STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE , MONROE TOWNSHIP, New Jersey, 08831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). Complaint #: NJ00188228, NJ00178962, and NJ00181821. Survey Dates: 07/21/25-07/24/25 Survey Census: 104 Sample Size: 24 Supplemental Sample: 20 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F0000		08/15/2025
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F0656	F656 1. As documented in the deficiency summary, Certified Nursing Assistant (C.N.A.) #1 was [NJ Exec Order 26.4b] upon completion of the internal investigation. The Director of Nursing (DON) notified the [NJ Exec Order] [NJ Exec Order] regarding the incident involving their staff member, who admitted to [NJ Exec Order 26.4b1] the resident alone using a [NJ Exec Order 26.4b1] The DON formally requested [NJ Exec Order 26.4b1] of the [US FOIA (b) (6)] from the facility assignment. 2. All residents requiring mechanical lift transfer have the potential to be affected by the deficient practice. 3. The DON provided in-service education to licensed nurses and C.N.A.s on proper following of a resident's care plan, with emphasis on proper mechanical lift use procedures. The DON also requested that the hospice agency deliver equivalent training to their staff. 4. The DON, or designee, will conduct a minimum of four	08/20/2025

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

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

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F0656 SS = D	Continued from page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of the facility policy, the facility failed to implement residents' care plans related to a [redacted] for one of 24 sampled residents (Resident (R) 112). This failure placed the resident at risk of [redacted] due to [redacted]. Findings include: Review of the facility's policy titled, "Resident Care Plan," dated 10/2024 revealed, "...Specific, individualized steps or approaches that staff will take to assist the resident to achieve goals will be listed. Interventions should be short and concise, easy for all staff to follow and serve as a care guide…" Review of R112's "Face Sheet" located on the "Home Page" of the electronic medical record (EMR) revealed the resident was admitted to the facility on [redacted] with diagnoses that included a history of [redacted] and [redacted]	F0656	Continued from page 1 weekly competency checks with licensed nurses, C.N.A.s, and hospice/agency aides to verify adherence to the care plan, specifically reviewing the two staff member requirement during mechanical lift use. Audit results will be reported at QAPI meetings monthly for three months, and for one quarter thereafter. The QAPI committee will determine if continued monitoring is necessary based on audit findings.	

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F0656 SS = D	Continued from page 2 Review of R112's annual "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of [redacted] revealed R112 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated R112 was NJ Exec Order 26.4b1 [redacted] The "MDS" also indicated the resident had [redacted] and was [redacted] on [redacted] staff members for [redacted] activities of daily living (ADLs) including [redacted] Review of R112's "Comprehensive Care Plan," dated [redacted] and located in the "Care Plan" tab of the EMR revealed, "…I am at risk for NJ Exec Order 26.4b1 [redacted] due to [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1, [redacted] NJ Exec Order 26.4b1, and [redacted] Interventions included but not limited to: "I am a NJ Exec Order 26.4b1 [redacted] staff will ensure I am being [redacted] from and to [redacted] via [redacted] with [redacted]." Review of R112's "Facility Investigation," dated [redacted] and provided by the facility revealed, "[Certified Nurse Aide (CNA) 1's Name] did not use a [redacted] to [redacted] resident to [redacted] on the 3-11PM shift. This was discovered after interviewing [CNA1's Name] a second time and watching the surveillance footage. This transfer occurred on NJ Exec Order 26.4b1 on [the] 3-11PM [shift]. That same day, our investigation revealed that the [redacted] this resident using a [redacted] without the assistance of another staff member. Both CNAs are stating that the [redacted] were without incident. The 11PM to 7AM staff from [redacted] did not notice any issues during changes that evening. CNA1 was [redacted] and [redacted] was asked not to NJ Exec Order 26.4b1 …CNA was asked to review the video footage and her recent statements. CNA1 had reported earlier that she and CNA3 had used the [redacted] the resident to bed between 7-7:30PM. CNA1 reported that no incident occurred. CNA1 then changes her statement too. [redacted] did not have a [redacted] under [redacted] this morning. We did [redacted] [CNA3's Name] and I.' When I asked how they did that [CNA1's Name] changed her statement again. [CNA1] stated, [redacted] has the [redacted] that is removable, and we removed it to use for someone else.' [CNA1] did not answer how they transferred the resident at this time…The video footage timeline was reviewed with [CNA1]. On [redacted] at 8:43PM, [CNA1] looks into room [number withheld] and continues down the hall. At 9:05 PM, the Medication Cart and Nurse are at the end of the hall. At 9:08 PM, the Nurse went into the room and left. At 9:52PM, [CNA1] is seen going into the room, placing the dirty	F0656		

