

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0L9278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/24/2025
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NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF MARLBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 3A SOUTH MAIN STREET MARLBORO, NJ 07746
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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 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00188278</p> <p>CENSUS: 66</p> <p>SAMPLE SIZE: 3</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/18/25

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188278 Based on interview and record review, it was determined that the facility Administrator failed to implement and ensure enforcement of its policy and procedure titled, "Incident and Event Reporting" and failed to develop and enforce a comprehensive policy and procedure regarding notification of the Registered Nurse (RN) and the Physician when there was a NJ Ex Order 26.4B1 for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 7/16/2025, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "Date of Event" NJ Ex Order 26.4B1, and a "Time of Event" of 12:55 p.m. The FRE revealed that a facility resident, Resident #3, was eating in the NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The resident was assisted to another area in the facility for privacy to be assessed by the nurse. Resident #3 became NJ Ex Order 26.4B1, and NJ Ex Order 26.4B1 initiated and NJ Ex Or called. Resident #3 was NJ Ex Order 26.4B1 by the Emergency Medical Technicians (EMTs).</p> <p>On 7/24/25 at 9:45 a.m., the surveyor interviewed the Executive Director (ED) about the NJ Ex Order 26.4B1 FRE. The surveyor requested copies of the facility's incident report and the facility's notification policy.</p> <p>At 10:00 a.m., the surveyor reviewed the Medical</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>Record (MR) of Resident #3 which revealed a NJ Ex Order 26. 4B1</p> <p>Review of a "Progress Note New (PNN)" dated NJ Ex Order 26. at 7:23 a.m. written by the Licensed Practice Nurse (LPN) revealed that Resident #3 had NJ Ex Order 26. 4B1 upon NJ Ex Order 26.4b1 and was taking a NJ Ex Order 26. 4B1 medication. Further review of the resident's MR revealed that there was no documented evidence that the RN and the Physician were notified of Resident #3's NJ Ex Order 26. 4B1.</p> <p>At 12:30 p.m., during a second interview, when the surveyor asked about the policy to notify the RN and the Physician by facility staff when there was a change in a resident's NJ Ex Order 26. 4B1, the ED stated that the facility does not have a "Notification" policy. She continued to say that the facility's protocol was to notify the RN and Physician when there was a NJ Ex Order 26. 4B1. She also confirmed that the facility staff were not reeducated on when to notify the RN or the resident's Physician after the incident was reported to the NJDOH on NJ Ex Order 26.</p> <p>In the same interview, the ED confirmed that an incident report was not completed in the facility internal event reporting system.</p> <p>At 2:41 p.m., the surveyor reviewed a facility training binder for staff to address training and reeducation opportunities as they were needed. The surveyor was not provided with any documented evidence of any training or reeducation completed after the NJ Ex Order 26. incident.</p>	A 310		

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A 310	Continued From page 3 Surveyor review of an undated facility policy titled, "Incident and Event Reporting ...Policy Number: GEN-0025" revealed, "Procedure: ...7. The Team Member who witnesses, discovers or who is involved in the resident event/incident, will: ... c. Enter the event in the [facility] internal event reporting system ...12. The ED/designee will ... institute appropriate measures to prevent similar future situations...."	A 310		
A 313	8:36-3.4(a)(4) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 4. Ensuring the provision of staff orientation and staff education; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188278 Based on interview and record review, it was determined that the facility failed to provide staff education and training on the notification of the Registered Nurse (RN) and the Physician when NJ Ex Order 26. 4B1 was noted, including a NJ Ex Order 26. 4B1 of 1 of 3 resident's reviewed, Resident #3. This deficient practice was evidenced by the following: On 7/16/2025, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "Date of Event" NJ Ex Order 26 , and a "Time of Event" of 12:55 p.m. The FRE revealed	A 313		

