STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH , OLD BRIDGE, New Jersey, 08857**

(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 # 2963484 STANDARD SURVEY: 4/21/26 to 4/27/26 CENSUS: 101 SAMPLE SIZE: 34 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F0000		05/06/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for	F0812	F 812: Procurement, Store/Prepare/Serve-Sanitary 1) Immediate Corrective Action: The Director of Dining Services removed the stacks of pans that were wet-nested to the pot washing area to be rewashed. 2) How will you identify other residents that have the potential to be affected by the same deficient practice: All residents have the potential to be affected. 3) What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur: Policy SAN 110 “Sanitizing of Equipment” will be reviewed with dietary staff; all dietary staff to be in-serviced to this policy and specifically to the proper use of drying racks so that all pans and other items are air dried without wet-nesting. In-service to be completed by Director or Dining Services or designee and to be completed by 5/8/26.	05/08/2026

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

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

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F0812 SS = F	Continued from page 1 food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interview, and review of facility provided documents, it was determined that the facility failed to maintain proper kitchen sanitation practices to prevent the development of food borne illness. This deficient practice was evidenced by the following: On 4/21/26 at 9:50 AM, during a tour of the kitchen with the U. S. FOIA (b) (2)), the surveyor observed a stainless steel utility rack with stacked pans on each shelf, all turned upside-down. The U.S. FOI identified this as the pan rack. The surveyor observed the following: 1. Eleven pans stacked together on the second shelf from the top. The U. S. FOIA identified these as "2-inch full size pans." The U. S. FOIA separated the 2nd and 3rd pans in the stack which revealed they were dripping a clear thin liquid. The pans were visibly wet on the inside and outside surfaces. The U. S. FOIA acknowledged the pans should not be stacked together while wet, and acknowledged they were improperly wet-nested (the practice of stacking or storing recently washed dishes or kitchenware while still wet, creating a moist environment that promotes bacterial growth). The U. S. FOIA removed the stack of pans to the pot washing area to be rewashed. 2. Two pans stacked together on the top rack identified by the U. S. FOIA as "4-inch-deep chafing pans." When removed from the shelf and separated by the U. S. FOIA, these pans were visibly wet and dripping. The U. S. FOIA stated his staff was responsible for putting items from the dishwasher onto a drying rack, then once dry, the pans were moved to the pan rack. The U. S. FOIA acknowledged the chafing pans were still wet when stacked on the pan rack. The U. S. FOIA removed them to the pot washing area to be rewashed. At 10:30 AM the surveyor observed seven (7) pans stacked together right-side-up on the counter in front of the cooking area. The U. S. FOIA stated the pans were set there to be used for lunch and identified these as "2-inch half pans." The U. S. FOIA separated the pans, which were visibly wet on the inside and outside surfaces between them. The U. S. FOIA acknowledged they were wet-nested. The U. S. FOIA removed them to the pot washing area to be	F0812	Continued from page 1 Food Service Director or designee to make rounds of the kitchen and visually observe and inspect the drying racks for items improperly placed and wet-nesting. This will be done daily for one week, then three times a week for three weeks and then once a week for two months. 4) How will the corrective action be monitored: Food Service Director or designee will complete a visual audit of the dish room and the drying racks to observe for incidents of wet-nesting. This audit will be completed weekly for 3 months as part of a QAPI plan. These audits will be presented to the facility's QAPI Committee for three months for review and to determine if need for further action/additional auditing/staff education is necessary on behalf of the residents.	05/08/2026

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F0812 SS = F	Continued from page 2 rewashed. On 4/23/26 at 8:46 AM, in the presence of the [U. S. FOIA] the surveyor observed several pans stacked upside-down on the pan rack. The [U. S. FOIA] separated a stack of pans identified as "half pans" on the second shelf from the top, which revealed visible moisture between the pans. The [U. S. FOIA] acknowledged the pans were not completely dried before being stacked. The [U. S. FOIA] removed the stack of pans to the pot washing area to be rewashed. On 4/27/26 at 10:27 AM, the [U. S. FOIA (b) (2)] and the [U. S. FOIA (b) (2)] were made aware of the above concerns. A review of the facility policy provided by the Administrator, titled "Sanitizing of Equipment" last reviewed January 2008 reflected Policy: All personnel will follow standard procedures… to ensure the safety of food served…Purpose: To ensure equipment used in the meal preparation is thoroughly cleaned and sanitized preventing injury and food-borne illness…Procedure:…8. Remove equipment from sink and place on the clean drying rack ensuring that the solution will drain completely. Allow to air dry. Do not stack until completely dry. NJAC 8:39-17.2(g)	F0812		05/08/2026
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F0607	Plan of Correction for F0607 1. Corrective Action(s) Taken for Affected Employee Employee #1 background check had been completed and reviewed by Human Resources, and the employee has been cleared for duty with no disqualifying findings. Documentation of the completed background check was placed in the employee's personnel file. 2. How the Facility will Identify of Other Employees Potentially Affected An audit of all newly hired employees (active and inactive) from December 11, 2024, through April 30, 2026, was conducted by the Director of Human Resources to ensure that required background checks were completed prior to hire. The audit verified that no other employees were missing pre-employment background checks. Any discrepancies identified during the audit (if	05/15/2026

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F0607 SS = D	Continued from page 3 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to complete a background check for 1 out of 48 employees (Employee #1). This deficient practice was identified for newly hired employees reviewed since last survey of 12/11/24. This deficient practice was evidenced by the following: On 4/21/26 at approximately 10:16 AM, during the entrance conference, the surveyor requested from the U. S. FOIA (b) (2) [redacted]), all newly hired employee files for active and inactive employees from 12/11/24 to the current date. A review of the employee personnel files revealed the following: For Employee #1, a U. S. FOIA (b) (2) [redacted] with a date of hire [redacted], there was no evidence of a background check prior to the start of employment. On 4/24/26 at 12:02 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that Employee #1 was on orientation following a U. S. FOIA [redacted] on a unit with residents on 1/12/26. On 4/27/26 at 8:55 AM, the surveyor interviewed the U. S. FOIA [redacted] who stated that background checks are to be completed for employees prior to hire. She further	F0607	Continued from page 3 applicable) were immediately corrected prior to allowing those employees to continue working. 3. Measures Put into place Prevent Recurrence The facility has implemented the following system changes: A stop action process has been implemented in the hiring workflow to prevent onboarding and scheduling of any employee until the background check is completed and approved. Only the Director of Human Resources or designee may clear candidates for hire after verification of all pre-employment requirements. Education was provided to the Human Resources staff, U.S. FOIA (b)(6), and department managers regarding: Facility hiring policies Abuse prevention requirements Mandatory completion of background checks prior to resident contact The U. S. FOIA (b) (2) will reinforce expectations to department heads that no employee is permitted to begin orientation or work on the unit without HR clearance. 4. How the facility will Monitor its corrective actions to Ensure Continued Compliance The Director of Human Resources or designee will conduct weekly audits of all new hires to ensure required background checks are completed prior to start dates for a period of 4 weeks. After 4 weeks, audits will be conducted monthly for 2 months. Audit results will be reported to the Quality	05/15/2026