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F0656 SS = D	Continued from page 3 linen and garbage bags outside the room. At 9:57 PM [CNA1] is placing linen and garbage into bag. Her phone is in her hand face up. It looks like she is looking at the phone. [CNA1] goes back into the room. At 10:08 PM, [CNA1] placed a NJ Exec Order 26.4b1 in the garbage bag. Picks up the dirty linen and garbage and leaves the area…This timeline was reviewed with [CNA1]. Explained to her that I noted her pushing the NJ Exec Order 26.4b1 the hall past [R112's room]. At no time did I see the NJ Exec Or or [CNA3] enter R112's room. I asked [CNA1] again what happened on NJ Exec Order 26.4 how did you NJ Exec Order R112 to bed. [CNA1] stated, "I did not use the NJ Exec Ord NJ Exec Order 26.4b NJ Ex on my own. Nothing happened." The "Facility investigation" included that the US FOIA (b)(was interviewed and verified that she was having difficulty when getting R112 NJ Exec Order 2 on NJ Exec Order 26.4b1. The US FOIA (b)(was asked how she NJ Exec Order 26.4b R112. The US FOIA (b)(stated, "I used the NJ Exec Order 26.4 both days without a second person. I could not find anyone." The US FOIA (b)(denied NJ Exec Order 26.4b1 or incidents related to the NJ Exec Order …Conclusion: …At this time, on 3 different occasions from NJ Exec Order 26.4b1 the resident's care plan was not followed. Policy and procedures were not followed…" During an interview on 07/24/25 at 9:18 AM, the US FOIA (b)(6) confirmed that CNA1 was NJ Exec Order 26.4b for not following policy and the US FOIA (b)(was asked NJ Exec Order 26.4b1 to the facility. During an interview on 07/24/25 at 12:27 PM, the US FOIA (b)(confirmed that she did not use NJ Exec Order 26.4b1 when NJ Exec Order 26.4b1 R112 per the care plan. NJAC 8:39-11.2(e) thru(i) NJAC 8:39-27.1(a)	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure activities of daily living (ADLs) were provided	F0677	F677 1. On 7/22/25, the Director of Nursing (DON) spoke with Residents R2 and R76 regarding their evening NJ Exec Order preferences. R2 NJ Exec Orde to a NJ Exec Orde and was assisted accordingly. R76 NJ Exec Order 26 a NJ Exec Order 2 Resident R76 stated they were NJ Exec O and preferred a NJ Exec Order 26. R76 stated they would notify the Certified Nursing Assistants (C.N.A.s) when they wished to have a NJ Exec Order 2 Care provided was documented. 2. All residents have the potential to be affected by the deficient practice. The DON, Social Worker (SW), and Unit Managers (UM) reviewed curren NJ Exec Order 26.4b1	08/20/2025

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F0677 SS = D	Continued from page 4 for two of three residents (Residents (R) 2 and R76) reviewed for ADLs out of 24 sampled residents. The facility failed to ensure [redacted] were received per the [redacted] schedule. This failure placed the residents at risk for a NJ Exec Order 26.4b1 . Findings include: Review of the facility policy titled, "Showering the Resident," revised 01/21/25 revealed, "A shower will be given to residents as requested or as per the care plan." 1. Review of R2's "Face Sheet" located on the "Home Page" of the electronic medical record (EMR) revealed R2 was admitted to the facility on [redacted]. Review of R2's admission "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) [redacted] revealed R2 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated R2 was NJ Exec Order 26.4b1 . The "MDS" also revealed R2 required NJ Exec Order 26.4b1 [redacted] with [redacted]. Review of R2's "Care Plan," dated [redacted] and located in the "Care Plan" tab of the EMR revealed, "I require [redacted] with care due to NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Interventions included: a. "I will be evaluated and treated by [redacted] as indicated." b. "Staff will NJ Exec Order 26.4b1 and as needed." c. "Staff will NJ Exec Order 26.4b1 [redacted] as I can [redacted] The "Care Plan" contained no further documentation related to NJ Exec Order 26.4b1 or resident preferences. During an interview on 07/22/25 at 9:01 AM, R2 was lying in bed, [redacted] was [redacted] R2 was asked if [redacted] was receiving [redacted] weekly. R2 stated, "I am only getting [redacted] a week, I think I am to get [redacted]	F0677	Continued from page 4 schedules and spoke with residents to confirm their preferences. Two residents requested their scheduled [redacted] be moved to the day shift. Care plans and schedules were updated accordingly, and C.N.A.s were notified to ensure adherence to the revised schedules. 3. The DON provided in-service education to licensed nursing staff and C.N.A.s regarding proper procedures for providing showers/baths, including the requirement to notify a licensed nurse if a resident refuses a scheduled shower/bath. The shower/bath schedule was added to the Medication Administration Record (MAR), with nurses required to initial when a shower/bath is completed or refused, ensuring accurate documentation. 4.The DON or designee will conduct audits of four scheduled showers/baths per week to verify completion and proper MAR documentation by the licensed nurse. Audit results will be presented at QAPI meetings monthly for three months, and one quarter thereafter. The QAPI committee will determine if continued monitoring is required based on audit findings.	

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F0677 SS = D	Continued from page 5 Review of R2's [redacted] sheet documentation dated from [redacted] and provided by the facility revealed the resident only received three [redacted]. The documentation revealed the resident did not refuse any [redacted] however, "[redacted]" was documented 26 times. Review of R2's "CNA Care Plan," dated [redacted] and provided by the facility revealed R2 was to receive a [redacted] ([redacted]) on [redacted] on the 3:00 PM to 11:00 PM shift and required [redacted] with [redacted]. 2. Review of R76's "Face Sheet" located on the "Home Page" of the EMR revealed R76 was admitted to the facility on [redacted] and readmitted [redacted]. Review of R76's admission "MDS" located in the "MDS" tab of the EMR with an ARD of [redacted] revealed R76 had a "BIMS" score of [redacted] out of 15 which indicated R76 was [redacted]. The "MDS" also indicated the resident required [redacted] with [redacted]. Review of R76's "Care Plan," dated [redacted] and located in the "Care Plan" tab of the EMR revealed, "I need [redacted] with care and [redacted] due to [redacted] and [redacted]." Interventions included: a. "My [redacted] at all times." b. "Staff will [redacted] and as needed." c. "Staff will [redacted] as I can [redacted] The "Care Plan" contained no further documentation related [redacted] or resident preferences. During an interview on 07/21/25 at 10:47 AM, R76 was sitting up in [redacted] wheelchair [redacted]. R76 was asked if [redacted] was receiving [redacted] per the facility schedule or [redacted] preferences. R76 stated, "I have not received but one [redacted] in the last [redacted] days."	F0677		

