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	55A009	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTISON CROSSING AT MANALAPAN AVENU	93 MANALAPAN AVENUE FREEHOLD, NJ 07728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Standard Census: 113 Sample Size: 7 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administrator's Responsibilities (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/19/25

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined that the Executive Director (ED) failed to implement and develop a policy and procedure titled, "Resident Call Alert System" regarding staff response time as well as failed to implement and enforce the policy and procedure titled, "Automated External Defibrillator (AED)". This deficient practice had the potential to affect all residents and was evidenced by the following:
1. The New Jersey Department of Health (DOH) conducted a standard survey on 10/21/25 and 10/22/25. On 10/22/25 at 10:38 a.m., the surveyor interviewed a Licensed Practical Nurse (LPN) regarding the procedure when a resident pushed their pendant to request assistance. The LPN stated that each staff member had a portable radio, which advised the location of the resident. The LPN also stated that a control panel, located in the Wellness Office, showed which pendant assigned to the resident was activated. The LPN
continued to state that the Receptionist also monitored when pendants were activated and when staff responded and de-activated the pendant. Furthermore, the LPN stated that the Receptionist requested assistance if the staff had not responded in a certain amount of time. When the surveyor asked about the time frame for staff to respond to a call pendant activation, the LPN stated ten (10) minutes.

At 10:59 a.m., the surveyor interviewed the Receptionist regarding the process after a resident activated their pendant seeking

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A 310	Continued From page 2	A 310		

assistance. The Receptionist stated that after a pendant was activated, the portable radios broadcasted which pendant number and the exact location of the pendant. In addition, the Receptionist stated that the staff in the Administrative Office monitored the pendant activations and that she believed an agency monitored them as well. During further surveyor interview, when asked about the staff's response to the pendant activation, the Receptionist stated, "As soon as we hear it, we go and respond to them."

At 11:54 a.m., the surveyor interviewed the ED and the Business Office Manager (BOM) regarding the process after a resident activated their pendant. The ED stated that after a pendant is activated, their system transmits the activation request to the central monitoring station, located in the main office, and the portable radios. The ED also stated that when staff arrive, they de-activate the pendant, which signals that someone arrived to assist the resident. In addition, the ED stated that after the resident is assisted, the staff member would reset the pendant, prior to leaving. When inquired about the staff response time frame, the ED stated that staff should respond before fifteen (15) minutes.

The surveyor observed the central monitoring area in the Administrative Office. Then at 12:02 p.m., the surveyor observed a demonstration of how the ED activated a resident's pendant and the pendant's number and location was broadcasted from the portable radio. The ED then de-activated and reset the resident's pendant.

At 12:40 p.m., the surveyor reviewed the facility's policy and procedure titled, "Resident Alert Call

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A 310	Continued From page 3	A 310		

System", dated 6/7/24, which revealed that "each assisted living resident will be provided with an alert device to use in the event that assistance is needed." The policy and procedure did not indicate a specified response time frame for when staff should respond.

2. On 10/22/25 at 9:11 a.m., the surveyor interviewed the Executive Director (ED) regarding the responsibility of checking the Automated External Defibrillators (AEDs) within the facility. The ED stated that the facility had a company that comes each month to monitor the AEDs. The surveyor requested documentation regarding the monthly checks. The ED stated she would contact the company and obtain the documentation.

At 9:30 a.m., the surveyor reviewed AED # 1 located in the "AB Wellness" area. The surveyor observed that the AED functioned properly. The surveyor also observed that a monthly checklist was not present in the cabinet that contained the AED. The surveyor interviewed the Certified Medication Technician (CMT) present in the Wellness area regarding who was responsible for checking the AED each month. The CMT stated that she thought Nursing or Maintenance was responsible for monitoring the AEDs.

At 9:39 a.m., the surveyor reviewed AED # 2 located in the "CDE Wellness" area. The surveyor observed that the AED functioned properly. The surveyor also observed that a monthly checklist was not present in the cabinet that contained the AED. The surveyor interviewed the Licensed Practical Nurse (LPN) present in the Wellness area regarding who was responsible for checking the AED each month. The LPN stated that she thought either Nursing or

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A 310	Continued From page 4 Maintenance was responsible for monitoring the AED. At 10:55 a.m., the surveyor reviewed AED # 3 located in the "Memory Care Wellness" office. The surveyor observed the AED functioned properly. The surveyor did not observe that a monthly checklist was not present in the cabinet that contained the AED. At 12:40 p.m., the surveyor reviewed the document policy titled, "Automated External Defibrillator (AED)", dated 6/7/24, which indicated " ...Procedure: ...6. The Facilities Director will initiate a manual self-test of the AED at lease monthly and/or per manufacturer's recommendation. 7. The Director of Health and Wellness will ensure adequate supplies are maintained, including any disposable supplies after AED use." At 2:44 p.m., during continued surveyor interview with the ED, the surveyor again requested the documentation regarding the monthly checks on the AEDs. The ED stated that she had contacted the company but had not received the documentation. The surveyor inquired about the facility policy regarding the Facilities Director manually checking the AEDs each month. The ED stated she would probably need him to do so.	A 310		
A 511	8:36-5.5(a) Personnel (a) The facility or program shall develop and implement written job descriptions to ensure that all personnel are assigned duties based upon their education, training, and competencies and in accordance with their job descriptions.	A 511		

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A 511	Continued From page 5	A 511		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined that the facility failed to maintain a written job description in the employee file for 1 of 10 employees reviewed, Employee #7. This deficient practice was evidenced by the following:

On 10/22/25 at 9:53 a.m., the surveyor reviewed ten (10) employee files provided by the Executive Director (ED), and observed that Employee #7's file did not have a signed job description for her current job position as the ED. The surveyor reviewed Employee #7's file and observed that the most recent signed job description was for Employee #7's prior position as the Business Office Director, which was signed on [redacted NJ Ex Order 26.4(

At 2:43 p.m. the surveyor interviewed the ED and inquired about the signed job description for Employee #7. The ED stated that a signed job description should be in the file and the job description should reflect the employee's current position/title.

During the interview, the ED confirmed that her job description for the ED position was not included in the employee file that she provided to the surveyor.

The surveyor reviewed a document, provided by the ED titled, "New Hire File Checklist," which included, " ... Job Description - Signed ..."

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A 517	Continued From page 6	A 517		
A 517	8:36-5.6(b)(1-7) Staffing Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; and 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19.	A 517		

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A 517	Continued From page 7	A 517		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined that the facility failed to ensure orientation at the time of employment and/or annual mandatory in-service education for 6 of 10 employees reviewed, Employee #'s 2, 4, 5, 7, #8, and 9. This deficient practice was evidenced by the following:

On 10/22/25 at 9:53 a.m., and 12:07 p.m., the surveyor reviewed ten (10) employee files and in-service training transcripts, which were provided by the Executive Director (ED), and observed that the above six (6) employee files and in-service transcripts did not have documentation, which reflected that they received a new-hire orientation and/or all the mandatory annual in-services. The findings were as follows:

1. Employee #2's last pain management in-service was dated 7/28/24.

2. Employee #4's last pain management in-service was dated 7/1/24.

3. Employee #5's last pain management and abuse and neglect in-services were dated 7/22/24.

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A 517	Continued From page 8 4. Employee #7's last pain management in-service was dated 9/6/24. 5. Employee #8 did not have a documented orientation checklist in her employee file. Additionally, Employee #8's last assisted living concepts in-service was dated 9/3/24, resident rights in-service was dated 8/26/24, and abuse and neglect in-service was dated 7/18/24. 6. Employee #9 did not have a documented orientation checklist in her employee file. Additionally, Employee #9 did not have an assisted living concepts, resident rights, abuse and neglect, emergency training, Alzheimer dementia, and pain management in-services documented on her in-service transcript. At 2:43 p.m., the surveyor interviewed the ED and inquired about orientation and the mandatory annual in-services. The ED stated that new-hire orientations should be in the employee files. Additionally, the ED stated that all in-services that were completed were documented on the in-service transcripts. The surveyor reviewed a document provided by the ED titled, "New Hire File Checklist," which included, " ... Orientation Checklist ..."	A 517		
A 535	8:36-5.6(e) Staffing Requirements (e) The facility or program shall employ reasonable efforts to ensure that no employee has been convicted of a crime relating adversely to the person's ability to provide resident care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children	A 535		

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A 535	Continued From page 9 or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to quality for employment at the facility or program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to obtain a background check for 1 of 10 employees reviewed, Employee #8. This deficient practice was evidenced by the following: On 10/22/25 at 9:53 a.m., the surveyor reviewed 10 (ten) employee files provided by the Executive Director (ED), and observed that Employee #8's file did not include documented evidence which reflected that a background check was completed prior to or upon the employee's *NJ Ex Order 26. 4B1* [redacted]. At 2:43 p.m. the surveyor interviewed the ED and inquired about Employee #8's background check. The ED confirmed that there was no documented evidence of Employee #8's background check in the employee's file. The surveyor reviewed a document, which was provided by the ED titled, "New Hire File Checklist," which included, " ... Background Check Results ..."	A 535		
A 537	8:36-5.7(a)(1) Policy and Procedure Manual	A 537		

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A 537	Continued From page 10 (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and resident care services of the facility or program; This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to review policies and procedures at least annually. This deficient practice was evidenced by the following: On 10/22/25 at 9:28 a.m., the surveyor conducted a record review which revealed no documented review or update to the facility's policy and procedure manual. The surveyor observed an undated document titled, "Cleaning Checklists and Temperature Logs", that disclosed no written evidence that revealed when the policy was created, reviewed, or updated. The surveyor also reviewed other undated	A 537		

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policies and procedures titled, "Opening Procedures", "Culinary Equipment", "Food Purchasing and Storage", and "Food Contamination and Storage", which revealed no written evidence detailing when it was created, reviewed, or updated.