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F0607 SS = D	Continued from page 4 stated that "This background check slipped by us." The U. S. FOIA (b) acknowledged that for Employee #1 the background check should have been completed prior to the employee working on the unit for orientation. On 4/27/26 at 10:12 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that Employee #1's background check was missed and wasn't completed prior to hire. She further stated that it was a "human resources error". She acknowledged that the background check should have been completed prior to hire. On 4/27/26 at 10:16 AM, the U. S. FOIA (b) (2) were made aware of the above concerns regarding background checks for newly hired employees. The U. S. FOIA (b) stated that they had no additional information for the above concerns. On 4/27/26 at 10:24 AM, the U. S. FOIA (b) stated that background checks should be completed prior to hire to ensure the employee can provide appropriate care for residents. A review of the facility's "Human Resources" policy, dated as reviewed 1/24 revealed…The Human Resources Department will coordinate the employment process for all new staff to include: candidate selection, background investigations, and references… to ensure that all employment related procedures are completed in a consistent and timely fashion…No offer of employment shall be made without completion of a criminal background check unless approved by the Director of Human Resources. The applicant must be informed that the offer is contingent upon successful completion of the background check. A review of the facility's "Abuse Policy" policy, dated as reviewed 2025 revealed...The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention…It is the policy of RCH to screen employees and volunteers prior to working with residents. Screening components include verification of references, certifications and verification of license and criminal background check…Before new employees are permitted to work with residents, the employment history provided by the prospective employee will be verified as well as appropriate board registrations and certifications regarding the prospective employee's background…A criminal	F0607	Continued from page 4 Assurance Performance Improvement (QAPI) Committee at the quarterly meeting in June, September, December. Any identified issues will result in immediate corrective action and re-education as needed. 5. Completion Date All corrective actions and system changes were fully implemented by: May 15, 2026	05/15/2026

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F0607 SS = D	Continued from page 5 background check (which includes the sex offender check) will be conducted by Human Resources, on all prospective employees… NJAC 8:39-9.3(b)	F0607		05/15/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure professional standards of nursing practice were followed by [NJ Ex Order 26.4(b)(1)]) a resident's [NJ Ex Orde] according to the physician's order. This deficient practice was identified for 1 of 1 resident (Resident #14) reviewed for prevention of [NJ Ex Order 26.4(b)(1)] and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as	F0686	1. How will the corrective action be accomplished for those residents found to have been affected? The [U. S. FOIA] immediately provided resident #14 with a [U. S. FOIA (b) (2)] to ensure proper [NJ Ex Order 26, 4B1] . 2. How will the facility identify other residents having the potential to be affected? Residents with physician orders for heel booties to offload their heels have the potential to be affected by this deficient practice. A report will be generated from the electronic medical record (EMR) system to identify all residents with orders for heel booties and/or heel offloading. These residents will be reviewed to ensure appropriate interventions are in place and implemented. 3. What measures will be put in place or what systemic changes will be made to ensure that the problem does not recur? The wound and skin care protocol policy will be reviewed and revised as needed. The admission order sets in the EMR related to heel booties and offloading will be revised to reflect "Offload Heels." All newly admitted residents will receive heel booties upon admission when an order for "Offload Heels" is present. The continued need for heel offloading will be reviewed by the nursing management team during the review of the 2-day skin assessments. The 2-day skin assessment template will be revised to better identify residents at risk who require continued heel offloading.	05/22/2026

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F0686 SS = D	Continued from page 6 prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 4/22/26 at 10:03 AM, during the initial tour, the surveyor observed Resident #14 in their bed, without NJ Ex Order 26, 4B1 Resident #14 was NJ Ex Order 26, 4B1 that NJ Ex Order 26, 4B1, and NJ Ex Order 26, 4B1. Resident #14 stated they had NJ Ex Order 26, 4B1 and was NJ Ex Order 26, 4B1. The resident stated the staff had to NJ Ex Order 26, 4B1 . At 11:00 AM, the surveyor interviewed the Registered Nurse (RN #1) who stated Resident #14 needed NJ Ex Order 26, 4B1 and had no NJ Ex Order 26, 4B1 . RN #1 stated she provided care to Resident #14 to NJ Ex Order 26, 4B1. In the presence of the surveyor, RN #1 reviewed Resident #14's electronic treatment administration record (eTAR) and stated Resident #14 had NJ Ex Order 26, 4B1) to NJ Ex Order 26, 4B1. RN #1 acknowledged she signed off (entered her initials electronically) that the NJ Ex Or were in place that morning. RN #1 stated if her initials were on the eTAR, that meant the NJ Ex Or on the resident. At 11:50 AM, in the presence of the surveyor, RN #1 went into Resident #14's room, where the NJ Ex Or were not observed. RN #1 looked on and under Resident #14's bed, in their bedside stand, and in their closet. RN #1 acknowledged she could not locate NJ Ex Order 26, 4B1 for Resident #14. At 11:58 AM, RN #1 spoke to the surveyor in the hallway, acknowledging "my mistake, [Resident #14] didn't have them NJ Ex Order 26, 4B1), I am going to get	F0686	Continued from page 6 For current long-term residents, the need for continued heel offloading will be reevaluated, and physician orders will be updated to reflect "Offload Heels" as appropriate. Nursing staff will be educated on verifying that interventions are in place and properly documented before charting in the EMR. I Nursing staff will be educated on verifying that interventions are in place and properly documented before charting in the EMR. The education will be provided by the U. S. FOIA (b) (2) and will be completed by May 22, 2026. 4. How will the facility monitor its corrective actions to ensure the problem is corrected and will not recur? An audit will be conducted for each shift for one week, then daily for four weeks, followed by three times per week for three months. These audits will be completed by the unit managers or nursing supervisors to ensure that residents with orders for heel offloading have appropriate interventions in place and in use. Audit results will be submitted to the Director of Nursing for review. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee and reviewed at scheduled quarterly meetings in June, September, and December to ensure ongoing compliance.	05/22/2026