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F0677 SS = D	Continued from page 6 Review of R76's "CNA Care Plan," dated NJ Exec Order 26 and provided by the US FOIA, revealed R76 had a preference for NJ Exec Order 26 they were to be given on NJ Exec Order 26.4b1 on the 3:00PM to 11:00PM shift and NJ E required NJ Exec to assist him. Review of R76's "NJ Exec Order Sheet" from NJ Exec Order 26.4b1 and provided by the facility revealed that R76 had NJ Exec Order NJ Exec Order assistance two times (the day he went to the hospital NJ Exec Order 26 and the day NJ E returned from the hospital NJ Exec Order 26) and was administered one NJ Exec Order on NJ Exec Order 2 per the documentation. During an interview on 07/23/25 at 11:39 AM, Certified Nurse Aide (CNA) 5 stated, "R76 has been here for about NJ Exec Order 26. The first NJ Exec Order 26.4b1 NJ E was in a lot of NJ Exec O so we did a NJ Exec Order 26. CNA5 was asked what did the word 'NJ Exec O mean on the NJ Exec Order sheets. CNA5 stated, "I have never heard that terminology before." CNA5 stated that when he worked, he would give R76 a NJ Exec Order CNA5 was asked when a resident NJ Exec Order a NJ Exec Order what was the protocol. CNA5 stated, "We are to let the nurse know and then reapproach. If they still NJ Exec Orde I document the NJ Exec Orde was NJ Exec Order 26. During an interview on 07/22/25 at 4:58 PM, The US FOIA stated, "There does not seem to be follow-up, by nursing, to ensure NJ Exec Order 2 are being done or documented to show why a NJ Exec Orde was not done." The US FOIA was asked what it meant if NJ Exec O was documented on the NJ Exec Orde sheets. The US FOIA stated, "A NJ Exec is just a NJ Exec Order 26, and is not considered to be a NJ Exec Order 26. NJAC 8:39-27.1(a)	F0677		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by:	F0684	F684 1. A. Following completion of the incident investigation regarding Resident R112, the facility NJ Exec Order 26.4b the US FOIA (b)(6) .) involved, and the US FOIA (b) (6) and US FOIA (b) (6) were instructed NJ Exec O . In addition, UM1 was counseled regarding proper rounding/supervision of nursing units. R112, who had been under NJ Exec Order 3 care prior to the incident, continued under NJ Exec Order 3 care, however, Resident R112 family opted to change NJ Exec Order 3 providers. Upon return from hospital, Resident R112 was transferred from the NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 for NJ Exec Ord	08/20/2025

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F0684 SS = D	Continued from page 7 Based on observations, interviews, record review and review of facility policy, the facility failed to provide care and services for two residents (Residents (R) 112 and R44) out of 24 sampled residents. The facility failed to ensure R112 had NJ Exec Order 26.4b1 and timely medical care after the facility identified NJ Exec Order 26.4b1 and NJ Exec Order 2 to R112's NJ Exec Order 2 which was later identified as a NJ Exec Order 26.4b1 . In addition, the facility failed to ensure R44 received medications as ordered by the provider. These failures placed residents at risk for unmet care needs and a diminished quality of life. Findings include: Review of the facility's policy titled, "Change of a Resident's Condition," dated 08/01/01 revealed, "…To ensure that when a resident has a change of condition, appropriate assessments are performed, documented and that timely notification of the resident's physician and family occurs…All accidents involving the resident which results in injury and has the potential for requiring physician intervention…A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications)…A decision to transfer or discharge the resident from the facility… When a change of condition occurs, the licensed nurse will perform an assessment based on the signs and symptoms the resident is experiencing…" 1. Review of R112's "Face Sheet" located on the "Home Page" of the electronic medical record (EMR) revealed R112 was admitted to the facility on NJ Exec Order 26 with diagnoses that included a history of NJ Exec Order 26.4b1 . Review of R112's annual "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec Order 26 revealed R112 had a Brief Interview for Mental Status (BIMS) score of NJ Exec O out of 15 which indicated R112 was NJ Exec Order 26.4b1 The "MDS" also indicated the resident had NJ E and was NJ Exec Order 26.4b1 on NJ Exec Order 26.4b staff members for NJ E activities of daily living (ADLs) including NJ Exec Order 26.4 In addition, R112 was on NJ Exec Order 26.4b1 medications and had NJ Exec Order 26.4 of NJ Exec which included NJ Exec O and NJ Exec O NJ Exec Order 26.4b1 of NJ Exec for one to two days out of the previous five days during the observation period.	F0684	Continued from page 7 NJ Exec Order 26.4b1 B. The Director of Nursing (DON) and Unit Manager (UM) reviewed the physician's orders for Resident R44 and confirmed that all prescribed medications were on hand and administered as ordered. No medications were found to be missing or unavailable. 2. All residents have the potential to be affected by the deficient practice. A. The DON reviewed incident reports and all resident hospital transfers. No delays or issues were identified in the timely transfer of residents from the facility to acute care. B. The DON and UM reviewed all medication orders for current residents and confirmed with the pharmacy that medications were being delivered promptly to ensure uninterrupted administration. No residents were found to have missed any prescribed doses. 3. A. The DON will conduct an in-service for licensed nursing staff emphasizing that if a resident requires non-emergent transfer to an acute care facility and the wait time is expected to exceed one hour, 9-1-1 must be called to facilitate the transfer. B. The DON, or designee, will in-service licensed nursing staff on the 11 p.m.–7 a.m. shift to perform daily checks of on-hand medications for all residents. If a medication is found to be unavailable, the DON or designee will immediately contact the pharmacy to request urgent delivery. 4. The DON, or designee, will complete four resident audits per week to verify that: A. Residents requiring non-emergent transfer to an acute care facility are transferred within one hour; if this is not possible, 9-1-1 is called to expedite transfer. B. All prescribed medications are present in the facility and administered as ordered. Audit results will be presented during QAPI meetings monthly for three months, and one quarter thereafter.	