At 12:40 p.m., during continued surveyor review of the facility's policy and procedure manual, the surveyor observed that two (2) documents, dated 6/7/24, revealed no written documentation that they were reviewed. These documents were titled, "Resident Alert Call System" and "Automated External Defibrillator (AED)".

At 2:23 p.m., the surveyor observed no written documentation of medication or pharmacy policies and procedures having had been reviewed or updated. The surveyor reviewed three (3) documents, all dated August 2016, titled, "Medication Ordering and Receipt", "Pharmacy Services", and "Medication Orders". The surveyor did not observe any documentation that these policies were reviewed or updated.

During continued review of the policy and procedure manual, the surveyor observed that the name on top of each page was different than the name of the facility.

At 2:44 p.m., the surveyor interviewed the Executive Director (ED) regarding documentation of the policies and procedures being reviewed and updated at least annually. The ED stated that the management company that recently purchased the facility was responsible. When asked about the name on top of the policies and procedures was the name of the management company that owned the facility.

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A 891	Continued From page 12	A 891		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, in accordance with the New Jersey Administrative Code (N.J.A.C.) 8:24 "Sanitation in Retail Food Establishments, Food and Beverage Vending Machines and Cottage Food Operations", it was determined that the dietary staff failed to implement personal hygiene and failed to date and store food upon opening to prevent food contamination. In addition, the facility failed to ensure that the equipment used to scoop ice was maintained in a drainable holder to prevent condensation. This deficient practice was evidenced by the following: On 10/21/25 at 9:41 a.m., during surveyor tour of the facility kitchen, in the presence of the Culinary Director (CD), the surveyor observed a staff	A 891		

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member was not wearing a hair net while cleaning the preparation area in the kitchen.

At 9:53 a.m., the surveyor observed three (3) opened clear bags of pasta, which were either tied or had clear plastic wrap around it. The surveyor also observed no written documentation of when the bags were opened or an expiration date. When the surveyor asked about the bags, the CD stated that she did not have a reason for why there was no written dates and the pasta not being properly stored.

At 10:09 a.m., the surveyor observed that a plastic bin holding the ice scoop was located on the wall near the ice machine. Upon opening the bin, the surveyor observed no drainage holes in the bottom of the bin for the melted ice. When the surveyor interviewed the Executive Chef (EC) about how excess moisture was eliminated from the scoop, the ED stated that maintenance will drill a couple of holes in the bottom of the bin. The EC also stated that the bin was removed from the wall and washed in the dishwasher every week.

At 1:13 p.m., the surveyor observed that the mixer and meat slicer were clean but uncovered. The surveyor interviewed the EC about the coverings. The EC stated that the facility did have bags to cover the equipment, but they were broken, so new bags were ordered. When the surveyor interviewed the CD regarding the coverings, she stated that she does have bags to cover the equipment, but did not know that they should be covered.

At 2:05 p.m., the surveyor reviewed an undated policy and procedure document titled, "Food Contamination and Storage", which revealed that

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A 891	Continued From page 14 "Personal Hygiene ... Staff must always wear clean uniforms, aprons, hair restraints, ...". In continued surveyor review of the facility's policies and procedures revealed an undated document titled, "Food Contamination and Storage". This document indicates that "2. Contamination Prevention is Food Storage ... All food items must be dated upon delivery" and "Cover, wrap, or store food in sealed, food grade containers to prevent cross-contamination and maintain freshness."	A 891		
A 901	8:36-10.5(c)(4) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 4. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus shall be posted in a conspicuous place in residents' area, and/or a copy of the menu shall be provided to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with changes or substitutes, shall be kept on file in the facility for at least 30 days; This REQUIREMENT is not met as evidenced by:	A 901		

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A 901	Continued From page 15 Based on observation, interview, and record review, it was determined that the facility failed to ensure that meals were prepared and served in accordance with, but not limited to, current menus with portion sizes and changes in menus being posted in the food preparation area. This deficient practice is evidenced by the following: On 10/21/25 at 11:13 a.m., the surveyor observed that during a tour of the facility kitchen, menus without portion sizes were posted in the meal preparation areas. At this time, the surveyor interviewed a cook regarding the menus without portion sizes, the cook stated that the Culinary Director (CD) had a binder in her office that contains the portion sizes. The cook also stated that the kitchen staff will go to the Culinary Director's office to look in the binder to find the portion sizes and put the appropriate utensil at each food. At 1:13 p.m., the surveyor interviewed the CD regarding the menus without the portion sizes posted in the food preparation areas, she stated that she has a binder in her office that contained the measurements of the ingredients and the portion sizes to be served. The CD stated that the kitchen staff looked in the binder for the portion sizes of the foods to be served to the residents. The surveyor informed the CD that the portion sizes were to be posted on the menus at the food preparation areas.	A 901		
A 925	8:36-11.2 Provisions of Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical	A 925		

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A 925	Continued From page 16	A 925		

services are provided to residents in accordance with
the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined that the facility failed to ensure that pharmaceutical services were provided in accordance with the prescriber orders for 1 of 7 residents reviewed, Resident #1. This deficient practice was evidenced by the following:

On 10/21/25 at 1:04 p.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that the resident was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1)

Continued surveyor review of Resident #1's MR revealed orders for *NJ Ex Order 26. 4B1* The surveyor reviewed Resident #1's *NJ Ex Order 26. 4B1* order and observed that the resident's scheduled dose was changed on NJ Ex Order 26.4(and the NJ Ex Order 26.4(b)(1) dose was also changed on NJ Ex Order 26.4(b)(. The findings were as follows:

1. The prescription dated NJ Ex Order 26.4(indicated, "a. [discontinue] standing *NJ Ex Order 26. 4B1* [times] daily [with] meals. b. Start *NJ Ex Order 26. 4B1* [times] daily [with] meals ..."

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A 925	Continued From page 17 2. The prescription order dated [redacted] documented the order change for Resident #1's [redacted] which indicated, " ... [redacted]]" On 10/21/25 at 11:45 a.m., the surveyor observed Resident #1's [redacted] in Medication Cart A. The surveyor observed that Resident #1's [redacted] was in a bag with a prescription label from the pharmacy which revealed, "[redacted]." The surveyor cross-referenced Resident #1's orders documented in the electronic medication administration record (EMAR) and observed a discrepancy between the [redacted] orders in the EMAR and the orders that were documented on the [redacted] bag label. At 11:46 a.m., the surveyor interviewed the Medication Technician (MT) and inquired about the discrepancy between the label on the [redacted] bag and the orders in the EMAR for Resident #1. The MT confirmed that there was a discrepancy and that the label on the [redacted] bag reflected the discontinued orders for Resident #1's [redacted] doses. On 10/22/25 at 12:38 p.m., the surveyor interviewed the MT and asked the MT if there was another [redacted] for Resident #1, with the correct label, in the medication cart. The MT stated that the facility never received a delivery of the new [redacted] after the dose order was	A 925		

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A 925	Continued From page 18 changed. At 2:01 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about Resident #1's [redacted] label. The DHW stated that the bag with the [redacted] and the discontinued orders should have been removed from the medication cart and replaced with the new order of the [redacted]. Additionally, the DHW stated that the facility's pharmacy notified the facility, via letter that there was a "glitch" with the pharmacy's system a few weeks ago. At 2:27 p.m., the surveyor reviewed the pharmacy's letter to the facility dated 9/26/25 provided by the DHW which revealed, " ... We are pleased to inform you that our pharmacy systems are now fully restored and we have resumed normal operations ... As we return to normal workflows, please note the following: 1. Backlog Processing We are actively working through the backlog of orders and refill requests received during the outage ..." The surveyor reviewed the facility's undated pharmacy policy, titled, "Medication Ordering and Receipt," which revealed, " ... K. Resident medication records will be updated when new medications are ordered as well as when medications are changed or discontinued ..." The surveyor reviewed another undated pharmacy policy, titled, "Quality Assurance," which revealed, "... Develop and supervise medication management systems to ensure that adequate supplies of medications are available to meet resident care needs ... delivered to residents in a timely, safe, and efficient manner; and labeled appropriately ..."	A 925		

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A 935	8:36-11.4(b) Administration of medications (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to administer medication in accordance with prescriber orders for 1 of 7 residents reviewed, Resident #1. This deficient practice was evidenced by the following: On 10/21/25 at 1:04 p.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that the resident was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1) Continued surveyor review of Resident #1's MR revealed orders for *NJ Ex Order 26. 4B1* The surveyor reviewed Resident #1's *NJ Ex Order 26. 4B1* orders and observed that the resident's scheduled dose was changed on NJ Ex Order 26.4(and that the NJ Ex Order 26.4(b)(1) dose was changed on NJ Ex Order 26.4(b)(1) The findings were as	A 935		

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A 935	Continued From page 20	A 935		

follows:

1. The prescription dated [redacted] indicated, "a). [discontinue] standing *NJ Ex Order 26. 4B1* [times] daily [with] meals. b). Start *NJ Ex Order 26. 4B1* [times] daily [with] meals ..."