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F0686 SS = D	Continued from page 7 them now." On 4/24/26 at 10:40 AM, the surveyor interviewed the U. S. FOIA (b) (2) who acknowledged it was her responsibility to review and update the care plan for Resident #14. She stated Resident #14 does not have any NJ Ex Order 26, 4B1. She stated to prevent breakdown the resident should have had NJ Ex Order 26, 4B1 off the mattress. The U. S. FOIA (b) (2) in the presence of the surveyor, reviewed the eTAR for Resident #14. The U. S. FOIA (b) stated the nurse's initials on the eTARS indicated the NJ Ex Order 26, 4B1 were on the resident, and it was the nurse's responsibility to ensure they were on. The surveyor reviewed the electronic medical record (EMR) for Resident #14. A review of the Resident Face Sheet, an admission summary, reflected the resident was admitted with diagnoses which included but were not limited to NJ Ex Order 26, 4B1), and NJ Ex Order 26, 4B A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, 4B, reflected the resident had a Brief Interview for Mental Status score of NJ Ex Order 26, 4B1, which indicated the resident was NJ Ex Order 26, 4B1 Further review of the MDS reflected the resident was at risk of developing NJ Ex Order 26, 4B1 A review of the Physician's Orders reflected an order dated NJ Ex Order 26 to NJ Ex Order 26, 4B1 when in bed. Check placement every shift." A review of the April eTAR reflected the order to apply NJ Ex Order 26, 4B1 when in bed. Further review reflected nurses' initials for each shift of each day starting on NJ Ex Order 26, 4 indicating the NJ Ex Or were applied when in bed and placement was checked. A review of the Care Plan Activity Report, an individualized comprehensive care plan, reflected a focus area for "Skin" effective 12/10/25…the resident	F0686		05/22/2026

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F0686 SS = D	Continued from page 8 was at risk for skin breakdown due to impaired mobility / impaired body movement…Interventions included heel protectors. A review of the undated facility-provided document titled "Wound and Skin Care Protocols" reflected the following: …Care interventions are directed toward minimizing and/or eliminating the effects of the causal/contributing factors pressure, moisture, friction/shear and nutrition. …Pressure:…3. Heels are extremely vulnerable and must be elevated completely off bed surface. NJAC 8:39-27.1(e)	F0686		05/22/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure professional standards of nursing practice were followed by administering [redacted] according to the physician's order. This deficient practice was identified for 1 of 1 resident (Resident #52) reviewed for [redacted] and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and	F0695	Plan of Correction – F0695 Respiratory/Tracheostomy Care and Suctioning 1. Corrective Action(s) Taken for the Resident(s) Found to Be Affected The [redacted] setting for Resident #52 was immediately checked and corrected to the physician-ordered setting of [redacted]. A [redacted] reading was obtained to ensure resident safety and measured [redacted] which is within an acceptable range. The nurse involved was immediately re-educated on the requirement to verify [redacted] settings at the start of each shift. 2. How the Facility Will Identify Other Residents Potentially Affected by the Same Practice All residents receiving oxygen therapy via concentrator have the potential to be affected by this deficient practice. The facility will generate a report from the electronic medical record (EMR) system to identify all residents currently receiving oxygen therapy to ensure appropriate oversight and monitoring. 3. Measures Put Into Place to Ensure the Deficient Practice Does Not Recur Licensed nursing staff will be re-educated on the	06/01/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH , OLD BRIDGE, New Jersey, 08857**

(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
F0695 SS = D	Continued from page 9 wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 4/21/26 at 11:11 AM, during an initial tour, the surveyor observed "No smoking, NJ Ex Order 26, 4B1 in use" signage at Resident #52's room door. The surveyor observed Resident #52 watching TV in their bed while receiving NJ Ex Order 26, 4B1 [redacted] The resident did not speak to how much [redacted] they were on. On 4/22/26 at 12:23 PM, the surveyor observed Resident #52 sitting in their wheelchair receiving [redacted] The surveyor reviewed the electronic medical record (EMR) for Resident #52 A review of the Resident Face Sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1 [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] revealed the resident had a Brief Interview for Mental Status of [redacted], indicating the resident had [redacted] Further review of the MDS revealed the resident was receiving [redacted] A review of the Physician's Orders revealed a	F0695	Continued from page 9 importance of verifying NJ Ex Order 26.4(b)(1) settings during rounds at the start of every shift. Nursing staff will be required to document verification by signing the eMAR, indicating that the [redacted] setting was checked and found to be correct. To ensure continued compliance: Daily audits of oxygen concentrator settings will be conducted on each unit by the unit manager or supervisor to confirm that all concentrators are set per physician orders. 4. How the Facility Will Monitor Its Corrective Actions to Ensure Compliance The results of the daily audits will be: Reviewed weekly by the Director of Nursing (DON) for twelve (12) weeks, and Reviewed monthly for an additional three (3) months to ensure sustained compliance. Audit findings and trends will be reported and reviewed at the facility's Quarterly Quality Assurance and Performance Improvement (QAPI) meetings occurring in June, September, and December. Corrective actions will be implemented as needed based on audit outcomes.	06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

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F0695 SS = D	Continued from page 10 Physician Order (PO) dated [redacted] for: [redacted] continuous a[redacted] A review of the [redacted] Medication Administration Record (MAR) for Resident #52 revealed nurses' signatures for each shift indicating the resident was being administered [redacted] On 4/22/26 at 12:23 PM, the surveyor interviewed the [redacted]) who stated they needed a PO for [redacted], so they knew how much [redacted] was needed and whether it was to be administered [redacted] or as needed. The [redacted] stated she had only one resident (Resident #52) who was on [redacted] and the resident was maintaining their [redacted] between [redacted] The [redacted] stated during her rounds at the beginning of her shift, she checked how much [redacted] Resident #52 was on. The surveyor accompanied the [redacted] to Resident #52's room and observed the resident's [redacted]. The [redacted] acknowledged that during rounds she should have made sure Resident #52's [redacted] was set to the amount that was ordered by the physician. The RN stated if the resident was on a low amount [redacted] they could go into [redacted] On 4/22/26 at 12:50 PM, the surveyor interviewed the [redacted] who stated if a resident had shortness of breath and their [redacted] was low, they would notify the physician to obtain [redacted] orders. The surveyor reviewed Resident #52's [redacted] with the [redacted] and the [redacted] stated the resident should be on [redacted]. The surveyor made the [redacted] aware of the above-mentioned concerns for Resident #52. The [redacted] stated the expectation for the nurses was to make sure the resident was on [redacted] at the right setting as per PO prior to signing the MARs. The [redacted] acknowledged that the [redacted] order was clearly for 2L and further stated "[redacted], and they (the nurses) should be following POs." On 4/23/26 at 11:24 AM, the surveyor made the [redacted] aware of the above-mentioned concerns for Resident #52. The [redacted] stated the nurses were signing off the MARs for how many liters of [redacted] the resident was getting. The [redacted] further stated that the expectation for the nurses was to follow POs for [redacted] administration.	F0695		06/01/2026

