviewed the investigation/ fall policy and there were no changes made to the policy The director of nursing/ designee in-service all other nursing staff on the investigation and fall policy and procedure on 10/29/2025 and is ongoing	11/27/2025

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F0689 SS = D	Continued from page 17 facility documentation, it was determined that the facility failed to comprehensively investigate a resident reported fall to ensure resident safety according to the facility's policy. This deficient practice was identified for 1 of 1 resident (Resident #1) reviewed for falls and accidents. This deficient practice was evidenced by the following: On 10/28/25 at 9:30 AM, the surveyor requested from the U.S. FOIA (b) (6)) all Facility Reported Event (FRE) investigations and a list of residents with NJ Ex O and NJ Ex Order 2 in the last six months. On 10/28/25 at 11:20 AM, the U.S. FOIA (provided the FRE investigations for the last six months. Resident #1 had one FRE investigation dated NJ Ex Order 2 for NJ Ex Order 26.4(b)(1 which occurred on NJ Ex Order 26. The surveyor reviewed a facility provided investigation dated NJ Ex Order 2 which indicated Resident #1 had an NJ Ex Orde for Resident #1 which occurred on NJ Ex Order 26.4 The investigation conclusion and incident note revealed the following: On 4/30/25 at 7:15 AM, Resident #1 was seen by a U.S. FIOA) at the bedside. At 7:50 AM, the primary nurse saw the resident and morning care was rendered by the U.S. FOIA (b) (6) with nothing unusual observed. At 9:30 AM, the U.S. FOIA (b) (6)) visited the resident for NJ Ex Order 26.4(in their room and the resident reported to the U.S. FOIA (that he/she NJ Ex Order 26.4(and complained of NJ Ex Order 26 NJ Ex Orde The U.S. FOIA (reported this to the resident's assigned U.S. FOIA (b) (6)). The U.S. FOI went to check the resident. There was no NJ Ex Order 26.4 or any previous NJ E reported. The U.S. FOI applied the resident's routine NJ Ex Order 26.4(b)(1) to their NJ Ex Order 26.4(b)(1) which was due to be given prior to their outpatient NJ Ex Order 2 treatments. The resident was sent out to their scheduled NJ Ex Order 2 session. At approximately 3:00 PM, the facility received a call from the NJ Ex Order 2 center stating that the resident was observed with NJ Ex Order 26.4(b)(1) and was transferred to the emergency room (ER) for further evaluation. The family was in the NJ Ex Order 2 center when the resident was transferred to the hospital, and then the physician was made aware by the facility of the resident's ER transfer.	F0689	Continued from page 17 The DON /designee will conduct audit on incidents and accidents that happen in the previous day: Weekly x 4 and thereafter quarterly x 2. The results of this audit will be submitted to the administrator and reviewed at the quality assurance performance improvement (QAPI) Meeting for two quarters for review and any further recommendations to ensure that this deficient practice will not reoccur	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 18 A review of the facility's investigation revealed that the U.S. FOI did not initiate an investigation as per the facility's NJ E protocol at the time of the resident's reported NJ Ex. Additionally, there was no documentation that the physician or U.S. F was informed at the time that the resident reported NJ Ex Order A review of the Electronic Health Record (EHR) revealed the Resident #1 was not in the facility. Resident #1's EHR revealed diagnoses which included but were not limited to NJ Ex Order 26 4B1 [redacted] A review of the comprehensive Minimum Data Set (MDS), a facility assessment tool to facilitate the plan of care, dated NJ Ex Order 26 revealed the resident's cognition using a Brief Interview of Mental Status (BIMS) test. Resident #1 scored a NJ Ex Order 26 4B1 which indicated the resident had NJ Ex Order 26 4B1 A review of the NJ Ex Order 26 4B1 order summary revealed: A physician's order for NJ Ex Order 26 4B1 [redacted] A physician's order for NJ Ex Order 26 4B1 that indicated to apply to the NJ Ex Order 26 4B1 [redacted] A physician's order for NJ Ex Order 26 4B1 five times per week for four weeks. On 10/28/25 at 2:40 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated if a resident had a NJ Ex Order 26 4B1 was reported, a NJ Ex O assessment and vital signs were completed. The U.S. F [redacted] explained the supervisor, the U.S. FOIA, the physician, and the U.S. FO were to be notified of the incident; and the resident's care plan would be updated; and an incident report started. On 10/29/25 at 11:52 AM, the surveyor interviewed the U.S. FOIA who was assigned to Resident #1 on NJ Ex Order 26. 7AM to 3PM shift. The U.S. FOIA confirmed that she was assigned to care for the resident and stated that the resident had	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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F0689 SS = D	Continued from page 19 NJ Ex Order 26 4B1 before they left for their appointment. On 10/29/25 at 12:09 PM, the surveyor interviewed the U.S. FOIA who was assigned to care for the resident on 4/30/25 for the 7AM to 3PM shift. The U.S. FOIA stated she recalled the U.S. FOIA A informed her that Resident #1 stated that they fell, and she went to check on the resident. The U.S. FOI stated that there was no change or NJ Ex Ord with the resident. The U.S. FOIA further explained that she applied lidocaine topical cream to the resident's NJ Ex access site as ordered and the resident was sent to NJ Ex Order 26 4B1. The U.S. FOI stated that the NJ Ex Order 26 4B1 called the facility and reported that the resident had a NJ Ex Order 26 4B1 and was going to the ER for evaluation. The U.S. FOIA confirmed that she did not report to the supervisor, the resident's physician and the U.S. FO that Resident #1 reported having a fall incident to a staff member. The U.S. FOI also confirmed that she did not initiate the facility's NJ Ex Order 26 4B1. On 10/29/25 at 2:00 PM, the surveyor interviewed the U.S. FOIA (D who confirmed that he treated Resident #1 in their room for NJ Ex Order 26 session that day and the resident reported they had NJ Ex Ord. The U.S. FOIA A further explained Resident #1 couldn't say when the NJ Ex Order 26 4B1 or what happened. The U.S. FOIA A stated that the resident complained of NJ Ex Order 26 4B1 NJ Ex Order 26.4(b)(1) and observed NJ Ex Order 26 4B1. On 10/29/25 at 3:10 PM, the surveyor informed the U.S. FOIA (D and the current U.S. FOIA regarding the concern that the U.S. FOI did not initiate an investigation as per facility NJ Ex protocol when the U.S. FOIA (D informed her that the resident said they NJ Ex C The current U.S. FOIA acknowledged that the U.S. FOI did not follow the facility's NJ Ex investigation protocol. On 10/29/25 at 3:59 PM, the U.S. FOIA A and the U.S. FOIA (D met with the surveyor. There was no additional information provided to the surveyor. A review of the undated facility policy titled, "Assessing Falls and Their Causes" revealed under Purpose, "The purpose of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall." NJAC 8:39-27.1(a)	F0689		
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)	F0806	Resident #4 had a meal ticket that stated pancakes for breakfast and resident #4 didn't receive pancakes which was listed on the meal ticket.	11/27/2025