2. The prescription order dated [redacted] documented the order change for Resident #1's [redacted] which indicated, " ... [redacted] before meals bedtime per [redacted]: *NJ Ex Order 26. 4B1* [redacted]"

On 10/21/25 at 11:42 a.m., the surveyor observed the Medication Technician (MT) obtain Resident #1's *NJ Ex Order 26. 4B1* and administer the *NJ Ex Order 26. 4B1* for the resident's scheduled dose and [redacted] dose. The surveyor observed the MT obtain Resident #1's [redacted] via the resident's personal *NJ Ex Order 26. 4B1* [redacted]. The surveyor observed the MT administer the scheduled *NJ Ex Order 26. 4B1* to Resident #1. Additionally, the MT administered [redacted] to Resident #1, for the [redacted] dose.

At 11:45 a.m., the surveyor referenced the electronic medication administration record (EMAR) and observed that the MT administered the incorrect dose of [redacted] to Resident #1. Surveyor review of Resident #1's [redacted] order revealed that with a [redacted], the resident should have received *NJ Ex Order 26. 4B1*. The MT administered *NJ Ex Order 26. 4B1* to Resident #1, [redacted] more units than prescribed by the physician.

At 11:46 a.m., the surveyor interviewed the MT and inquired about the doses of [redacted] that she

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A 935	Continued From page 21 administered to Resident #1. The MT stated that since Resident #1's NJ Ex Order 26. 4B1, she administered NJ Ex Order 26. 4B1 in addition to the scheduled NJ Ex Order 26. 4B1. The MT reviewed Resident #1's NJ Ex Order 26.4(b)(1) as it was documented in the EMAR and confirmed that she administered Resident #1 NJ Ex Order 26. 4B1 additional units than what was prescribed by the physician. At 1:18 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about Resident #1's NJ Ex Order 26. medication error that was identified on NJ Ex Order 26.4(b)(1. The DHW confirmed that the MT notified her of the NJ Ex Order 26. dose error for Resident #1. Additionally, the DHW stated that the MT should have verified the order within the EMAR. Further, the DHW stated that if a staff member required clarification regarding a medication order, they were expected to notify the DHW directly to request clarification. The surveyor reviewed a facility policy titled, "Documenting Medication Pass," dated 6/7/24, which revealed, "... All medication staff members will pour the medication they are giving and verify the medication three (3) times during the pour process. a. All medications are administered per physician orders ..."	A 935		
A 937	8:36-11.5(a) Certified Medication Aide Program (a) The administration of medications is within the scope of practice and remains the responsibility of the registered professional nurse.	A 937		

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A 937	Continued From page 22	A 937		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined that the facility's Registered Nurse (RN), failed to ensure the responsibility of accurate administration of medication to 1 of 7 residents reviewed, Resident #1. This deficient practice was evidenced by the following:

On 10/21/25 at 1:04 p.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that the resident was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1) Continued surveyor review of Resident #1's MR revealed orders for *NJ Ex Order 26. 4B1* . The surveyor reviewed Resident #1's *NJ Ex Order 26. 4B1* orders and observed that the resident's scheduled dose was changed on NJ Ex Order 26.4(and the NJ Ex Order 26.4(b)(1) dose was changed on NJ Ex Order 26.4(b)(1). The findings were as follows:

1. The prescription dated NJ Ex Order 26.4(revealed, "a). [discontinue] standing *NJ Ex Order 26. 4B1* daily [with] meals. b). Start *NJ Ex Order 26. 4B1* [times] daily [with] meals ..."

2. The prescription order dated NJ Ex Order 26.4(b)(1) documented the order change for Resident #1's NJ Ex Order 26. NJ Ex Order 26.4(b)(1) which revealed, " ... NJ Ex Order 2 before meals bedtime per NJ Ex Order 26.4(b)(1): *NJ Ex Order 26. 4B1*]"

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A 937	Continued From page 23 On 10/21/25 at 11:42 a.m., the surveyor observed the Medication Technician (MT) check Resident #1's NJ Ex Order 26. 4B1 and administered the NJ Ex Order 26. 4B1 for the resident's scheduled dose and also the NJ Ex Order 26.4(b)(1) dose. The surveyor observed the MT obtain Resident #1's NJ Ex O via the resident's personal NJ Ex Order 26. 4B1 . The surveyor observed the MT administer the scheduled NJ Ex Order 26. 4B1 to Resident #1. Additionally, the MT administered NJ to Resident #1, for the NJ Ex Order 26 dose. At 11:45 a.m., the surveyor observed Resident #1's NJ Ex Order 26. 4B1 in a bag with a prescription label from the pharmacy which revealed, "NJ Ex Order 26. 4B1 ." The surveyor cross-referenced Resident #1's orders documented in the electronic medication administration record (EMAR) and observed a discrepancy between the NJ Ex Order 26. 4B1 orders in the EMAR and the NJ Ex Order 26. 4B1 bag label. Surveyor review of Resident #1's NJ Ex Order 26. NJ Ex Order 26.4(b)(1) order revealed that with a NJ Ex Order 26. 4B1 , the resident should have received NJ Ex Order 26. 4B1 . However, the MT administered NJ Ex Order 26. 4B1 to Resident #1, NJ Ex Order 26. 4B1 more units than prescribed. At 11:46 a.m., the surveyor interviewed the MT and inquired about the discrepancy between the label on the NJ Ex Order 26. 4B1 bag and the orders in the EMAR for Resident #1. The MT confirmed that there was a discrepancy and the label on the NJ Ex Order 26. 4B1 bag reflected the discontinued orders	A 937		

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A 937	Continued From page 24 for Resident #1's NJ Ex Order 26. 4B1 doses. At 1:18 p.m., the surveyor interviewed the Director of Health and Wellness (DHW), a RN, and inquired about Resident #1's NJ Ex Order 26. medication error that was identified on NJ Ex Order 26.4(b)(1). The DHW stated that the MT notified her of the NJ Ex Order 26. dose error for Resident #1. During continued surveyor interview, the DHW stated that the MT should have verified the order within the EMAR. Further, the DHW stated that if a staff member required clarification regarding a medication order, they were expected to notify the DHW directly to request clarification. On 10/22/25 at 2:01 p.m., the surveyor interviewed the DHW and inquired about the facility's protocol in discontinuing medications and medications order changes. The DHW stated that it was her responsibility, as the RN to audit the medication carts and remove the discontinued medications. Additionally, the DHW stated that when a medication order was changed, she would ensure that a new medication per the physician's orders was available in the cart. The surveyor reviewed a facility policy titled, "GP17 - Nurse Delegation," dated 6/7/24, which revealed, " ... The RN takes responsibility and accountability for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurses obligation to provide optimum resident care ... The RN shall provide appropriate documentation, periodic inspection, supervision, and re-evaluation of a delegated task of nursing care ..."	A 937		

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A 963	Continued From page 25	A 963		
A 963	8:36-11.5(f) Certified Medication Aide Program (f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure medications were accurately administered and documented by properly authorized individuals, in accordance with prescribed orders to 6 of 7 residents reviewed, Resident #'s 1, 2, 3, 4, 5, and 7. This deficient practice was evidenced by the following: 1.On 10/22/25 at 11:15 a.m., the surveyor reviewed the medical record (MR) for Resident # 1, which revealed that the resident was admitted to the facility on NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1). The surveyor observed there were multiple blank spaces in his/her electronic Medical Record (eMAR) for NJ Ex Order 26.4(to NJ Ex Order 26.4(b) The blank spaces were as follows: NJ Ex Order 26. 4B1 at 6:00 a.m. and NJ Ex Order 26. 4B1 at 5:00 a.m on NJ Ex Order 26.4(. NJ Ex Order 26. 4B1 at 6:00 a.m. and NJ Ex Order 26. 4B1 at 5:00 a.m. on NJ Ex Order 26.4(b) NJ Ex Order 26. 4B1 at 9:00 p.m. and NJ Ex Order 26. 4B1 at 9:00 p.m. on NJ Ex Order 26.4(b)	A 963		

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NJ Ex Order 26. 4B1 at 6:00 a.m. and NJ Ex Order 26. 4B1 at 5:00 a.m. on NJ Ex Order 26.4(b)(NJ Ex Order 26. 4B1 at 5:00 a.m. on NJ Ex Order 26.4(. NJ Ex Order 26. 4B1 at 5:00 a.m. on NJ Ex Order 26.4(b) NJ Ex Order 26. 4B1 at 12:00 p.m. and NJ Ex Order 26. 4B1 at 6:00 a.m. on NJ Ex Order 26.4(. NJ Ex Order 26. 4B1 at 6:00 a.m. and NJ Ex Order 26. 4B1 at 5:00 a.m. on NJ Ex Order 26.4(b)

2. At 11:30 a.m., the surveyor reviewed the MR of Resident # 2, which revealed that the resident was NJ Ex Order 26. 4B1 . Review of Resident # 2's eMAR revealed that blank spaces were present between NJ Ex Order 26.4(to NJ Ex Order 26.4(. The blanks were as follows:

NJ Ex Order 26. 4B1 at 10:00 a.m., NJ Ex Order 26. 4B1 at 10:00 a.m.(NJ Ex Order 2), NJ Ex Order 26. 4B1 at 10:00 a.m. NJ Ex Order 26. 4B1 at 10:00 a.m., NJ Ex Order 26. 4B1 at 10:00 a.m., NJ Ex Order 26. 4B1 at 10:00 a.m., NJ Ex Order 26. 4B1 at 10:00 a.m., NJ Ex Order 26. 4B1 at 9:00 a.m. and NJ Ex Order 26. 4B1 at 7:30 a.m. on NJ Ex Order 26.4(. NJ Ex Order 26. 4B1 at 9:00 a.m. on NJ Ex Order 26.4(.