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F0695 SS = D	Continued from page 11 On 4/23/26 at 12:04 PM, the survey team met with the [redacted] and the [redacted]. The surveyor made the facility administration aware of the above-mentioned concerns for Resident #52. A review of the facility policy "Oxygen Administration" reviewed 2026 revealed under Procedure: 1. Check for MD (physician)/Nurse Practitioner (NP) order. A review of the facility job description titled, "Staff Nurse" provided by the DON included but was not limited to; Under Essential Functions: Communicates with physician/ Advanced Practice Nurse (APN) and transcribed, documents, and implements physician's orders. NJAC 8:39-11.2(b); 27.1(a)	F0695		06/01/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030709	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH , OLD BRIDGE, New Jersey, 08857**

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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		05/06/2026
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: Based on interview and review of pertinent facility documents, 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 5 out of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents	S0560	S0560 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? To ensure all residents have access to the care they require, immediate corrective actions were implemented. Licensed nursing staff were cross-trained and assigned to perform Certified Nursing Assistant (CNA) duties as needed during the day shift to meet resident care needs during staffing shortages. Nurse managers and Supervisors also provide direct resident care as necessary to maintain continuity of services. A daytime nurse supervisor position was also created to assist with coverage. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by CNA staffing shortages. The facility assesses resident care needs daily and reviews staffing levels to ensure adequate coverage. In the event of shortages, contingency staffing measures are implemented, including redeployment of licensed staff to direct care roles and utilization of temporary staffing resources. Admissions are also curtailed 3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice will not recur? The facility has implemented multiple systemic measures to address and prevent CNA staffing	05/07/2026

Office of Primary Care and Health Systems Management

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: 030709	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0560	Continued from page 1 for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing reports (AAS-11) for the weeks of 4/5/26 to 4/18/26. 1. For the 2 weeks of AAS-11 staffing prior to survey from 4/5/26 to 4/18/26, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -04/05/26 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -04/10/26 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/11/26 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/17/26 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/18/26 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. On 4/24/26 at 10:33 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated she was aware of the CNA staffing ratios. The SC stated she was made aware of the staffing ratios by the Director of Nursing. The SC further stated that the facility had per diem staff and agency staff that worked when there were call outs. A review of the facility's policy "Staffing", reviewed date of 5/25, revealed Policy Statement: It is the policy of Reformed Church Home to follow the Department of Health guidelines for staffing according to census and acuity… Procedure: If there are vacancies in the schedule, the Staffing Coordinator will first try to fill the vacancies with per diem staff. If per diem staff do not pick up the shift, calls will be placed to all agencies…	S0560	Continued from page 1 concerns. Recruitment efforts are ongoing and include advertising across multiple platforms, maintaining a competitive wage scale, and offering enhanced tuition reimbursement to attract and retain staff. The facility has also petitioned for six visas through United Methodist Healthcare Recruitment for long-term CNA staffing support. Additionally, the facility contracts with multiple staffing agencies to supplement staffing during shortages and offers overtime to existing staff when vacancies occur due to illness or unexpected absences. A day supervisor position was also created to help alleviate shortages caused by last-minute call outs. In addition, any regular staff that call out on weekends are required to make up a shift on another weekend. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Director of Nursing and Staffing Coordinator will review daily and weekly staffing levels to ensure compliance with required staffing ratios. Staffing data and trends will be reviewed on an ongoing basis. A quarterly staffing report will be presented to the Quality Assurance (QA) Committee for oversight. Any concerns identified through monitoring will be addressed promptly through corrective action. Completion date: May 7, 2026	05/07/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 6/3/26 in relation to the 4/27/26 Recertification 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 Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030709	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 6/3/26 in relation to the 4/27/26 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code survey was conducted on 04/22/2026 and 04/23/2026 by the New Jersey Department of Health and The Reformed Church Home was found to be in Non-Compliance with NFPA 101:2012 edition. The nursing home building construction was stated to be 1990s with no current major renovations or noted additions. It is a 3-story building Type II (222) construction and is fully sprinklered. The facility has 17 smoke zones, 2-exterior diesel generators that power 100% of the building. The building has a partial basement with no access to residents. Resident areas consist of 1/2 of each story with Assisted Living occupancies on the other 1/2 of each floor. There is supervised smoke detection located in the corridors, spaces open to the corridors and battery operated in resident rooms. The generators outside the facility are stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 108 certified beds. At the time of the survey the census was 101.	K0000		05/06/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K0324	TAG: K0324 – Cooking Facilities Part 1: Corrective Actions Taken The facility implemented a formal and documented Owner's Inspection program for the kitchen range hood fire suppression system in accordance with NFPA 96 and NFPA 17A. Immediate corrective actions include: A complete Owner's Inspection of the kitchen range hood fire suppression system was performed on April 30, 2026, by the Maintenance Director.	04/30/2026

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.

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K0324 SS = F Bldg. 01	Continued from page 1 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation, interview and record review on 04/22/2026 in the presence of the [redacted], it was determined that the facility failed to conduct a monthly Owner's Inspection of the Range-Hood Fire Suppression system in accordance with NFPA 101: 2012 edition, Section 19.3.2.5 and NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6. This deficient practice had the potential to affect all 101 residents and was evidenced by the following: A record review of the facility's Life Safety Code inspection binder revealed there was no documented monthly Owner's Inspection of the Range-Hood Fire Suppression system. An observation in the Main Kitchen at 12:31 PM revealed there were no entries on the Range-Hood Fire Suppression system tag at the pull station to indicate monthly Owners Inspections were performed by the facility. In an interview at the time, the [redacted] stated that the facility does not conduct a monthly Owners inspection on the Range-Hood Fire Suppression system. The U. S. FOIA (b) (2) [redacted] were notified of the deficient practice at the Life Safety Code Exit on 03/23/2026 at 3:05 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K0324	Continued from page 1 Documentation of this inspection was recorded on the fire suppression system inspection tag, including date, initials, and findings. The inspection verified that all system components were: Unobstructed Accessible Free of visible damage Properly mounted and in apparent working condition No deficiencies were identified during the inspection. Part 2: Identification Failure to conduct required Owner's Inspections of the kitchen range hood fire suppression system had the potential to place residents at risk due to impaired or delayed activation of the fire suppression system during a cooking-related fire. A full review of the kitchen fire suppression system was conducted following identification of the concern. No additional deficient practices were identified. Part 3: Measures and Systemic Changes to Prevent Recurrence Owner's Inspections will be conducted monthly. Inspections are incorporated into the preventative maintenance program, meaning they are included in the facility's recurring, scheduled maintenance tasks tracked via maintenance logs/work orders. Inspection timing is synchronized with monthly portable fire extinguisher inspections to ensure consistency and compliance.	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/27/2026**