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F0684 SS = D	Continued from page 8 Review of R112's "NJ Exec Order 26.4b1" note dated NJ Exec Order 26 at 2:34 PM, completed by Licensed Practical Nurse (LPN) 2 and located in the "Assessments" tab of the EMR revealed, "I was asked by the aide to come and look at NJ Exec Order on resident's NJ Exec Order 26.4b1. I observed NJ Exec Order and NJ Exec Order in the area. I asked the resident if NJ Exec Order 26.4b1. I also noticed the NJ Exec had NJ Exec [sic] to NJ Exec at the NJ Exec Order area. I went to NJ Exec Order 26.4b [another unit in the facility] to inform the US FOIA (b) (6) to come assess the resident. She was not there; [sic] I then went to NJ Exec Order [another unit in the facility] and couldn't find her. I went to NJ Exec Order [another unit in the facility] and spoke with the Nurse there. We called the US FOIA (b) (6) on the phone, and she didn't answer. I asked the nurse if she see [sic] her can she please tell her I am looking for her. I was told by the Nurse on NJ Exec Order 26.4 that the US FOIA (b) (6) did come to NJ Exec Order and she [was] informed that I was looking for her and that my resident had NJ Exec Order and NJ Exec Order and NJ Exec Order from NJ Exec Order 26.4b1, however, the US FOIA (b) (6) never came to NJ Exec Order 26.4b1 [sic] to see me and I then endorsed to the 3-11PM Nurse of my finding…I applied NJ Exec to the area for the NJ Exec Order 26.4 Review of R112's EMR and hard chart revealed no documented evidence LPN2 had notified the US FOIA (b) (6) had done a NJ Exec assessment after the identification of the NJ Exec Order and NJ Exec Order or documented if R112 was having NJ Exec and what intervention NJ Exec performed to control NJ Ex NJ Exec Review of the "Facility Investigation [for R112]" provided by the US FOIA (b) (6) revealed, "Type: NJ Exec Order 26.4b…Reported by: [Licensed Practical Nurse (LPN) 1's Name] on NJ Exec Order 26.4 at 3:15 PM…Location: Unknown; Assigned Caregiver: [Certified Nurse Aide (CNA) 1's Name]; Physician notified on NJ Exec Order 26.4 at 3:17 PM…Family notification on NJ Exec Order 26.4b1 3:20 PM… NJ Exec Order 26.4b1 called on NJ Exec Order 26.4 at 5:00 PM…Sent to Hospital on NJ Exec Order 26 at 9:00 PM." Review of R112's "Nurse's Note," dated NJ Exec Order 26, completed by LPN1 and located in the "Facility Investigation" revealed "[On NJ Exec Order 26] Around 3:15 PM, US FOIA (b) (6) reported NJ Exec Order 26.4b1 on resident's NJ Upon assessment, noted NJ Exec Order NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on NJ and NJ Exec Order 26.4b1 on NJ NJ Exec was noted when the NJ Exec Order 26.4b1 is NJ Exec Order 26 and with NJ Exec Order 26.4b1 The US FOIA (b) (6) assessed the resident's affected area and notified resident's NJ Exec and US FOIA (b) (6). Resident was transferred to	F0684	Continued from page 8 The QAPI committee will determine the need for continued monitoring based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0684 SS = D	Continued from page 9 [hospital] for NJ Exec Order 26.4b1], NJ Exec O NJ Exec Order and NJ Exec Order 2...Resident NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1..." The Conclusion of the "Facility Investigation" revealed "...Team met to discuss the NJ Exec Or to NJ Exec Order 26.4b1 NJ Exec O Spoke with the US FOIA (b)(6) and she reported that R112 was NJ Exec Order 2 on NJ Exec Order 26.4b1 when getting NJ Exec Order 2 NJ Exec was NJ Exec Orde and NJ Exec Order 26 at NJ Exec Order 26.4b. US FOIA reports there was a NJ Exec Order 26.4b1 after the incident...At this time R112 is in the hospital for the NJ Exec Order 26.4b1 . Investigation is on-going...R112 returned on NJ Exec Order 26 on the 3-11(PM) shift...Investigation was unable to conclude the NJ Exec Order 2 Resident is NJ Exec Order 26.4b1 candidate. Returned with NJ Exec Order 26.4b1 will follow up with NJ Exec Order 26.4b1 Continues to be a NJ Exec Order 26.4b1 and NJ Exec Orde for NJ Exec Orde Review of the NJ Exec Order 26.4 at 11:02 PM "Hospital Records" provided by the US FOIA revealed, "Chief complaint" NJ Exec O On arrival here, the NJ Exec O and NJ Exec Order 26.4b are NJ Exec Order 26.4b and NJ Exec Order 26.4b1. ED [Emergency Department] spoke with the facility and they NJ Exec Order 26.4b1 . NJ Exec is essentially NJ Exec Order 26.4b1 ; except for NJ Exec Order 26. Patient is NJ Exec Order 26.4b1 NJ Exec Order 2 here suggests NJ Exec Order 2 ." During an interview of 07/24/25 at 8:30 AM, Unit Manager (UM) 1 was asked if she remembered the incident from NJ Exec Order 26.4b1 regarding R112's NJ Exec Order 26 UM1 stated, "I really do not remember the event. I do remember that on NJ Exec Order 26 when NJ Exec went out to the hospital, NJ Exec was having NJ Exec or a NJ Exec Orde I think. I remember she (LPN2) had not come looking for me. People came to me and stated that no one came looking for me. UM1 was asked if she made rounds on the NJ Exec Order 26.4b1 unit on NJ Exec Order 26.4b1 UM1 stated, "I did not make rounds on NJ Exec Order 26.4b1 in the morning but, I did make rounds in the afternoon. I was not made aware that there were any problems..." During an interview on 07/24/25 at 9:18 AM, the US FOIA (b)(6) was asked why there was a delay in treatment on NJ Exec Order 26.4 from 5:00 PM when the NJ Exec Order 26.4b was called to 9:00 PM before R112 had left in the NJ Exec Order 26.4b1 The US FOIA (b)(6) stated, "I can only guess it was a NJ Exec Order 26.4b1 ." During an interview on 07/24/25 at 12:27 PM, US FOIA (b)(6) was asked about the incident involving R112 on NJ Exec Order 26.4b1 . The US FOIA (b) stated, "I was the	F0684		