3. At 11:45 a.m., the surveyor reviewed Resident # 3's MR which revealed that the resident was admitted to the facility on NJ Ex Order 26.4(b)(1) with diagnoses that included NJ Ex Order 26.4(b)(and NJ Ex Orde The surveyor reviewed Resident # 3's eMAR which revealed blank spaces within the

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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) COMPLETE DATE
A 963	Continued From page 27	A 963		

time period of NJ Ex Order 26.4(b) to NJ Ex Order 26.4(b)(1):

NJ Ex Order 26. 4B1 at 6:00 a.m. on NJ Ex Order 26.4(b)(1).
NJ Ex Order 26. 4B1 at 2:00 p.m. on NJ Ex Order 26.4(b)(1).
NJ Ex Order 26. 4B1 at 2 p.m. on NJ Ex Order 26.4(b)(1).
NJ Ex Order 26. 4B1 at 2:00 p.m and 9:30 p.m., NJ Ex Order 26. 4B1 at 8:00 p.m. (NJ Ex Order 26. 4B1) and NJ Ex Order 26. 4B1 at 7:30 p.m.(NJ Ex Order 26. 4B1) on NJ Ex Order 26.4(b)(1).

4. At 11:54 a.m., the surveyor review Resident # 4's MR which revealed the resident was admitted to the facility in NJ Ex Order 26.4(b)(1) with diagnoses that included a NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order The surveyor reviewed the resident's eMAR from NJ Ex Order 26.4(b) to NJ Ex Order 26.4(b)(1) which revealed multiple blank spaces:

NJ Ex Order 26. 4B1 at 9:00 p.m. on NJ Ex Order 26.4(b).
NJ Ex Order 26. 4B1 at 8:00 p.m., NJ Ex Order 26. 4B1 at 8:00 p.m. (NJ Ex Order 26. 4B1), NJ Ex Order 26. 4B1 at 9:00 p.m. and NJ Ex Order 26. 4B1 at 5:00 p.m.on NJ Ex Order 26.4(b)(1).
NJ Ex Order 26. 4B1 at 5:00 p.m. and NJ Ex Order 26. 4B1 at 5:00 p.m. on NJ Ex Order 26.4(b)(1).
NJ Ex Order 26. 4B1 at 9:00 a.m., NJ Ex Order 26. 4B1 at 8:00 a.m., NJ Ex Order 26. 4B1 at 9:00 a.m., NJ Ex Order 26. 4B1 at 8:00 a.m.
NJ Ex Order 26. 4B1 at 9:00 a.m., NJ Ex Order 26. 4B1 at 7:30 a.m., NJ Ex Order 26. 4B1 at 9:00 a.m. and NJ Ex Order 26. 4B1 at 8:00 a.m. on NJ Ex Order 26.4(b)(1) NJ Ex Order 26. 4B1 at 8:p.m., NJ Ex Order 26. 4B1 at 8:00 p.m., NJ Ex Order 26. 4B1 at 7:30 a.m. and NJ Ex Order 26. 4B1 at 9:00 p.m. on NJ Ex Order 26.4(b)(1)

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	55A009	A. BUILDING: _____ B. WING _____	10/22/2025

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MATTISON CROSSING AT MANALAPAN AVENU	93 MANALAPAN AVENUE FREEHOLD, NJ 07728

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5. At 12:11 p.m., the surveyor reviewed Resident # 5's MR which revealed that the resident was admitted to the facility in NJ Ex Order 26.4(b)(1) with diagnoses that included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Continued surveyor review revealed blank spaces in Resident # 5's eMAR from NJ Ex Order 26.4(to NJ Ex Order 26.4(b)(1)

NJ Ex Order 26. 4B1 at 9:00 p.m.,
NJ Ex Order 26. 4B1 at 9:00 p.m.,
NJ Ex Order 26. 4B1 at 9:00 p.m. and
NJ Ex Order 26. 4B1 at 9:00 p.m. on NJ Ex Order 26.4(b)
NJ Ex Order 26. 4B1 at 5:00 p.m.,
NJ Ex Order 26. 4B1 at 5:00 p.m.,
NJ Ex Order 26. 4B1 at 5:00 p.m. and
NJ Ex Order 26. 4B1 at 5:00 p.m. on
NJ Ex Order 26.4(b)(1).
NJ Ex Order 26. 4B1 at 9:00 a.m., NJ Ex Order 26. 4B1 at 9:00 a.m. and 1 p.m.,
NJ Ex Order 26. 4B1 at 9:00 a.m. and 1:00 p.m., NJ Ex Order 26. 4B1 at 9:00 a.m.,
NJ Ex Order 26. 4B1 at 9:00 a.m.,
NJ Ex Order 26. 4B1 at 9:00 a.m., NJ Ex Order 26. 4B1 at 9:00 a.m., NJ Ex Order 26. 4B1 at 9:00 a.m. and NJ Ex Order 26. 4B1 at 9:00 a.m. on NJ Ex Order 26.4(b)(1).
NJ Ex Order 26. 4B1 at 5:00 p.m.,
NJ Ex Order 26. 4B1 at 5:00 p.m.,
NJ Ex Order 26. 4B1 at 5:00 p.m. and
NJ Ex Order 26. 4B1 at 5:00 p.m. on
NJ Ex Order 26.4(b)(1)
NJ Ex Order 26. 4B1 at 5:00 p.m., NJ Ex Order 26. 4B1 at 1:00 p.m., NJ Ex Order 26. 4B1 at 1:00 p.m. and 5:00 p.m., NJ Ex Order 26. 4B1 at 5:00 p.m. and NJ Ex Order 26. 4B1 at 5:00 p.m. on NJ Ex Order 26.4(b)(1)
NJ Ex Order 26. 4B1 at 5:00 p.m., NJ Ex Order 26. 4B1 at 1:00 p.m. and 9:00 p.m.,

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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) COMPLETE DATE
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NJ Ex Order 26. 4B1 at 1:00 p.m., 5:00 p.m., and 9:00 p.m., NJ Ex Order 26. 4B1 at 5:00 p.m., NJ Ex Order 26. 4B1 at 9:00 p.m., NJ Ex Order 26. 4B1 at 5:00 p.m. and NJ Ex Order 26. 4B1 at 9:00 p.m. on NJ Ex Order 26.4(b)(1).

6. At 12:25 p.m., the surveyor reviewed Resident # 7's MR which revealed that the resident was admitted to the facility in NJ Ex Order 26.4(b)(1) with diagnoses that included NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Continued surveyor review revealed blank spaces on Resident # 7's eMAR during the time period of NJ Ex Order 26.4(to NJ Ex Order 26.4(b)(1)

NJ Ex Order 26. 4B1 at 9:00 a.m., NJ Ex Order 26. 4B1 at 9:00 p.m., NJ Ex Order 26. 4B1 at 9:00 p.m., NJ Ex Order 26. 4B1 at 9:00 a.m., NJ Ex Order 26. 4B1 9:00 a.m. and 5:00 p.m., NJ Ex Order 26. 4B1 at 9:00 a.m. and NJ Ex Order 26. 4B1 at 9:00 a.m. on NJ Ex Order 26.4(.
NJ Ex Order 26. 4B1 at 9:00 p.m., NJ Ex Order 26. 4B1 at 9:00 p.m. and NJ Ex Order 26. 4B1 at 5:00 p.m. on NJ Ex Order 26.4(b)(1
NJ Ex Order 26. 4B1 at 9:00 p.m. and NJ Ex Order 26. 4B1 at 9:00 p.m. on NJ Ex Order 26.4(b)
NJ Ex Order 26. 4B1 at 9:00 p.m. and NJ Ex Order 26. 4B1 at 9:00 p.m. on NJ Ex Order 26.4(b)
NJ Ex Order 26. 4B1 at 9:00 p.m. and NJ Ex Order 26. 4B1 at 9:00 p.m. on NJ Ex Order 26.4(b)
NJ Ex Order 26. 4B1 at 9:00 p.m. and NJ Ex Order 26. 4B1 at 9:00 p.m. on NJ Ex Order 26.4(b)(1.
NJ Ex Order 26. 4B1 at 5:00 p.m. on NJ Ex Order 26.4(b)(1.
NJ Ex Order 26. 4B1 at 5:00 p.m. on NJ Ex Order 26.4(b)(1)
NJ Ex Order 26. 4B1 at 9:00 p.m., NJ Ex Order 26. 4B1 at 9:00 p.m. and NJ Ex Order 26. 4B1 at 5:00 p.m. on NJ Ex Order 26.4(b)(1)

On 10/22/25 at 2:02 p.m., the surveyor interviewed the Health and Wellness Nurse

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A 963	Continued From page 30 (HWN) regarding the blank spaces on the residents' MARs. The HWN stated that the MARs were audited weekly by her and she addressed the blank spaces with the appropriate staff member. Further surveyor document review revealed a policy and procedure titled, "Medication Ordering and Receipt", dated August 2016. A section within this document revealed "Medications obtained by resident or family/responsible party for residents who independently manage and administer their own medications ... Policy ... Procedures (All Pharmacies) ... F. Current medication orders will be documented on the resident's medication record ...".	A 963		
A 999	8:36-11.7(e) Storage and Control of Medications (e) Discontinued or expired medications shall be destroyed within 30 days in the facility, or, if unopened and properly labeled, returned to the pharmacy for credit, if allowable, and in conformance with N.J.A.C. 13:39 and other State and Federal laws, codes, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to destroy 5 expired medications in Medication Cart A, within 30 days. This deficient practice was evidenced by the following:	A 999		