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K0324 SS = F Bldg. 01		K0324	Continued from page 2 Education Provided Education: Maintenance Director Who Received Education: U. S. FOIA (b) (2) Date Education Provided: April 29, 2026 Subject Matter: NFPA 96 and NFPA 17A requirements for Owner's Inspections Monthly inspection procedures and required elements Proper documentation on inspection tags and maintenance logs Importance of maintaining unobstructed and functional fire suppression systems Evidence of Education: Signed attendance in-service sheet Training materials/handouts maintained on file Part 4: Monitoring Inspection documentation will be reviewed monthly by the Facility Director (or designee). Compliance will be tracked and trended through the QAPI Committee on a quarterly basis. Any missed, incomplete, or undocumented inspections will result in immediate corrective action, including re-education and completion of the inspection.	04/30/2026

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K0324 SS = F Bldg. 01		K0324	Continued from page 3 Random audits will be conducted to ensure ongoing compliance with inspection requirements. Part 5: Responsible Party Maintenance Staff: Conduct monthly Owner's Inspections Maintenance Director: Ensures inspections are completed, provides education, and maintains documentation Completion Date: April 30, 2026	04/30/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observations, interview and record review on 04/22/2026 and 04/23/2026 in the presence of the[U. S. FOIA (b) (2)]), it was determined that the facility failed 1.) to conduct sensitivity testing on smoke detectors every other year, 2.) failed to replace non-restorable fixed temperature heat detectors greater than 15 years old and 3.) provide annual testing of drop down doors in accordance with NFPA 101:2012 edition, Section 9.6.1.3 and NFPA 72: 2010 edition, Chapter 14. These deficient practices had the potential to affect all 101 residents and were evidenced by the following: Observations during a tour of the facility on 04/22/2026 revealed there were smoke detectors located in corridors and spaces open to the corridor.	K0345	TAG: K0345 – Fire Alarm System Testing and Maintenance Part 1: Corrective Actions Taken Corrective action was completed to address three separate deficiencies cited under this tag. Issue 1 – Smoke Detector Sensitivity Testing • Documentation was obtained from a licensed vendor confirming completion of smoke detector sensitivity testing in accordance with NFPA 72 requirements. • Documentation was filed in the facility fire alarm book logs as evidence of compliance. Issue 2 – Replacement of Fixed Temperature Heat Detectors • Fixed temperature heat detectors exceeding 15 years of service life were identified and replaced on 05/12/2026 in accordance with NFPA requirements. • Vendor replacement documentation was obtained and maintained in the facility fire alarm records as evidence of corrective action completion. Issue 3 – Kitchen Pass Through Drop Down Fire Door Testing • Annual testing of the kitchen pass through drop down fire door was completed by a licensed fire	05/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH , OLD BRIDGE, New Jersey, 08857

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K0345 SS = F Bldg. 01	Continued from page 4 In an interview, the [redacted] stated that corridors and open spaces were provided with smoke detection that was connected to the fire alarm system. Resident rooms were provided with battery operated smoke detection that was connected to the call bell system for low battery and activation. A record review of the facility's Life Safety inspection binder revealed there were no sensitivity tests conducted on the smoke detectors. In an interview, the [redacted] stated he would reach out to the inspection vendor. No documentation of sensitivity testing was provided by survey exit. A record review of the facility's Life Safety inspection binder on 04/23/2026 revealed that the licensed inspection vendor identified that 25 heat detectors required replacement due to age exceeding 15 years and were due to be replaced 03/19/2025. This deficient practice was identified by the licensed vendor on fire alarm system inspection reports dated 06/11/2025, 09/11/2025 and 03/29/2026. In an interview, the [redacted] stated that he was not aware of the inspection report results. An observation of the kitchen on 04/22/2026 at 12:30 PM revealed there was a drop-down pass-through door between the main kitchen and the service corridor. In an interview, the [redacted] stated he did not know when the door was last tested but would contact the licensed fire alarm vendor. No documentation was provided by survey exit. The U. S. FOIA (b) (2) [redacted] were notified of the deficient practices at the Life Safety Code Exit on 03/23/2026 at 3:05 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K0345	Continued from page 4 protection vendor on 05/04/2026. • Testing verified proper release and closure function during a fire event. • Documentation of testing was obtained and maintained in the facility life safety records as evidence of compliance. Part 2: Identification Failure to complete required fire alarm testing, timely detector replacement, and annual fire door testing had the potential to delay fire detection, alarm activation, and compartmentation, increasing risk to residents, staff, and visitors. A facility-wide review of fire alarm system components, detector replacement records, and fire door testing documentation was conducted. No additional unaddressed deficiencies were identified. Part 3: Measures and Systems to Ensure the Deficient Practice Will Not Recur • Fire alarm system components are individually tracked through the facility preventive maintenance program. • Testing, replacement, and inspection intervals are documented within the facility preventive maintenance schedule and compliance calendar. • Education was provided by the Maintenance Director to the Maintenance staff regarding fire alarm testing requirements, detector replacement requirements, fire door testing requirements, and documentation procedures. • Attendance sheets and education records are maintained by the facility as evidence of training completion. Part 4: Monitoring • Required vendor testing and inspection intervals will be maintained on the facility preventive maintenance schedule and compliance calendar. • The Facility Director or designee will monitor due dates to ensure vendor services are scheduled and completed within required NFPA timeframes.	05/12/2026

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K0345 SS = F Bldg. 01		K0345	Continued from page 5 • Smoke detector sensitivity testing will be scheduled and monitored every two years in accordance with NFPA 72 requirements. • Annual testing of the kitchen pass through drop down fire door will be scheduled and monitored annually through a licensed fire protection vendor. • Fixed temperature heat detectors were replaced on 05/12/2026 and will continue to be monitored during required fire alarm inspections conducted by the licensed fire alarm vendor. • Vendor reports and supporting documentation will be reviewed upon completion and maintained in the facility life safety records as evidence of compliance. • Any identified concerns or overdue inspections will be addressed immediately and documented by the Facility Director. Part 5: Responsible Party • Maintenance Director: Responsible for oversight of the facility preventive maintenance program, scheduling required vendor inspections/testing, reviewing documentation, maintaining compliance records, conducting monitoring activities, and ensuring corrective actions are completed. Responsible for coordinating vendor services, maintaining testing schedules, tracking due dates, and ensuring required documentation is maintained in facility life safety records. Completion Date: 05/12/2026	05/12/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K0353	TAG: K0353 – Sprinkler System Maintenance and Testing Part 1: Corrective Actions Taken • The required three-year full trip/air test of the dry sprinkler system was completed on 06/02/2026 in accordance with NFPA 25 requirements. • Documentation confirming completion of the full trip/air test was obtained and maintained in the facility sprinkler system records as evidence of compliance. Part 2: Identification Failure to conduct the required dry sprinkler full	06/02/2026