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F0684 SS = D	Continued from page 10 NJ Exec the morning of the NJ Exec on the 7-3 shift. I usually start at about 6:00 am. Everything was fine. I returned on NJ Exec Order 26 at the same time and when I saw [R112's Name], NJ Exec was all 'tucked in tightly.' I went to get my supplies and NJ Exec clothes and when I uncovered NJ Exec and took NJ Exec Order 26.4b1, I noticed that the NJ Exec was NJ Exec Order 2 and the NJ Exec Orde of the NJ Exec was NJ Exec Order 26. The US FOIA (b)(further stated, "I went to tell the nurse around 7:00AM-7:30 AM about the NJ Exec Order 2 and the NJ Exec Orde The nurse left the medication cart, and she followed me to the room. I brought R112 to the dining table for breakfast and I told the nurse NJ Exec was in NJ Exec and she said she would give NJ Exec something. I don't know if she did or not as I went on to care for my other residents there." Review of R112's 'NJ Exec Order 26.4b1 Medication Administration Record (MAR)" revealed R112 had received, 'NJ Exec Order 26.4b1]. Give (2) tablets one time daily before NJ Exec Orde care." Dated NJ Exec Order 26.4 Documentation showed that NJ Exec received this dose of NJ Exec Orde as scheduled but the time of the administration is unknown per the EMR. In addition, R112's MAR showed that NJ Exec had as needed medications for NJ Exec which included NJ Exec Order 26.4 and NJ Exec Order 2 but the MAR indicated that these had not been administered to R112 during the entire month of NJ Exec Order 26.4b1 During an interview on 07/24/25 at 2:20 PM, the US FOIA was asked why LPN2 asked not to return to the facility. The US FOIA stated, "She was an NJ Exec Order 2 I think it was not finding the US FOIA (b) (6) but I can't prove it." The US FOIA was asked about the investigation which showed that UM1 did not make rounds on NJ Exec Order 26.4b1 The US FOIA stated, "Yes, she was NJ Exec Order 26.4 for that as she did not make rounds as she should have." The US FOIA stated LPN2 should have notified R112's physician, completed a documented assessment of R112, and documented them both in the resident's medical record when she became aware of the resident's NJ Exec Order 26.4b1. The US FOIA was asked why it took so long for the NJ Exec Order 26.4b1 to arrive at it four hours since the NJ Exec Order 26.4b1 was called. The US FOIA stated, "I can't answer this." The US FOIA was asked if it was appropriate to wait four hours as there was no documentation in the EMR to indicate the condition of the resident while waiting for the NJ Exec Order 26.4b1 transfer on NJ Exec Order 2 The US FOIA stated, "I see what you are saying." The US FOIA was asked if US FOIA (b)(was interviewed during the investigation. She stated, "I think the US F did." There was no documentation to show that the US FOIA (b)(was interviewed for the investigation. There was no documentation to show after the US FOIA (b)(	F0684		

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F0684 SS = D	Continued from page 11 informed LPN2 that R112 had [NJ Exec Order 2] to [NJ Exec Order 26.4b1] and [NJ Exec Order 2] or the condition of the resident at the time she was informed. The information was placed on a 24-hour report (in-house report) indicating at 3:15 PM the information was shared (endorsed) to the next shift. There was no documentation in the EMR to show if R112 had [NJ Exec] or the physician was contacted until 3:17 PM. According to the investigation, the [NJ Exec Order 26.4b1] left the facility with R112 at 9:20 PM and arrived at the hospital at 11:02 PM when [NJ Exe] was seen by the physician. 2. Review of the facility's policy titled "Medication and Treatment Orders," revised 02/06/18, provided by the facility revealed "Orders for medications and treatments will be consistent with principles of safe and effective order writing." "11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available." Review of R44's quarterly "Minimum Data Set (MDS,)" with an Assessment Reference Date (ARD) date of [NJ Exec Order 26], located in the "MDS" tab of the Electronic Medical Record (EMR) revealed an admission date of [NJ Exec Order 26.4] The "MDS" also revealed the facility assessed R44 to have a Brief Interview for Mental Status (BIMS) score of [NJ E] out of 15, indicating R44 was [NJ Exec Order 26.4b] . The "MDS" further revealed R44 had diagnosis of [NJ Exec Order 26.4b1] . Review R44's "Medication Administration Record (MAR)," dated [NJ Exec Order 26.4b1] and located in the resident's EMR under the "MAR" tab revealed an ordered dated [NJ Exec Order 26] of '[NJ Exec Order 26.4b1] capsule (1 capsule) capsule one time weekly starting [NJ Exec Order 26] for a [NJ Exec Order 26.4b1] and an order dated [NJ Exec Order 26.4b1] of '[NJ Exec Order 26.4b1] , two times daily for [NJ Exec Order 26.4b1] Continued review of the "MAR" revealed the resident was not administered the [NJ Exec Order 26.4b1] on [NJ Exec Order 26] and was not administered the [NJ Exec Order 26.4b1] on [NJ Exec Order 26]. The "MAR" indicated the medications were "…not administered (pharmacy called-med being delivered)." Review of R44's "Pharmacy Order Details" provided by the facility revealed the [NJ Exec Order 26.4b1] was ordered from the pharmacy on [NJ Exec Order 26.4] the same day the	F0684		