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A 999	Continued From page 31 On 10/21/25 at 11:36 a.m., the surveyor observed five (5) expired medications that were inside of Medication Cart A, which revealed the followings: 1. One (1) dulera 200 microgram (mcg) - 5 mcg inhaler, which had a label that revealed, "Do Not Use After 6/27/25." 2. One (1) package of Ondansetron 4 milligram (mg) tablets, which had a label that revealed, "Discard After: 3/23/25." 3. One (1) package of acetaminophen 650 mg suppositories, which had a label that revealed, "Discard After: 7/21/25." 4. One (1) package of bisacodyl 10 mg suppositories, which had a label that revealed, "Discard After: 7/21/25." 5. One (1) package of hyoscyamine 0.125 mg sublingual tablets, which had a label that revealed, "Discard After: 7/21/25." At 11:39 a.m., the surveyor interviewed a Medication Technician (MT) and inquired about the expired medications in Medication Cart A. The MT confirmed that the five (5) medications identified were expired and that the expired medications should have been removed from the medication cart. On 10/22/25 at 2:01 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about medication cart audits. The DHW stated that she was responsible for performing the medication cart audits each month. During continued surveyor interview, the DHW stated that all expired medications should have been removed from the medication carts.	A 999		

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A 999	Continued From page 32 The surveyor reviewed a facility policy titled, "MP21 - Medication Disposal and Destruction," dated 6/7/24, which revealed, "... Expired, discontinued, or unneeded medications will be disposed of or destroyed ..."	A 999		
A1033	8:36-14.2(a) Emergency Plans and Procedures (a) The facility shall develop written emergency plans, policies, and procedures which shall include plans and procedures to be followed in case of medical emergencies, power failures, fire, and natural disasters. The emergency plans shall be filed with the Department and the Department shall be notified when the plans are changed. Copies of emergency plans shall also be forwarded to other agencies in accordance with State and municipal laws.. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the Emergency Preparedness Plan (EPP) was reviewed and updated at least every two years, in accordance with Appendix Z, Emergency Preparedness for all Provider and Supplier Types. This deficient practice was evidenced by evidenced by the following: On 10/21/25 the surveyor reviewed the EPP and observed the followings: 1. No signature page to indicate review of the EPP program for the year 2025 or any previous	A1033		

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A1033	Continued From page 33 years. 2. No Transfer Agreements between other facilities. 3. No revision dates within the last two years for any policies and procedures. On 10/22/25 at 1:30 p.m., during surveyor interview with the Executive Director (ED), the ED confirmed that the EPP had not been updated or forwarded to other agencies in accordance with State and Municipal laws. N.J.A.C. 8:36-14.2(a) N.J.A.C. 5:70 NFPA 101	A1033		
A1041	8:36-14.3(a) Drills and Tests (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills.	A1041		

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A1041	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire conditions in accordance with NFPA 101; 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was evidenced by the following: On 10/21/25 in the presence of the Executive Director (ED) and the Director of Building Services (DBS), the surveyor reviewed the fire drill records. The fire drill records provided by the ED revealed 9 of the last 12 months fire drills completed in 2025. There was no documentation to indicate that fire drills were conducted in the month of February, August and September of 2025. On 10/22/25 at 2:30 p.m., during interview with the ED and DBS, both confirmed that the fire drills were not conducted in the month of February, August and September of 2025. NJAC 8:36-14.3(a)	A1041		
A1043	8:36-14.3(b) Drills and Tests (b) The facility shall request of the local fire department that at least one joint fire drill be conducted annually. Upon scheduling a joint fire drill, the facility shall notify first aid and civil defense agencies of this drill and shall participate in community-wide disaster drills.	A1043		

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A1043	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to request of the local fire department at least one joint fire drill be conducted annually. This deficient practice was evidenced by the following: On 10/21/25 at 12:15 p.m., in the presence of the Executive Director (ED) and the Director of Building Services (DBS), the surveyor reviewed the facility's Emergency Preparedness Plan. Surveyor review of all Fire/Emergency drills revealed that there were no documentation indicating a joint fire drill with the local fire department or any documentation of notification to the local authorities requesting participation in a drill with the facility. On 10/22/25 at 1:30 p.m., during interview with the ED. the ED confirmed the above fire drill concerns. N.J.A.C. 8:36-14.2(a)	A1043		
A1095	8:36-16.5(b) Automatic Fire Detection System (b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended	A1095		

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A1095	Continued From page 36 and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101.. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to inspect, test and maintain the automatic fire detection system in accordance with NFPA 72 National Fire Alarm Code and N.J.A.C. 8:36-16.5(b). This deficient practice was evidenced by the following: On 10/21/25, the surveyor inspected the fire alarm panel in the presence of the Executive Director (ED) and the Director of Building Services (DBS), and observed that the fire alarm system was in trouble mode. Additionally, observations of the 2nd floor B Pod mechanical room revealed, the main fire alarm control panel, 2 booster subpanels and the cellular communicator antennas were located in the room. The Mechanical room was not continuously occupied and there was no smoke detector protection. On 10/22/25, surveyor record review revealed, the "Trouble" was identified during the semiannual fire alarm system inspection in April of 2025. More than 5 months have passed with the fire alarm system not being repaired.	A1095		

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A1095	Continued From page 37 During surveyor interview with the DBS, the DBS acknowledged the fire alarm system and the mechanical room concerns.	A1095		
A1097	8:36-16.6 Fire Suppression Systems All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that fire sprinkler systems were Inspected, Tested and Maintained (ITM) in accordance with NFPA 25:2011 Edition, Section 5.1.3, Table 5.1.1.2, 14.2.1, 5.2.4 and 5.3.2. This deficient practice was evidenced by the following: Surveyor documentation review on 10/21/2025 revealed sprinkler system quarterly inspections on systems marked ID 3 and ID 4 on 6/4/2025, quarterly inspection on systems marked ID 3 on 3/6/2025, system marked ID 4 on 3/4/2025 and	A1097		

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A1097	Continued From page 38 an annual on systems marked ID 3 and 4 on 12/10/2024. Documentation did not include a sprinkler inspection for September of 2025. An observation on 10/21/2025 at 1:43 PM revealed that the gauges on the dry sprinkler system were dated 08/04/2025 to be replaced or tested 8/04/2025. Gauges had not been replaced at time of survey. A documentation review on 10/21/2025, of the sprinkler system inspections from 6/4/2025, 3/4/2025 and 12/10/2024 revealed no documented testing of said gauges. On 10/22/2025 at 2:30 PM the surveyor interviewed the ED and DBS and both acknowledged the above concerns. N.J.A.C. 5:23 N.J.A.C 8:36-16.6(a) NFPA 25	A1097		
A1105	8:36-16.8(c) General Residential Unit Requirements (c) Residential units shall be lockable by the occupant(s). Egress from the unit shall be possible at all times and locking hardware shall enable occupant(s) to gain egress from within by means of a simple operation. All residential units shall be accessible by means of a master key or similar system which is available at all times in the facility, and available at all times for use by designated staff.	A1105		

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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) COMPLETE DATE
A1105	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/21/25 in the presence of the Director of Building Services (DBS), it was determined that the facility failed to ensure residents units were lockable by the occupant with locking hardware that enables egress with a simple operation for 3 of 10 observed rooms in accordance with NJAC 8:36-16.8(c). This deficient practice was evidenced by the following: At 1:20 p.m., the surveyor inspected the 3rd floor D pod area which revealed, resident rooms NJ Ex Order 26 [redacted] did not have any door handle hardware of any kind. The doors had a hole through the door where the hardware would go. During interviews with the DBS, the DBS confirmed the observations and stated that the rooms were unoccupied. However, the beds were licensed beds and the unit was not closed off. On 10/22/25 at 2:30 p.m., the surveyor informed the facility's Executive Director and Director of Building Services of the above concerns.	A1105		
A1125	8:36-16.12(d) Laundry Equipment (d) All dryers shall be vented to the outside of the building and properly maintained including the removal of lint.	A1125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55A009	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTISON CROSSING AT MANALAPAN AVENU	93 MANALAPAN AVENUE FREEHOLD, NJ 07728

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A1125	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to clean the commercial type laundry dryer ducts on a regular schedule in accordance with NJAC 8:36-16.12(d). This deficient practice was evidenced by the following: 10/21/25 in the presence of the Executive Director (ED) and the Director of Building Services (DBS), the surveyor reviewed the documentation provided by the facility and record revealed that there was no documentation that the commercial laundry dryer ducts had been cleaned in the last 12 months. On 10/22/23 at 2:30 p.m., during surveyor interview with the DBS and the ED, the DBS confirmed the above laundry dryer ducts concern.	A1125		
A1169	8:36-16.15(a) Fire Extinguisher Specifications (a) Fire extinguishers shall comply with National Fire Protection Association (NFPA) 10, Standards For Portable Fire Extinguishers, 2002 edition, incorporated herein by reference, as amended and supplemented, available from: NFPA, One Batterymarch Park, Quincy, MA, 02169-7471, http://www.nfpa.org, 1-800-344-3555. This REQUIREMENT is not met as evidenced by:	A1169		