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K0353 SS = F Bldg. 01	Continued from page 6 _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review an interview on 04/23/2026 in the presence of the U. S. FOIA (b) (2) it was determined that the facility failed to conduct a Full Trip/Air test of the fire sprinkler dry valve system every 3 years in accordance with NFPA 101:2012 edition, Section 9.7.5 and NFPA 25. This deficient practice had the potential to affect all 101 residents and was evidenced by the following: A review of the facility's Life Safety inspection binder revealed that there was no documentation of a full trip/air test of the fire sprinkler system dry valve. In an interview, the U.S. FO [redacted] stated he would reach out to the licensed inspection vendor for documentation. No documentation was provided prior to the Life Safety Code (LSC) exit. Post LSC exit, the facility provided inspection documentation revealing the last 3-year full trip/air test was conducted on 06/15/2022, more than 3-years ago. The U. S. FOIA (b) (2) [redacted] were notified of the deficient practice at the Life Safety Code Exit on 03/23/2026 at 3:05 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K0353	Continued from page 6 trip/air test had the potential to impair fire suppression system effectiveness, placing residents, staff, and visitors at increased risk during a fire emergency. A facility-wide review of sprinkler inspection and testing documentation was conducted. No additional unaddressed deficiencies were identified. Part 3: Measures and Systems to Ensure the Deficient Practice Will Not Recur • Sprinkler inspection and testing intervals were incorporated into the facility preventive maintenance schedule and compliance calendar. • Required sprinkler testing due dates are tracked to ensure inspections and testing are completed within NFPA required timeframes. • Education was provided on 06/02/2026 by the Facility/Maintenance Director to Maintenance staff regarding sprinkler inspection/testing requirements, scheduling procedures, documentation requirements, and compliance tracking procedures. • Attendance sheets and education records are maintained by the facility as evidence of training completion. Part 4: Monitoring • Required sprinkler inspection and testing due dates will be maintained on the facility preventive maintenance schedule and compliance calendar. • The Facility/Maintenance Director or designee will monitor due dates to ensure required testing is completed within NFPA required timeframes. • Sprinkler testing documentation will be reviewed upon completion and maintained in facility sprinkler system records as evidence of compliance. • Sprinkler system compliance will be reviewed through the facility QAPI process quarterly to ensure required testing and documentation remain current. • Any identified concerns or overdue inspections/testing will be addressed immediately and documented by the Facility/Maintenance Director.	06/02/2026

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K0353 SS = F Bldg. 01		K0353	Continued from page 7 Part 5: Responsible Party • Facility/Maintenance Director: Responsible for oversight of the sprinkler inspection and testing program, scheduling required testing, monitoring compliance, reviewing documentation, providing staff education, maintaining compliance records, and ensuring corrective actions are completed. • Maintenance Staff: Responsible for assisting with compliance tracking, maintaining documentation, and reporting any identified concerns related to sprinkler system testing requirements. Completion Date: 06/02/2026	06/02/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 04/23/2026 in the presence of the U. S. FOIA (b) (2), it was determined that the facility failed to conduct fire drills Quarterly on each shift, under varying conditions and failed to activate the fire alarm system monthly when fire drills were conducted without the activation of the fire alarm system in accordance with NFPA 101:2012 edition, Section 19.7.1.7 and NFPA 72. This deficient practice had the potential to affect all 101 residents and was evidence by the following: A review of the facility's fire drills for the last 12 months revealed the facility conducted drills monthly by facility staff. Further review revealed that the facility did not conduct fire drills Quarterly on each shift as follows: -A 2nd shift fire drill was conducted 10/13/2025 and then on 03/24/2026, more than 5 months later.	K0712	TAG: K0712 – Fire Drills Part 1: Corrective Actions Taken Corrective action was completed to address three separate deficiencies cited under this tag. Issue 1 – Fire Drills Not Conducted Quarterly on Each Shift • Fire drill schedules were reviewed and corrected to ensure quarterly fire drills are conducted on each shift in proper sequence in accordance with Life Safety Code requirements. • Updated fire drill schedules and documentation were maintained in facility fire drill records as evidence of compliance. Issue 2 – Silent Fire Drills Lacked Active Simulation • Fire drill procedures were revised to require active simulation during silent fire drills, including staff movement, role execution, fire scenario identification, and verbalization of response actions. • Staff were instructed on silent fire drill participation requirements and expectations. • Updated drill procedures and completed drill documentation are maintained in facility records as evidence of compliance. Issue 3 – Monthly Fire Alarm Pull Station Testing • A formal monthly fire alarm pull station testing process was implemented on 04/30/2026. • Testing includes verification that alarm signals are successfully transmitted and received by the	04/30/2026

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K0712 SS = F Bldg. 01	Continued from page 8 -A 3rd shift fire drill was conducted 07/10/2025 and then on 12/16/2025, more than 5 months later. A review of the fire drill documentation revealed that 8 of 12 fire drills were conducted as a silent drill. Documents indicated that no actual drill was performed but the drill coordinator went to nursing stations and asked staff about procedures. Seven of the 12 drills did not indicate a fire scenario. The record review revealed there was no documentation that the fire alarm system was activated the months of the silent drills to test the fire alarm system notification systems. In an interview, the [redacted] confirmed the drills were not conducted Quarterly each shift and said he was told if he followed the Quarterly (3-month) pattern, the drills would be non-compliant for predictability. The [redacted] also confirmed that the silent drills were not conducted as drills and the fire alarm system was not activated those months to test the notification system. The [redacted] were notified of the deficient practice at the Life Safety Code Exit on 03/23/2026 at 3:05 PM. NJAC 8:39-31.2(e) NFPA 72	K0712	Continued from page 8 monitoring company. • Documentation of pull station testing is maintained in the facility fire alarm book logs as evidence of compliance. Part 2: Identification Failure to ensure compliant fire drill frequency, active simulation during silent drills, and verified fire alarm signaling had the potential to delay staff response and emergency coordination, placing residents, staff, and visitors at increased risk during a fire emergency. A facility-wide review of fire drill schedules, drill procedures, and pull station testing documentation was conducted. No additional unaddressed deficiencies were identified. Part 3: Measures and Systems to Ensure the Deficient Practice Will Not Recur • Fire drill schedules and required drill frequencies are maintained through the facility compliance calendar and preventive maintenance program. • Fire drill procedures were updated to include active participation requirements during silent drills. • Monthly fire alarm pull station testing requirements were incorporated into the facility preventive maintenance schedule. • Education was provided on 04/29/2026 by the Facility/Maintenance Director to Maintenance staff regarding: o Quarterly fire drill requirements for all shifts o Active simulation requirements during silent fire drills o Monthly pull station testing procedures o Fire drill documentation requirements • Attendance sheets and education records are maintained by the facility as evidence of training completion. Fire Drill compliance will be reviewed through the facility QAPI process quarterly to ensure required testing and documentation remain current.	04/30/2026