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F0684 SS = D	Continued from page 12 resident missed the dose of medication due to the facility not having in on hand. The "Pharmacy Order Details" also revealed the resident's [NJ Exec Order 26.4b] [NJ Exec Order 26.4b1] was ordered from the pharmacy on [NJ Exec Order 26]; however, the medication was not available at the facility on [NJ Exec Order 26.] and the resident missed the dose of the medication. Review of R44's "MAR," dated [NJ Exec Order 26.4b1] and located in the EMR under the "MAR" tab revealed an order dated [NJ Exec Order 26] of [NJ Exec Order 26.4b1] one time daily…for a [NJ Exec Order 26.4b1] and an order dated [NJ Exec Order 26] of '[NJ Exec Order 26.4b1] one time daily for [NJ Exec Order 26.4b1]." The "MAR" revealed the [NJ Exec Order 26.4] was not administered to the resident on [NJ Exec Order 26.4] and the [NJ Exec Order 26.] was not administered to the resident on [NJ Exec Order 26.] nor on [NJ Exec Order 26]. The "MAR" indicated the medications were "…not administered (pharmacy called-med being delivered)." Review of R44's "Pharmacy Order Details" provided by the facility revealed the [NJ Exec Order 26.4] was ordered from the pharmacy on [NJ Exec Order 26.], the same day the resident missed the dose of medication due to the facility not having in on hand. The "Pharmacy Order Details" also revealed the resident's [NJ Exec Order 26] was ordered from the pharmacy on [NJ Exec Order 26] two days after the facility ran out of the mediation. Review of R44's "MAR," dated [NJ Exec Order 26.4b1] and located in the EMR under the "MAR" tab revealed the resident was ordered '[NJ Exec Order 26.4b1] one time daily… for [NJ Exec Or]." The "MAR" indicated the medication was not administered to the resident on [NJ Exec Order 26.4b1]. The "MAR" also indicated the mediation was "…not administered (pharmacy called-med being delivered)." Review of R44's "Pharmacy Order Details" provided by the facility revealed the [NJ Exec Order 26] was ordered from the pharmacy on [NJ Exec Order 26.4b1], the same days the resident missed the doses of medication due to the facility not having in on hand. Review of R44's "MAR," dated [NJ Exec Order 26.4b] and located in the EMR under the "MAR" tab revealed the resident was ordered '[NJ Exec Order 26.4b1] one time daily… for [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] …one time weekly starting…for a [NJ Exec Order 26.4b1]. The "MAR" revealed the [NJ Exec Order 26.4b] was not administered to the resident on [NJ Exec Order 26.] and the [NJ Exec Order 26.4b1] was not	F0684		

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F0684 SS = D	Continued from page 13 administered to the resident on NJ Exec Order 26.4. The "MAR" indicated the medications were "…not administered (pharmacy called-med being delivered)." Review of R44's "Pharmacy Order Details" provided by the facility revealed the NJ Exec Order 26.4b was ordered from the pharmacy on NJ Exec Order 26, the same day the resident missed the dose of medication due to the facility not having in on hand. The "Pharmacy Order Details" also revealed the resident's NJ Exec Order 26.4b1 was ordered from the pharmacy on NJ Exec Order 26 the same day the resident missed the dose of medication due to the facility not having in on hand. Review of R44's "MAR," dated NJ Exec Order 26.4b and located in the EMR under the "MAR" tab revealed the resident was ordered 'NJ Exec Order 26.4b1 one time daily…for NJ Exec O [NJ Exec Order 26.4b1]" and NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1) .. NJ Exec one time daily…for NJ Exec Order 26.4b1 ." The "MAR" revealed the NJ Exec Order 26 was not administered to the resident on NJ Exec Order 26; and the NJ Exec Order 26.4 was not administered to the resident on NJ Exec Order 26. The "MAR" indicated the medications were "…not administered (pharmacy called-med being delivered)." Review of R44's "Pharmacy Order Details" provided by the facility revealed the NJ Exec Order 26 was ordered from the pharmacy on NJ Exec Order 26, the same day the resident missed the dose of medication due to the facility not having in on hand. The "Pharmacy Order Details" also revealed the resident's NJ Exec Order 26.4 was ordered from the pharmacy on NJ Exec Order 26.4 the same day the facility did not have the medication on hand for the medication to be administered. The medication was delivered on NJ Exec Order 26.4 however, the medication was not administered to the resident on NJ Exec Order 26.4b1 During an observation on 07/21/24 at 12:09 PM, R44 was in NJ Exe room sitting in NJ Exe wheelchair, NJ Exec Order 2 and NJ Exec Order 26.4 R44 was asked if NJ Exe received NJ Exe medications timely. R44 responded, "some days, not always" as NJ Exe NJ Exec Order 26.4b1 and other medications were not given because they run out due to "poor planning." R44 stated NJ Exe was especially NJ Exec Order 26.4b about NJ Exec Order 26.4b1 medication and the effect it could have on NJ Exec Order 26.4 R44 stated so far, NJ Exec Order 26.4b1 had been NJ Exec O During an interview on 07/23/25 at 4:33 PM, Unit Manager (UM) 1 was asked why R44's NJ Exec Order 26.4b1 through NJ Exec Order 26.4b "MARs" revealed medications were "not administered (pharmacy called- med being delivered)"	F0684		