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F0806 SS = D	Continued from page 20 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Repeat Deficiency Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to ensure a resident's dietary preferences were honored for 1 of 4 residents (Resident #4) reviewed for food concerns. This deficient practice was evidenced by the following: On 10/28/25 at 10:40 AM, the surveyor accompanied by the[redacted] were conducting [redacted]. Resident #4 was observed lying in their bed with the head of the bed elevated. The resident was [redacted] and [redacted]. Resident #4 had a meal tray on their overbed table positioned in front of them. Resident #4 stated they only received cereal and biscuit on their tray and nothing else. The resident further explained that they were also supposed to receive pancakes on their tray and another staff already went to follow up with the kitchen. Resident #4 stated that this was not the first time that they did not receive food items ordered on their meal tray. The [redacted] informed the resident she would follow up with the staff regarding their pancakes. On 10/28/25 at 12:56 PM, the surveyor reviewed the electronic medical record (EMR) of Resident #4. The Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to [redacted]. A quarterly Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated [redacted] indicated the facility assessed the resident's	F0806	Continued from page 20 The dietary aid failed to ensure that all items listed on the meal ticket are present on the resident's food tray. The director of the kitchen gave a 1 to 1 Inservice to the dietary aid on tray accuracy which includes checking and ensuring that the food on the tray matches the meal ticket. Resident was offered an alternative but resident #4 did not want the alternative and requested a sandwich which was given on 10/28/2025 All residents have the potential to be affected by this deficient practice, however no other residents were affected by this deficient practice The kitchen director reviewed with the kitchen staff policy and procedure of tray accuracy. Inservice the dietary aid responsible for the tray accuracy on 10/28/25 and the kithchen director Inservice all other kitchen staff on 10/28/2025 for tray accuracy The kitchen Director/ designee will conduct an audit on tray accuracy daily for 4 weeks and thereafter monthly x1 and quarterly x 2. The results of this audit will be submitted to the administrator and reviewed at the quality assurance performance (QAPI) meeting to ensure that this deficient practice will not reoccur	