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A1169	Continued From page 41 Based on observation and interview on, it was determined that the facility failed to conduct monthly fire extinguisher inspections for 19 of 19 fire extinguishers observed, in accordance with NFPA 10: 2002 Edition, Section 7.1, 7.2, 7.3, 7.2.7.3 and 7.2.4.5. This deficient practice had the potential to affect all residents and was evidenced by the following: The surveyor toured the facility on 10/21/25 at 10:43 a.m., and 2:33 p.m., and on 10/22/25 at 9:53 a.m., and 12:43 p.m., in the presence of the Director of Building Services (DBS), which revealed the following: 1. The 15 fire extinguishers observed throughout the facility had an annual inspection and service tag dated April 2025 and the monthly (30 day) inspection record on the back of the tag was filled out for the months of May, June, July and August. August 1st was the last entry on all of these tags. There were no more monthly inspections documented in September or the current month of October and at the time of survey it has been 79 days from 08/01/25 inspection. Additionally, there was no documentation provided of 30 day inspections for the prior 6 months from October 2024 to March 2025. Documentation was required for the past 12 months. 2. The two (2) fire extinguishers observed had blank tags with no monthly inspections recorded since the annual inspection in August 2025 and no documentation of prior inspections going back 12 months from survey. 3. The two (2) fire extinguishers observed had annual inspection tags dated August 2025 and	A1169		

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A1169	Continued From page 42 the date 10/15 recorded on the back were missing 10 of the last 12 months of 30 day inspections from September 2025 to October 2024. On 10/22/25 at 2:30 p.m., during surveyor interview with the DBS, the DBS confirmed the above fire extinguisher concerns. NJAC 8:36-16.15(a)	A1169		
A1179	8:36-17.1(a) Provision of Services (a) The facility shall provide and maintain a sanitary and safe environment for residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide Carbon Monoxide (CO) detection in the immediate vicinity of all sources of CO in accordance with NJAC 5:70 and BULLETIN 2017 - 1. This deficient practice was evidenced by the following: On 10/21/25 and 10/22/25, the Director of Building Services (DBS) and Executive Director (ED) were asked to provide documentation of all Physical Environment or Life Safety Inspections, Tests and Maintenance (ITM) conducted by the facility in the last 12 months.	A1179		

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A1179	Continued From page 43 Surveyor review of the records provided by the ED revealed that there was no documentation of monthly CO devices being tested in the last 12 months. During the facility tour on 10/21/25 and 10/22/25 of the resident laundry rooms the surveyor observed that the facility had natural gas fueled dryer units in each room. There was no CO detection installed in the following laundry rooms: Basement Pod B, 3rd floor Pod E, 3rd floor Pod D, 3rd floor Pod B, 3rd floor Pod A, and 2nd floor Pod D. Further surveyor observations of the kitchen revealed that there were 7 natural gas fueled appliances and no CO detection in the kitchen or surrounding area. On 10/22/25 at 2:30 p.m., during surveyor interview with the DBS, the DBS confirmed that there was no CO detection installed in the laundry rooms. NJAC 8:36-17.1(a)	A1179		
A1249	8:36-17.7 Building and Grounds Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.	A1249		

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A1249	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that elevators were inspected, tested and maintained in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A 17.1/CSA B 44, Safety Code for Elevators and Escalators and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4, 9.4.2, and 9.4.6. This deficient practice was evidenced by the following: 1. On 10/21/25, the surveyor reviewed the documentation provided by the facility which revealed that an annual certificate of compliance could not be produced for 3 of 3 the elevators that served the facility. At 11:00 a.m., the surveyor observed that there were no Certificates of Compliance within the elevator room. Additionally, surveyor record review revealed that the quarterly Fire Official Inspections were not present for the years 2023, 2024 or 2025. On 10/22/25 at 1:30 p.m., during interview the Executive Director (ED) and the Director of Building Services (DBS), both confirmed the above elevators concerns. N.J.A.C 8:36-17.1(a) and 17.7 ASME A 17.1/CSA B 44	A1249		

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A1307	8:36-18.4(a)(1) Infection Prevention and Control Services (a) Each new employee upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to perform annual *NJ Ex Order 26. 4B1* screenings for 7 of 10 employees reviewed, Employees #'s 1, 2, 3, 4, 5,	A1307		

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A1307	Continued From page 46	A1307		

6, and 7. This deficient practice was evidenced by the following:

On 10/22/25 at 9:53 a.m., the surveyor reviewed employee files provided by the Executive Director (ED), and observed that seven (7) employee files did not have documented evidence which reflected that the employees completed an annual NJ Ex Order 26. 4B1 within the last year. The findings were as follows:

1. Employee #1's last NJ Ex Order 26. was dated 8/16/24.
2. Employee #2's last NJ Ex Order 26. was dated 9/5/23.
3. Employee #3's last NJ Ex Order 26. was dated 4/23/24.
4. Employee #4's last NJ Ex Order 26. was dated 1/13/23.
5. Employee #5's last NJ Ex Order 26. was dated 1/12/23.
6. Employee #6's last NJ Ex Order 26. was dated 4/17/24.
7. Employee #7's last NJ Ex Order 26. was dated 1/4/23.

At 2:43 p.m., the surveyor interviewed the ED and inquired about the above employees NJ Ex Order 26. 4B. The ED stated that she was unaware that a questionnaire should be completed annually. Additionally, the ED stated that she would have to refer to the facility's policy regarding the timeframe for when a NJ Ex Order 26. should be completed.

The surveyor reviewed a facility policy titled, "IC15 - Tuberculosis: Care Staff," dated 6/7/24, which revealed, " ... The Community will screen all care staff for tuberculosis (TB) infection and disease, per state regulations prior to the start of employment and annually thereafter ... Documentation will be retained in the employee's file ..."

POC#3 received 12/29/25
Accepted 12/30/25

Mattison Crossing- 55A009
Original Visit 10/22/25

MATTISON CROSSING

A Discovery Management Group Community

Plan of Correction revised date 12/28/2025

Original Visit 10/22/2025

A310 – 8:36-3.4(a)(1) Administrator's Responsibilities

Residents were not affected with the current (AED) Automated External Defibrillator policy or Call Bell Policy. The Call Bell Policy and the Automated External Defibrillator policies were reviewed by the Regional Director of Nursing and Interim Administrator. The above policies and procedures will be included in our all-staff in-service policy, yearly.

All residents could potentially be affected by this deficiency if the AED (AED) Automated External Defibrillator is not working properly, or the Call Bell system policy is not effective.

Once a month, the Director of Facilities or designee will check the (AED) Automated External Defibrillator, this will be checked the same day as Fire Extinguishers. A paper check list has been put into the AED machines 10/24/25, and results will be entered in the maintenance department workorder and tracking system. Director of Health and Wellness or designee will order AED supplies as needed. All staff will have an in-service on how to use the Automated External Defibrillator (AED) system the same time as their CPR training.

Policy was reviewed with Maintenance Director, Executive Director and Director of Nursing. The Nursing Department is reviewing the call bell report weekly times 3 and addressing with staff if the call bells are not answered with in the 15 minutes. An in-service will be done with the care team on the expectations regarding call bells alarms response time and process. The corrections for this deficiency will be completed by 12/31/25 and ongoing.

[redacted] NJ Ex Order

approved
12/30/25

A511-8:36-5.5(a) Personnel

Residents were not affected directly by this deficiency. Employees 2,4, and 5 will receive pain management training and other in-services training by 12/31/25

Employee #7 has been terminated from position, Employee #8 Background check is completed and located in her employee files as of 10/22/25, in-services and orientation will be completed by all staff 12/31/25

Employee# 9, in-services checklist and in-services will be completed 12/31/25

All residents have the potential to be affected by this deficient practice.

The Business Office Director and Executive Director will audit all employee files by 01/15/26. They will ensure job descriptions are signed. The Business Office Director will review the New Hire Checklist and will be responsible to ensure compliance for all newly hired team upon hire. Employee Files will be reviewed before date of hire than quarterly.

All team members will complete the required orientation and training with in the first couple of days upon hire.

Executive Director will in-service all Department heads will receive on team member training and orientation requirements and will ensure all employee trainings and background screening are completed before the employees start date. This will be completed by 12/30/25.

Business Office Director/Executive Director and Business Office Assistant will be responsible for maintaining the orientation check list and completing upon hires and then quarterly reviews of all employee files. Completion date 1/15/26 than weekly times weeks, then quarterly.

[redacted] approved 12/30/25

A517-8:36-5.6 (b) Staffing Requirements (element #1)

Residents were not affected. Employee 2,4,5,8.9. all will have training completed by 12/30/25

All residents have the potential to be affected by this deficient practice.

All new hire paperwork must be completed before employment begins. The Executive Director and Business Office Director will conduct an audit of all state required training started audit started on 10/26/25. Completion date 12/31/25.

[redacted] approved 12/30/25

new team members will complete state required training with-in the first couple days after hire date. Department heads will receive training on the state required in-services to be completed prior to their official start of their position. This will be completed from the Regional Director of Resident Care. This will be completed by 12/30/25. Executive Director and Business Office Director will conduct an audit upon hire and quarterly to ensure compliance with training and education.

Business office Director and Business office assistant will be responsible to maintaining orientation and new hire checklist.

A535- 8:36-5.6(e) Staffing requirements (element #2)

Residents were not affected. Employee #8's background is completed as of 12/17/25.

All residents have the potential to be affected by this deficient practice. The Executive Director and Business Office Director will conduct an audit of all personnel files to ensure compliance with background screening regulation. Business office Manager will audit all employees' files for background screening this will be completed by 12/31/25.

Business Office Director or designee will review the new hire checklist and will be responsible for compliance of background screening being completed and in personnel before hire date and then quarterly compliance checks, completion date is 12/31/25.