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K0712 SS = F Bldg. 01		K0712	Continued from page 9 Part 4: Monitoring • Fire drill schedules and required testing intervals will be maintained on the facility compliance calendar. • The Facility/Maintenance Director or designee will monitor due dates to ensure fire drills and pull station testing are completed within required timeframes. • Fire drill documentation will be reviewed following each completed drill to ensure compliance with quarterly scheduling and active simulation requirements. • Monthly pull station testing documentation will be reviewed and maintained in facility fire alarm records as evidence of compliance. • Any identified concerns or overdue drills/testing will be addressed immediately and documented by the Facility/Maintenance Director. Part 5: Responsible Party • Facility/Maintenance Director: Responsible for oversight of fire drill scheduling, monitoring compliance, reviewing documentation, coordinating pull station testing, providing staff education, maintaining testing schedules, and ensuring corrective actions are completed. • Maintenance Staff: Responsible for participating in required fire drills, completing pull station testing, and maintaining required documentation. Completion Date: 04/30/2026	04/30/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches	K0918	TAG: K0918 – Emergency Power Systems Part 1: Corrective Actions Taken • Diesel fuel samples for the emergency generator were taken on 05/06/2026 in accordance with NFPA requirements. • Documentation confirming completion of fuel sample collection was obtained and maintained in the facility generator records as evidence of compliance.	05/06/2026

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K0918 SS = F Bldg. 01	Continued from page 10 are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a record review and interview on 4/23/2026 in the presence of the U. S. FOIA (b) (2) [redacted]), it was determined that the facility failed to ensure that the emergency and standby power generator diesel fuel quality was tested annually and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. This deficient practice had the potential to affect all 101 residents and was evidenced by the following: A review of the facility Life Safety binder revealed no documented fuel quality testing for the facility's 2 diesel fueled emergency electrical generating units. In an interview, the [redacted] confirmed the facility does not conduct annual fuel testing. Documentation provided post survey revealed the facility's licensed vendor confirmed they do not test the diesel fuel. The U. S. FOIA (b) (2) [redacted] were notified of the deficient practice at the Life Safety Code Exit on 03/23/2026 at 3:05 PM. NJAC 8:39-31.2(e), 31.2(g)	K0918	Continued from page 10 Part 2: Identification Failure to conduct required diesel fuel quality testing had the potential to compromise emergency generator performance during a utility outage, all residents at risk due to possible loss of emergency power, lighting, life safety systems, and resident care equipment. A facility-wide review of generator preventive maintenance records and testing requirements was conducted. No additional unaddressed deficiencies were identified. Part 3: Measures and Systems to Ensure the Deficient Practice Will Not Recur • Annual diesel fuel quality testing requirements were incorporated into the facility preventive maintenance schedule and compliance calendar. • Required generator preventive maintenance intervals are tracked to ensure annual fuel quality testing is completed timely. • Education was provided on 04/29/2026 by the Facility/Maintenance Director to Maintenance staff regarding annual diesel fuel quality testing requirements, generator preventive maintenance scheduling requirements, and documentation procedures. • Attendance sheets and education records are maintained by the facility as evidence of training completion. Part 4: Monitoring • Annual diesel fuel quality testing due dates will be maintained on the facility preventive maintenance schedule and compliance calendar. • The Facility/Maintenance Director or designee will monitor due dates to ensure annual testing is scheduled and completed within required NFPA timeframes. • Generator preventive maintenance and fuel quality testing documentation will be reviewed annually upon completion and maintained in facility generator records as evidence of compliance. • Emergency power system compliance will be reviewed through the facility QAPI process quarterly	05/06/2026

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K0918 SS = F Bldg. 01	Continued from page 11 NFPA 99, 110	K0918	Continued from page 11 to ensure required testing and documentation remain current. • Any identified concerns or overdue testing will be addressed immediately and documented by the Facility/Maintenance Director. Part 5: Responsible Party • Facility/Maintenance Director: Responsible for oversight of the emergency power system preventive maintenance program, scheduling required generator testing, monitoring compliance, reviewing documentation, providing staff education, maintaining compliance records, and ensuring corrective actions are completed. • Maintenance Staff: Responsible for assisting with generator compliance tracking, maintaining required documentation, and reporting any concerns related to emergency power system testing or maintenance. Completion Date: 05/06/2026	05/06/2026
K0921 SS = E Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.	K0921	TAG: K0921 – Patient Care Related Electrical Equipment (PCREE) Part 1: Corrective Actions Taken • A comprehensive facility-wide inspection and risk categorization of patient care related electrical equipment (PCREE) was completed on 05/12/2026 in accordance with NFPA 99 (2012), Chapter 10. • A PCREE inspection, testing, documentation, and risk categorization program was implemented for all applicable equipment. Category 1 PCREE (Quantitative Electrical Testing Required): • Oxygen concentrators • Enteral feeding pumps • Suction machines Category 2–4 PCREE (Maintenance Based Inspection): • Nebulizers • Electric beds with hand controls • Electrically powered therapy equipment	05/12/2026