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F0806 SS = D	Continued from page 21 cognition using a Brief Interview Mental Status (BIMS) test. Resident #4 scored a [NJ Ex Order 26 4B1] which indicated the resident was [NJ Ex Order 26 4B1] A physician's order dated [NJ Ex Order 26] revealed the resident was on a [NJ Ex Order 26, 4B1] On 10/29/25 at 10:19 AM, the surveyor interviewed the [U.S. FOIA (b)] to follow up on the resident's breakfast yesterday. The [U.S. FOIA (b)] stated after following up with the kitchen, the resident did not receive pancakes. The [U.S. FOIA (b)] further explained that the kitchen did not have it, and the resident was given a sandwich as a substitute. The [U.S. FOIA (b)] acknowledged the resident should have received what was listed on the meal ticket for their meal. On 10/29/25 at 2:18 PM, the surveyor informed the [U.S. FOIA (b) (6)]), and the [U.S. FOIA (b) (6)]) of the above concern for Resident #4 not receiving the food ordered and what was listed on their meal ticket for their breakfast meal. The [U.S. FOIA (b)] stated the resident's food was substituted. The surveyor asked if prior to receiving their breakfast tray, was the resident informed that their pancakes were not available and provided substitution options as the resident had received their meal tray without pancakes or its substitute. There was no further verbal response from the facility at this time. On 10/29/25 at 3:59 PM, the [U.S. FOIA (b)] and the [U.S. FOIA] met with the survey team. There was no additional information provided to the surveyor. The surveyor reviewed the facility provided policy titled, "Dining and Food Preferences" with a last review date of October 2022. Under Policy Statement revealed: "Individual dining, food, and beverage preferences are identified for all residents/patients". Under Procedures revealed: "…The alternate meal and/or beverage selection will be provided in a timely manner…" NJAC 8:39-17.4 (e); 27.1 (a)	F0806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	**103 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052**

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		11/26/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #423030 and #2622045 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey for 4 of 28-day shifts. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:	S0560	The facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey for 4 of 28-day shifts the employees that were scheduled to work those day shifts called out and the supervisor asked the employees of the previous shift if they would like to pick up the available shift, but no one picked up. the Director of nursing/ Assistant Director of nursing gave Inservice to the staffing coordinator and supervisor on reaching out to our contracted agencies on 11/18/2025 and is ongoing all residents are potentially affected by this deficient practice Director of nursing / Designee will continue to review staffing needs with staffing coordinator and supervisors daily to ensure adequate staffing on all shifts to assure mandatory staffing is maintained. Staffing coordinator /Designee will continue to maintain a recruitment and hiring log, to track all CNA applicants and outcomes. educate staffing coordinator and supervisors to reach out to the contracted agencies for staffing needs, and facility to continue to offer incentive referral bonus to ensure positively attracting staff and offering bonuses to our regular staff for picking up extra shifts	11/27/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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S0560	Continued from page 1 (1) one certified nurse aide to every eight residents for the day shift. (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... 1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for one week of staffing from 05/25/2025 to 05/31/2025, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -05/25/25 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.	S0560	Continued from page 1 DON/Designee will review staffing reports daily and preform weekly audits on CNA staffing levels for the first 3 months and then quarterly thereafter any negative findings will have immediate corrective actions taking by the DON/ Designee and reported to the Administrator. All findings of the audits will be presented to the facility QAPI meeting for monthly for 3 months then quarterly thereafter for 12 months	

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S0560	Continued from page 2 -05/26/25 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. 2. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for one week of staffing from 09/07/2025 to 09/13/2025, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -09/09/25 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. 3. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for two weeks of staffing from 10/12/2025 to 10/25/2025, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -10/20/25 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. On 10/28/25 at 1:38 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that the staffing schedule was on the resident census and what the needs were on the units. She stated that they used agency staff and asked facility staff to fill in for call outs. The SC stated that the facility was meeting minimum staffing requirements. The SC stated she was familiar with the New Jersey state regulations for CNA to resident ratios. The SC explained there should be at least 1 CNA:8 residents for day shift; 1 CNA:10 residents for evening shift; and 1 CNA:14 residents for night shift. A review of the most recent facility policy titled “Staffing Policy” dated January 2024 revealed under Purpose, “To ensure adequate staffing to meet the physical, emotional, and psychosocial needs of residents in compliance with Federal and State regulations.”	S0560		

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/22/2025 in relation to the 10/29/2025 complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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

New Jersey State Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/22/2025 in relation to the 10/29/2025 State of New Jersey complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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