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F0684 SS = D	Continued from page 14 but the nurse initialed the med for that day. UM1 stated the pharmacy was late getting the medication delivered to them, stating for example if they call that day, the pharmacy may not get it until after the dose was due. UM1 stated the nurse should be ordering the medication three to five days ahead of time before running out. UM1 stated they do have a medication machine the nurse could have gotten a backup medication, but it should have been documented on the "MAR." During an interview on 07/24/25 at 10:40 AM, the US FOIA (b)(6)) was asked how far in advance should staff reorder medications. The US FOIA P stated she instructed the staff to reorder them a week in advance. The US FOIA was asked if she was aware some of R44's medications were not administered due to not being reordered timely. The US FOIA stated she was only aware of R44's NJ Exec Order 26.4b1 medication because the facility paid for it. However, the US FOIA was not aware of other medications. The US FOIA was asked if she completed audits and she stated she reviewed the pharmacy reports. During a follow up interview on 07/24/25 at 11:08 AM, UM1 was asked about the notes at the end of R44's NJ Exec Order 2 through NJ Exec Order 26.4b "MARs" that listed medications that were not administered. UM1 reviewed the "MARs" and stated some of the medications were stock medications and the nurse could have retrieved them from the stock. UM1 was asked if that was the case, why was the medication not administered. UM1 then checked the nurses' names on the MARs and stated the nursing staff that failed to reorder timely or use the stock medications, were agency nurses and they must not have been educated on the process. UM1 asked if the agency nurse was on duty and she stated, "No." During an interview on 07/24/25 at 5:24 PM, the US FOIA (b)(6)) was asked to run a report for R44's medications listed on the last page of the NJ Exec Order 26.4b1 "MAR" to confirm if they were or were not administered as the nurse had initialed the MAR but also documented a note that stated the medication was not administered. The US FOIA reviewed the NJ Exec Order 26 date for NJ Exec Order 26.4b1) and the NJ Exec Order 26.4b1 dates for NJ Exec Order 26.4b NJ Exec Order 26.4b1 These dates were highlighted in red. The US FOIA stated the red meant the medications were not administered and the nurse's initials did not confirm the medication was given. US FOIA stated if the other "MARs" had the same note "not administered" the date would be red as well for the medications not administered.	F0684		

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F0684 SS = D	Continued from page 15 NJAC 8:39-27.1(a)	F0684		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners,	F0842	F842 1. The DON interviewed Resident R5 to confirm Resident had reported to physician that Resident R5 had NJ Exec Order 26.4b1 at the time. The DON confirmed directly with the physician that the order for a NJ Exec Order 26.4 was given based upon symptoms reported by resident. Physician will ensure the reason for the NJ Exec Order 26.4 is documented in resident's medical record. 2. All residents have the potential to be affected by this deficient practice. The DON and Unit Managers (UM) reviewed all residents with current urinalysis orders and verified that each medical record contained documentation supporting the reason for the test. All reviewed records were found to be compliant. 3. The DON, or designee, will conduct an in-service for licensed nursing staff on the requirement to document signs/symptoms or other justifications for urinalysis orders in each resident's medical record. 4. The DON, or designee, will review urinalysis orders and each corresponding medical record to verify the presence of a documented reason for the test. Audit results will be presented at QAPI meetings monthly for three months, and one quarter thereafter. The QAPI committee will determine the need for continued monitoring based on audit findings.	08/20/2025