Business office Director and Business office assistant will be responsible for maintaining orientation and new hire checklist. Business office Director and Business office assistant will conduct an audit to ensure compliance with background screening regulations files Employee files review completion date is 12/31/25. Going forward the employee records will be audited, upon hire, and then quarterly to ensure employee compliance.

[redacted] approved 12/30/25

A537-8:36-5.7(a)(1) Policy and procedure Manual

Residents were not affected.

All residents have the potential to be affected by this deficient practice.

An organizational chart delineating the lines of authority, responsibility and accountability for the administration and resident care services and has been placed in policy and procedure manual. An attestation form will be created for all policies and procedure manuals, indicating that it was reviewed, and all policies are current and will be signed off

and reviewed twice yearly by VP of Resident Care for DSL and the RN Clinical Policy Committee.

This Organizational chart will be and will be posted in the emergency policy and procedure handbook. This will be completed by 12/31/25. [redacted] approved 12/30/25

A891- 8:36-10.5(a) Dining Services

Residents were not affected

All residents have the potential to be affected by this deficient practice.

The opening and closing procedures have been formally reviewed, finalized and dated by the Director of Culinary on 12/4/25 to establish documented creation and implementation. These policies will be reviewed with all culinary staff during schedule in-service training to ensure understanding and compliance. This will be completed by 12/31/25

The covers for the meat slicers were ordered and received, and the staff were in-serviced on sanitation. Ice scooper replaced 11/17/25 and drainage hole in the ice machine was completed on 11/17/25.

Director of Culinary will do ongoing policy review weekly and this will be incorporated into routine training and Quarterly Quality Assurance meetings to ensure continued adherence to state regulations and community standards.

Completion Date for compliance 12/31/25 [redacted] approved 12/30/25

A901- 8:36-10.5(c)(4) Dining Services

Residents were not affected

All residents have the potential to be affected by this deficient practice.

The Director of Culinary posted four-week menu cycle with standardized portion controls has been posted in all food production areas and is readily accessible to culinary staff.

Completed on 10/22/25

Director of Culinary Ongoing monitoring will be conducted by culinary leadership. Culinarily leadership will audit portion sizes daily completed daily x's 3 months then quarterly. Completed - 10/22/25 [redacted] approved 12/30/25

A925-8:36-11.2 Provisions of Pharmaceutical Services

Certified Medication aide immediately notified the Director of Health and wellness. Resident #1 was assessed for NJ Ex Order 26. 4B1 and closely monitored for any change in condition or status. The physician and family were notified. The resident was assessed with NJ Ex Order 26.4(b)(1). The incident was documented in residents' medication record.

Resident #1 continues to be NJ Ex Order 26. 4B1 . Currently, as NJ Ex Order 26.4(b)(1) he/she is still at NJ Ex Order 26. 4B1 .

Medication Carts Audits will be completed by 1/9/26 by Director of Health and Wellness. Completion date 1/9/26.

The Director of Health and Wellness will provide education to the nurses and Certified Mediation aides. Completion Date 1/9/26.

The community will have all new orders from practitioners given to the Director of Health and Wellness (DWS) or designee for updating once the updated order is in place the DHW or designee will then ensure the pharmacy has the most current order and remove all discontinued or order changed medications from the active medication cart.

All residents have the potential to be affected by this deficient practice. The Director of Health and Wellness or designee will review the pharmacy check in and follow up to ensure medications have been received.

Director of Health and Wellness or designee will receive all new orders from visiting practitioners and ensure the new or changed orders are entered into the Electronic Medication Administration Record system, sent to pharmacy and follow up to ensure receipt of the medications as well as discontinued medications are removed from the medication cart. A (MAR) Medication Administration Record to medication cart audit will be performed weekly x 4 then biweekly x2 until 100% compliance is achieved. All nurses and Certified Medication Aides will be educated on the following policies: Medication Orders, Receiving Order New Medication(s), Changes to Medication Orders and Order Clarification from Physician by 12/31/2025.

The community Director of Health and wellness or designee will continue to audit the active (MAR) Medication Administration Record and cart at least once per month to ensure

active medication orders are present on the cart and discontinued orders are removed. Completion date 1/9/26. [redacted] approved 12/30/25

A935 -8:36-11.4(b) Administration of Medication

Certified Medication aide immediately notified the DON. Resident #1 was assessed for [redacted] and closely monitored for any change in condition or status. The Physician and family were notified. The resident was assessed with [redacted]. The incident was documented in our medical record system.

Resident #1 continues to be [redacted]. Currently, as [redacted] he/she is still at [redacted].

Medication Carts Audits will be completed by 1/9/26 by Director of Health and Wellness. Completion date 1/9/26.

The Director of Health and Wellness will provide education to the nurses and Certified Mediation aides. Completion Date 1/9/2026.

Director of Health and wellness will audit all insulin orders for accuracy based on the last MD prescription and ensure the e-MAR (Medication Administration Record) reflects the same direction as well as packaging.

All diabetic residents with insulin orders have the potential to be affected by this deficient practice.

All current residents with active insulin orders will be audited by 10/26/25 to ensure all current orders are updated in the e-MAR (Medication Administration Record) as well as all packaging matches the orders and are current.

New orders are reviewed once uploaded by [redacted] into the Medication pass application Extended Care Professionals.

The Director of Health and Wellness will provide education to the nurses and Certified Mediation aides. Completion Date: 1/9/2026.

Director of Health and Wellness (DHW) or designee will review all new orders for changes in the administration or dosage, ensuring the e-MAR (Medication Administration Record) is

updated and pharmacy has the order. In addition, DHW or designee will remove, if needed, discontinued medication from the medication cart. Active MAR-Medication cart audits will take place weekly x4 then biweekly x2 until 100% compliance is achieved. All nurses and Certified Medication Aides will be educated on the following policies: Medication Orders, Receiving Order New Medication(s), Changes to Medication Orders and Order Clarification from Physician by 01/09/26.

(DHW) Director of Health and Wellness or designee will perform weekly (Medication Administration Record) MAR-Medication Cart Audits to ensure the medication and orders are current, active and packaging reflects as such weekly x 4 and biweekly x2 until 100% compliance is achieved. Completion Date:1/09/2026

[redacted] approved 12/30/25

A937 - 8:36-11.5(a) Certified Medication Aide Program

Certified Medication aide immediately notified the DON. Resident was assessed for [redacted] and closely monitored for any change in condition or status. The Physician and family were notified. Resident #1 was assessed with [redacted]. The incident was documented in our medication record.

Resident #1 continues to be [redacted] Currently, as [redacted] he/she is still at [redacted]

All residents have the potential to be affected by the deficient practice.

The Director of Health and Wellness or her designee initial audit was performed on 10/21/25 a MAR/EMAR audit and continue this weekly. In addition, a monthly med cart audit will be performed by a RN or LPN. The Initial MAR/EMAR audit for residents #1, #2, #3 and #4 were audited by the Director of Health and wellness on 10/21/25 and ongoing.

The RN will perform the weekly RN delegation and review each CMA's medication administration practices, documentation and adherence to current prescriber orders.

Staff will verify all medication orders against the current EMAR/MAR and the medication label prior to administering any medication to ensure accuracy and compliance with prescriber orders.

The Director of wellness or designee will conduct Quarterly observations of medications administration (med passes) will be performed to ensure compliance with orders, proper documentation and correct administration procedures.

The Director of Health and Wellness or designee will provide monthly medication education, including a Medication of the Month in -service, to reinforce high-risk medication topics, documentation, accuracy and regulatory expectations. Completion Date 1/09/26 and ongoing monthly and quarterly.

[redacted] approved 12/30/25

A963 -8:36-5.6 (f) Certified Medication Aide Program

Resident #1 continues to be[redacted]. Currently, as[redacted] he/she is still at[redacted].

Resident #5,[redacted], Resident #6[redacted]
Resident 2,3,4, remain in the community.

The Director of Health and wellness audited the MARs for resident #1, #2, #3 and#4 residents and provided education on 10/22/25 to Nurses as Medication aides.

Director of Health and Wellness (DHW) or designee will audit the MAR (Medication Administration Record) for completion of all documentation weekly, if areas of omission are noted the DHW or designee will review with Certified Medication Aide or Nurse for follow up. The DHW or designee will provide education to all certified medication aides and nurses on Documenting Medication Pass Policy.

All residents have the potential to be affected by the deficient practice. MAR audits will be completed weekly to identify omissions in the MAR and will contact the corresponding certified medication aide or nurse for validation and corrections if needed.

Director of Health and Wellness or designee will perform MAR audits weekly x 4 then biweekly x2 until 100% compliance is achieved. The DHW or designee will provide education to all certified medication aides and nurses on Documenting Medication Pass Policy completed by 01/9/26.

Director of Health and Wellness or designee will perform MAR audits weekly x4 then biweekly x2 until compliance is achieved. DHW or designee will continue to review the MAR for documentation omission and follow up with the corresponding Certified Medication Aide or Nurse or validation and further completion. 1/9/26 completion date

[redacted] approved 12/30/25

A999- 8:36-11.7(e) Storage and Control of Medications

On 10/21/25 all medications that were located during the survey as to be expired were removed from the medication cart. The Director of Health and Wellness is responsible for the Medication carts will check for expired medications and if such are located those medications will be removed from the medication cart and the pharmacy will be contacted for medications that need to be reordered. If the medication is as needed and has not been used Director of Health and Wellness or designee will contact practitioners for potential discontinuation of the medication order due to nonuse.