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K0921 SS = E Bldg. 01	Continued from page 12 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on interview and record review on 4/22/26 in the presence of the U. S. FOIA (b) (2)), it was determined the facility failed to ensure Patient Care Related Electrical Equipment (PCREE) was inspected, tested and maintained based on policies and protocols and a record of electrical equipment tests and repairs was maintained to demonstrate compliance annually in accordance with NFPA 99: 2012 Edition. Sections 10.3, 10.5, 10.5.1, 10.5.2.7. This deficient practice had the potential to affect all 101 residents and was evidenced by the following: Observations during a tour of the facility beginning at 09:30 AM revealed that there were electric resident beds, air mattresses, Oxygen concentrators, nebulizers and a negative air machine in various areas throughout the facility. A review of the facility's Life Safety binder revealed no documentation of PCREE inspections. In an interview, the [redacted] stated the facility does not conduct PCREE inspections and that there was no policy and procedure to conduct PCREE inspections on the equipment. The U. S. FOIA (b) (2) were notified of the deficient practice at the Life Safety Code Exit on 03/23/2026 at 3:05 PM. NJAC 8:39-31.2(e) NFPA 99	K0921	Continued from page 12 • Inspection, testing, and categorization documentation was completed and maintained in facility compliance records as evidence of corrective action completion. Part 2: Identification Failure to inspect, test, maintain, and properly categorize patient care related electrical equipment had the potential to expose residents to electrical hazards, equipment malfunction, or interruption of essential therapeutic equipment, placing residents at increased risk. A facility-wide review of patient care related electrical equipment and documentation requirements was conducted. No additional unaddressed deficiencies were identified. Part 3: Measures and Systems to Ensure the Deficient Practice Will Not Recur • A written PCREE policy was implemented in accordance with NFPA 99 requirements. • Risk categorization, inspection, testing, and documentation requirements were established for all applicable equipment. • Annual inspection and testing schedules were incorporated into the facility preventive maintenance schedule and compliance calendar. • Education was provided on 04/29/2026 by the Facility/Maintenance Director to Maintenance staff regarding PCREE categorization requirements, inspection/testing procedures, and documentation requirements. • Attendance sheets and education records are maintained by the facility as evidence of training completion. Part 4: Monitoring • Annual PCREE inspection and testing due dates will be maintained on the facility preventive maintenance schedule and compliance calendar. • The Facility/Maintenance Director or designee will monitor due dates to ensure required inspections and testing are completed timely.	05/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH , OLD BRIDGE, New Jersey, 08857

(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
K0921 SS = E Bldg. 01		K0921	Continued from page 13 • PCREE inspection, testing, and categorization documentation will be reviewed annually for accuracy and completeness and maintained in facility compliance records as evidence of compliance. • PCREE compliance will be reviewed through the facility QAPI process quarterly to ensure inspection, testing, and documentation requirements remain current. • Any identified concerns or overdue inspections/testing will be addressed immediately and documented by the Facility/Maintenance Director. Part 5: Responsible Party • Facility/Maintenance Director: Responsible for oversight of the PCREE program, monitoring compliance, reviewing documentation, providing staff education, maintaining compliance records, and ensuring corrective actions are completed. • Maintenance Staff: Responsible for assisting with inspections, maintaining documentation, and reporting any identified concerns related to PCREE equipment. Completion Date: 05/12/2026	05/12/2026
K0355 SS = C Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observations, record review and interview on 04/22/2026 in the presence of the [redacted], it was determined that the facility failed to inspect portable fire extinguishers at intervals not to exceed 30 days in accordance with NFPA 101:2012 edition, Section 19.3.5.12 and NFPA 10: 2010 edition, Section 7.2.1.2. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0355	TAG: K0355 – Portable Fire Extinguishers Part 1: Corrective Actions Taken • Fire extinguisher documentation was revised to clearly distinguish: o Monthly maintenance staff inspection dates o Facility/Maintenance Director supervisory verification dates • All fire extinguishers were inspected on 04/30/2026 and confirmed to be charged, accessible, properly tagged, and annually inspected in accordance with NFPA requirements. • Updated inspection documentation was maintained in facility life safety records as evidence of compliance. Part 2: Identification	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH , OLD BRIDGE, New Jersey, 08857

(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
K0355 SS = C Bldg. 01	Continued from page 14 Observations during a tour of the facility on 04/22/2026 revealed portable fire extinguishers had current Annual inspection tags indicating the fire extinguishers were inspect by the licensed vendor 04/2026. A review of the facility's Life Safety inspection binder confirmed the extinguishers were inspected on 04/13/2026. The review also revealed that the monthly inspection log did not include full dates, only the month and year. A review of the tickler log for the binder documented the full dates and revealed 8 of 12 monthly inspections exceeded the limit of the 30-day interval as follows: -05/02/2025 to 06/03/2025 = 32 days -06/03/2025 to 07/11/2025 = 38 days -07/11/2025 to 08/15/2025 = 35 days -08/15/2025 to 09/25/2025 = 41 days -11/05/2025 to 12/12/2025 = 37 days -12/12/2025 to 01/13/2026 = 32 days -01/13/2026 to 02/18/2026 = 36 days -03/07/2026 to 04/13/2026 = 37 days. In an interview, the [redacted] confirmed the findings. The [redacted] were notified of the deficient practice at the Life Safety Code Exit on 03/23/2026 at 3:05 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K0355	Continued from page 14 Failure to maintain clear and complete fire extinguisher inspection documentation had the potential to delay identification of missing, discharged, or inaccessible extinguishers during a fire emergency, placing residents, staff, and visitors at increased risk. A facility-wide review of fire extinguisher inspection records and documentation procedures was conducted. No additional unaddressed deficiencies were identified. Part 3: Measures and Systems to Ensure the Deficient Practice Will Not Recur • Fire extinguisher inspection schedules and documentation requirements were incorporated into the facility preventive maintenance schedule and compliance calendar. • Documentation tools were revised to clearly identify monthly inspection completion and supervisory review requirements. • Education was provided on 04/29/2026 by the Facility/Maintenance Director to Maintenance staff regarding monthly fire extinguisher inspection requirements, documentation procedures, and supervisory verification requirements. • Attendance sheets and education records are maintained by the facility as evidence of training completion. Part 4: Monitoring • Monthly fire extinguisher inspection due dates will be maintained on the facility preventive maintenance schedule and compliance calendar. • The Facility/Maintenance Director or designee will monitor due dates to ensure monthly inspections are completed timely. • Fire extinguisher inspection documentation will be reviewed monthly for accuracy and completeness and maintained in facility life safety records as evidence of compliance. • Fire extinguisher compliance will be reviewed through the facility QAPI process quarterly to ensure inspections and documentation remain current.	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH , OLD BRIDGE, New Jersey, 08857**

(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
K0355 SS = C Bldg. 01		K0355	Continued from page 15 • Any identified concerns or overdue inspections will be addressed immediately and documented by the Facility/Maintenance Director. Part 5: Responsible Party • Facility/Maintenance Director: Responsible for oversight of the fire extinguisher inspection program, monitoring compliance, reviewing documentation, providing staff education, maintaining compliance records, and ensuring corrective actions are completed. • Maintenance Staff: Responsible for conducting monthly inspections, maintaining documentation, and reporting any identified concerns. Completion Date: 04/30/2026	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/22/2026 and 04/23/2026. The Reformed Church Home was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		05/06/2026

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: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/09/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH , OLD BRIDGE, New Jersey, 08857**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 6/9/2026 in relation to the 4/27/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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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: 315417	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 6/9/2026 in relation to the 4/27/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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