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F0842 SS = D	Continued from page 16 funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of the facility policy, the facility failed to ensure the medical record was complete and accurate for one resident (Resident (R) 5) out of 24 sampled residents. This failure placed the residents at risk for unmet care needs. Findings include: Review of the facility's policy titled, "Charting and Documentation," dated 01/10/25 revealed, "All services provided to the resident, progress toward the care plan	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE , MONROE TOWNSHIP, New Jersey, 08831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = D	Continued from page 17 goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." Review of R5's "Face Sheet" located on the "Home Page" of the electronic medical record (EMR) revealed that R5 was admitted to the facility on [redacted] with diagnoses that included [redacted]. Review of R5's admission "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of [redacted] revealed R5 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated R5 was [redacted]. Review of R5's "Care Plan," dated [redacted] and revised on [redacted] revealed, "I have the potential for [redacted] and [redacted] due to the use of an [redacted] in my [redacted] due to [redacted]." Interventions included: a. a. "Staff will provide [redacted] care every shift." b. b. "Staff will assess me for [redacted] or [redacted] of [redacted]." c. c. "Staff will confer with MD regarding the continued need for a [redacted] d. d. "Staff will maintain a [redacted] ensuring that the [redacted]." e. e. "Staff will monitor my [redacted] appearance noting [redacted] and [redacted] every shift." Review of R5's "Physician Order," dated [redacted] and located in the resident's EMR under the "Orders" tab indicated that the [redacted] was removed on [redacted]." Review of R5's "[redacted] Report," dated [redacted] and located in the hard chart revealed that R5 had an [redacted] report which indicated per the [redacted] that R5 had [redacted] in [redacted] and would require [redacted] Review of R5's "Physician Order," dated [redacted] and located in the hard chart revealed, "[redacted] give twice daily for seven days for a [redacted])."	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE , MONROE TOWNSHIP, New Jersey, 08831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = D	Continued from page 18 Review of R5's "Assessments" tab in the EMR showed no documentation as to what symptoms R5 was having or the reason for the [NJ Exec Order 26.4b] test. Review of R5's"Skilled Nursing Documentation," dated [NJ Exec Order 26.4] and located in the EMR under the "Assessments" tab revealed '[NJ Exec Order 26.4] was checked however, there was no narrative at the bottom of the page to indicate why R5 was on an [NJ Exec Order 26.4]. During an interview on 07/23/25 at 3:04 PM, the [US FOIA (b)(6)] stated, "I did not find a note [from the nurses] regarding the signs/symptoms of the [NJ Exec]. It was noted on the 24-hour report that the [NJ Exec Order 26.4] was obtained. I spoke to [Registered Nurse (RN) 2's Name] who stated that the resident had complained to the doctor about [NJ Exec Order 26.4b1] on the [NJ Exec Order 26.4b1]." The [US FOIA (b)] was asked if there should be a progress note or [NJ Exec Order 26.4b1] note in the EMR. The [US FOIA (b)] stated, "Yes, there should have been a progress note in the EMR." NJAC 8:39-35.2	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE , MONROE TOWNSHIP, New Jersey, 08831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		08/15/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for	S0560	S560 1. The Administrator and Human Resources (HR) will conduct bi-weekly Staff Recruitment Meetings for eight weeks and monthly thereafter to review open positions, staffing needs, recruitment efforts, and any active applications or resumes. Direct care staff positions will be advertised through multiple channels, including the company website, online recruitment platforms, local vocational/technical schools, Certified Nursing Aide training programs, and social media. Staffing agency contracts will be utilized as needed to supplement direct care coverage. 2. All residents have the potential to be affected by staffing shortages. 3.When a staffing ratio imbalance is identified, the facility will: Contact all available staff to work additional shifts, offering incentive bonus pay to volunteers. Engage contracted staffing agencies to maintain required direct care staffing levels. Additionally, the Administrator, Director of Nursing (DON)/designee, and HR will review wages and benefits to remain competitive and offer sign-on and referral bonuses to current staff and new hires. The Staffing	08/20/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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VILLAGE POINT	THREE DAVID BRAINERD DRIVE , MONROE TOWNSHIP, New Jersey, 08831

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S0560	Continued from page 1 the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 3 weeks of Complaint staffing from 10/13/2024 to 11/02/2024, the facility was deficient in CNA staffing for residents on 2 of 21 day shifts as follows: -10/19/24 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/23/24 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. 2. For the 3 weeks of Complaint staffing from 12/15/2024 to 0104/25, the facility was deficient in CNA staffing for residents on 2 of 21 day shifts as follows: -12/30/24 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -01/03/25 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs.	S0560	Continued from page 1 Scheduler and DON/designee will review the upcoming week's schedule weekly to ensure compliance with regulatory staffing requirements. 4.The DON/designee will review daily staffing levels and present findings monthly for three months to the QAPI Committee. Any staffing level deficiencies will be addressed with appropriate corrective action. HR will also report the outcomes of Staff Recruitment Meetings monthly for three months to the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	**THREE DAVID BRAINERD DRIVE , MONROE TOWNSHIP, New Jersey, 08831**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 9/17/2025 in relation to the 7/24/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **061219**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	**THREE DAVID BRAINERD DRIVE , MONROE TOWNSHIP, New Jersey, 08831**

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 9/17/2025 in relation to the 7/24/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - VILLAGE POINT, ... B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINT	THREE DAVID BRAINERD DRIVE , MONROE TOWNSHIP, New Jersey, 08831

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/22/25 and was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Village Point is a two-story building built in 2018. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator powers 100% of the building per the Maintenance Director. The current occupied beds are 104 of 119.	K0000		08/15/2025
K0293 SS = F Bldg. 02	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to provide illuminated exit signs from the Aspen and Evergreen courtyards to a public way in accordance with NFPA 101 Life Safety Code (2012 Edition) section 7.7.3.2. This deficient practice had the potential to affect 104 residents and was evidenced by the following: Observations on 07/22/25 at 2:45 PM revealed that two exit stairs opened into the [redacted] Courtyard and two exit stairs opened into the [redacted] Courtyard but did	K0293	TK0293 1. Illuminated Exit Directional signs will be installed in [redacted] and [redacted] Courtyard areas attached to the six-foot-high composite fence leading to a public way. 2.All residents in the facility have the potential of being affected by this deficient practice. 3. Illuminated Exit Directional signs installed in [redacted] and [redacted] Courtyard areas were added to the existing list for monthly inspection. 4. The exit signs will be monitored monthly by the Maintenance Director or Designee. The completion of the tests will be submitted to the Quality Assurance and Performance Improvement Committee monthly for three months.	08/15/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - VILLAGE POINT, ... B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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VILLAGE POINT	THREE DAVID BRAINERD DRIVE , MONROE TOWNSHIP, New Jersey, 08831

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K0293 SS = F Bldg. 02	Continued from page 1 not show how to exit out of the courtyards to a public way due to the six feet high composite fence installed in the courtyards. During an interview at the time of observation, the US FOIA (b)(6) confirmed there were no illuminated exit signs installed leading to a public way. NJAC 8:39-31.2(e)	K0293		

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/22/25. The facility was found to be in compliance with 42 CFR 483.73.	E0000		08/15/2025

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K0000 Bldg. 02	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 9/17/2025 in relation to the 7/24/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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

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