All residents have the potential to be affected by the deficient practice.

Director of Health and Wellness or designee will perform weekly Medication Cart audits with focus on medication expiration dates. All certified medication aides and nurses will be educated on how to perform the medication cart audit to identify medications that are expired and on the Expired Medications policy by 01/9/2026

Director of Health and Wellness or designee will perform audits of the medication cart with focus on expired or expiring medications weekly x4 then biweekly x2 until 100% compliance is achieved. Completion Date:01/09/26 [redacted] approved 12/30/25

A1033 -8:36-14.2(a) Emergency Plans and Procedures

Residents were not affected

All residents have the potential to be affected by this deficient practice.

Emergency plan policy and procedures were printed and put into two binders and placed in documented places within the facility. The staff will be notified where the Emergency manual is located.

Staff will be provided in-services monthly regarding Emergency Plans and procedures and where the emergency binders are located. This will be completed by 12/31/25. On going education will be conducted monthly. [redacted] approved 12/24/25

A1041-8:36-14.3(a) Drills and Tests

Residents were not affected

All residents could potentially be affected by this deficiency.

All documentation for missing fire drill reports for 2/25/25, 8/25/25 and 9/25/25 were received and filed in the fire disaster drill binder. completed 10/29/25. The Director of Facilities has reviewed the requirement for monthly emergency plans has placed dates into the building management software platform) to ensure compliance. The Director of Facilities will review monthly reports to ensure all inspections are completed. Completed 10/29/25 [redacted] approved 12/24/25

A1043- 8:36-14.3(b) Drills and Tests

Residents were not affected.

All residents have the potential to be affected by this deficient practice.

The Director of Facilities reviewed the requirement for an annual joint fire drill with the local fire department and has called the local Fire Department to schedule a date to complete an annual joint fire drill. Date Completed 12/23/25. [redacted] approved 12/24/25

A1095- 8:36-16.5(b) Automatic Fire Detection System

Residents were not affected.

All residents have the potential to be affected by this deficient practice.

Director of Facilities contacted the fire system vendor [redacted] to devise a plan to identify and repair alarms of fire panels. Completed Date 12/23/25

Vendor will schedule a visit to provide a quote for repairs for fire panel. Will be completed by 01/09/26

All inspections will be put in the building management software platform system to ensure compliance. The Director of Facilities will check alarm monitoring system daily to ensure monitoring codes are clear. Completion date 1/09/2026 [redacted] approved 12/24/25

A1097- 8:36-16.6 Fire Suppression System

Residents were not affected.

All residents have the potential to be affected by this deficient practice.

Director of Facilities contacted vendor and had inspection completed on 11/3/25, gauges were replaced.

The Director of Facilities along with (vendor), NJ Ex Order 26.4(b)(1) will inspect gauges quarterly along with the fire suppression systems.

The Director of Facilities will enter the building management software platform system to ensure compliance, by pulling monthly reports to ensure all inspections are completed. Date Completed times quarterly. Completion Date11/3/25 NJ Ex Order 26. 4B1 approved 12/24/25

A1105- 8:36-16.8(c) General Residential Unit Requirements

Residents were not affected.

All residents have the potential to be affected by this deficient practice.

Director of Facilities has placed a Neighborhood closed" Do Not Enter" Sign in NJ Ex Order 26. 4B1 door on 12/8/25. All missing doorknobs will be replaced by a locksmith vendor. Completion date 1/9/26.

Director of Facilities or alternate team members will make daily rounds of NJ Ex Order 26. 4B1 neighborhood to ensure compliance. Daily Completion date 01/09/2026 NJ Ex Order 26. 4B1 approved 12/24/25

A1125- 8:36-16.12(d) Laundry Equipment

Residents were not affected.

All residents have the potential to be affected by this deficient practice.

Director of Facilities contacted the vendor and revived a quote on 12/5/2025 for quarterly chute /vent cleaning. Dryer vents will be clean by 1/9/26

Director of facilities will place monthly and semi-annual date in building management software platform system to ensure compliance.

The Director of Facilities will enter the building management software platform system to ensure compliance, by pulling monthly reports to ensure all inspections are completed. Date completed times monthly. Completions Date 1/9/26 NJ Ex Order 26. 4B1 approved 12/24/25

A1169- 8:36-16.5(a) Fire Extinguisher

Residents were not affected.

All residents have the potential to be affected by this deficient practice.

Vendor was contacted for a copy of the annual inspection All fire extinguishers were inspected April 2025 and will be entered, maintenance management software platform system to ensure compliance. Completion Date 04/2025. Next Inspections 04/2026

The Director of facilities will create a monthly check list to verify all the fire extinguishers are checked and signed off. Completion Date: 01/09/26

The Director of Facilities will enter the building management software platform system to ensure compliance, by pulling monthly reports to ensure all inspections are completed. Date Completed times monthly. Completion Date 01/09/26 [redacted] approved 12/24/25

A1179-8:36-17.1(a) Provision of Services

Residents were not affected. Director of Facility Maintenance installed (28) CO2 detection units On 12/1/25 Including kitchen and laundry room detection units.

All residents have the potential to be affected by this deficient practice.

Director of Facility Maintenance installed 28- CO2 detection units On 12/1/25 and placed orders for additional kitchen and laundry room detection units.

Monthly Director of Facilities will create a check list for all the CO2 detection units and check them monthly to ensure they are working. 1/09/26

The Director of Facilities will enter the building management software platform system to ensure compliance, by pulling monthly reports to ensure all inspections are completed. Date Completed: 01/09/26 [redacted] approved 12/24/25

A1249- 8:36-17.7 Building Grounds Maintenance

Residents were not affected

All residents have the potential to be affected by this deficient practice.

The director of facilities contacted the elevator vendor 11/1/25 and state regarding the annual inspection and documentation. Elevator repairs will be completed (once the part is in), and new inspection will be processed by 1/15/26.

The Director of Facilities will enter the building management software platform system to ensure compliance, by pulling monthly reports to ensure all inspections are completed. Completion Date 1/15/26 [redacted] approved 12/24/25

A1307-8:36-18.4(a) Infection and Prevention and Control Services

Employee #1, #2, #3, #4, #5, #6, #7 has completed the [redacted] form. Completion date 12/13/25

Residents were not affected

All residents have the potential to be affected by this deficient practice.

All current employees will complete the [redacted]. This will be completed by 12/31/25 and placed in all employees' files

All prospective employees will complete the [redacted] and [redacted] prior to the first day of employment. The Infection Prevention and/or DON will perform monthly audits for three months, then quarterly ongoing, to ensure all employees are completed with annual [redacted] completed [redacted] accurately, and reporting [redacted] promptly. Education Sessions will be held annually for all staff on the Importance of [redacted], completing the [redacted] promptly. Target date for implementation all corrective actions will be Implemented by 12/31/25 [redacted] approved 12/30/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
55A009 Y1	A. Building B. Wing Y2	12/30/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTISON CROSSING AT MANALAPAN AVENUE	93 MANALAPAN AVENUE FREEHOLD, NJ 07728

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 12/31/2025	ID Prefix A0511 Reg. # 8:36-5.5(a) LSC	Correction Completed 01/15/2026	ID Prefix A0517 Reg. # 8:36-5.6(b)(1-7) LSC	Correction Completed 12/31/2025
ID Prefix A0535 Reg. # 8:36-5.6(e) LSC	Correction Completed 12/31/2025	ID Prefix A0537 Reg. # 8:36-5.7(a)(1) LSC	Correction Completed 12/31/2025	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 12/31/2025
ID Prefix A0901 Reg. # 8:36-10.5(c)(4) LSC	Correction Completed 10/22/2025	ID Prefix A0925 Reg. # 8:36-11.2 LSC	Correction Completed 01/09/2026	ID Prefix A0935 Reg. # 8:36-11.4(b) LSC	Correction Completed 01/09/2026
ID Prefix A0937 Reg. # 8:36-11.5(a) LSC	Correction Completed 01/09/2026	ID Prefix A0963 Reg. # 8:36-11.5(f) LSC	Correction Completed 01/09/2026	ID Prefix A0999 Reg. # 8:36-11.7(e) LSC	Correction Completed 01/09/2026
ID Prefix A1033 Reg. # 8:36-14.2(a) LSC	Correction Completed 12/31/2025	ID Prefix A1041 Reg. # 8:36-14.3(a) LSC	Correction Completed 10/29/2025	ID Prefix A1043 Reg. # 8:36-14.3(b) LSC	Correction Completed 12/23/2025

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

STATE FORM: REVISIT REPORT

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1095	Correction	ID Prefix A1097	Correction	ID Prefix A1105	Correction
Reg. # 8:36-16.5(b)	Completed	Reg. # 8:36-16.6	Completed	Reg. # 8:36-16.8(c)	Completed
LSC	01/09/2026	LSC	11/03/2025	LSC	01/09/2026
ID Prefix A1125	Correction	ID Prefix A1169	Correction	ID Prefix A1179	Correction
Reg. # 8:36-16.12(d)	Completed	Reg. # 8:36-16.15(a)	Completed	Reg. # 8:36-17.1(a)	Completed
LSC	01/09/2026	LSC	01/09/2026	LSC	01/09/2026
ID Prefix A1249	Correction	ID Prefix A1307	Correction		
Reg. # 8:36-17.7	Completed	Reg. # 8:36-18.4(a)(1)	Completed		
LSC	01/15/2026	LSC	12/31/2025		

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/22/2025	☐ YES ☐ NO