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A 313	<p>Continued From page 4</p> <p>that a facility resident, Resident #3, was eating in the NJ Exec Order 26.4b1 and became NJ Exec Order 26.4b1. The resident was assisted to another area in the facility for privacy to be assessed by the nurse. Resident #3 became NJ Ex Order 26.4B1 and NJ Ex Order 26.4B1 initiated and NJ Ex Or called. Resident #3 was NJ Ex Order 26.4B1 by the Emergency Medical Technicians (EMTs).</p> <p>On 7/24/25 at 10:00 a.m., the surveyor reviewed the Medical Record (MR) of Resident #3 which revealed a revealed a NJ Ex Order 26.4B1</p> <p>At 11:03 a.m., the surveyor interviewed a facility Licensed Practical Nurse (LPN), who stated that she was notified by a facility Care Manager (CM) that Resident #3 had NJ Ex Order 26.4B1 upon NJ Exec Order 26.4b1 on the morning on NJ Ex Order 26.4B1. The LPN confirmed that this was a NJ Exec Order 26.4B1 in Resident #3's NJ Ex Order 26.4B1. She also stated that she NJ Exec Order Resident #3's NJ Ex Order 26.4B1 out with NJ Exec Order and the NJ Ex Order 26.4B1 stopped.</p> <p>In the same interview, when the surveyor asked the LPN if she notified the RN or the Physician of Resident #3's NJ Ex Order 26.4B1, she stated that she didn't notify Resident #3's RN or Physician because there was no further NJ Ex Order 26.4B1. Upon further interview, the LPN stated that the RN and Physician should have been notified of Resident #3's NJ Ex Order 26.4B1.</p> <p>At 12:30 p.m., during an interview with the Executive Director (ED), when asked about staff education and trainings after the NJ Exec Order 26.4B1 incident, the ED stated that staff trainings were completed upon hire and yearly using their online training</p>	A 313		

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A 313	<p>Continued From page 5</p> <p>systems, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. She also stated that any additional trainings were completed as needed and a sign in sheet with the topic and staff signatures were placed in a binder that was kept in the business office. The ED confirmed that there was no additional staff training completed regarding the procedure for notification of an RN and the Physician when a NJ Ex Order 26.4B1 is observed, including after Resident #3's NJ Ex Order 26.4B1 incident on NJ Ex Order 26.4B, which was confirmed a NJ Ex Order 26.4B1.</p> <p>The facility did not ensure that the staff were immediately trained to ensure changes in conditions of all residents were reported to the RN and the physician for timely interventions and for the health safety of its residents.</p> <p>On 7/29/25 at 3:12 p.m., during a post survey telephone interview, the ED confirmed that she was not aware of a written facility policy regarding training and re-education of staff to address re-training opportunities as they needed after an incident.</p>	A 313		
A 357	<p>8:36-4.1(a)(2) Resident Rights</p> <p>(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:</p> <p>2. The right to receive a level of care and services that addresses the resident's changing physical and psychosocial status;</p>	A 357		

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A 357	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188278</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide a resident with a level of care and services that addressed NJ Ex Order 26. 4B1 for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 7/16/2025, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "Date of Event" NJ Ex Order 26., and a "Time of Event" of 12:55 p.m. The FRE revealed that a facility resident, Resident #3, was eating in the NJ Exec Order 26.4b1 and became NJ Ex Order 26. The resident was assisted to another area in the facility for privacy to be assessed by the nurse. Resident #3 became NJ Ex Order 26. 4B1 and NJ Ex Order 26. initiated and NJ Ex Or called. Resident #3 was NJ Ex Order 26. 4B1 by the Emergency Medical Technicians (EMTs).</p> <p>On 7/24/25 at 10:00 a.m., the surveyor reviewed the Medical Record (MR) of Resident #3 which revealed a NJ Ex Order 26. 4B1</p> <p>Review of a "Progress Note New (PNN)" dated NJ Ex Order 26. at 7:23 a.m. written by the Licensed</p>	A 357		
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A 357	<p>Continued From page 7</p> <p>Practice Nurse (LPN) revealed that Resident #3 had NJ Ex Order 26. 4B1 upon wakening and was taking a NJ Ex Order 26. 4B1 medication. Further review of the MR revealed that there was no documented evidence that the RN and the resident's Physician were notified of Resident #3's NJ Ex Order 26. 4B1.</p> <p>At 11:03 a.m. the surveyor interviewed a facility LPN who stated that she was notified by a facility Care Manager (CM) that Resident #3 had NJ Ex Order 26. 4B1 upon NJ Ex Order 26. 4B1 on the morning of NJ Ex Order 26. 4B1. The LPN also confirmed that this was a NJ Ex Order 26. 4B1 Resident #3's NJ Ex Order 26. 4B1. She also stated that she NJ Ex Order 26. 4B1 Resident #3's NJ Ex Order 26. 4B1 out with NJ Ex Order 26. 4B1 and the NJ Ex Order 26. 4B1 stopped.</p> <p>In the same interview, the LPN stated that Resident #3 told the LPN that [he/she] NJ Ex Order 26. 4B1. She stated Resident #3 was NJ Ex Order 26. 4B1 but [his/her] NJ Ex Order 26. 4B1 wasn't any NJ Ex Order 26. 4B1 than [his/her] NJ Ex Order 26. 4B1. The LPN stated that she checked the resident's vital signs that included [his/her] NJ Ex Order 26. 4B1. The LPN stated that she did not report Resident #3's NJ Ex Order 26. 4B1 to the Registered Nurse (RN) or Resident #3's Physician as she didn't think it was anything NJ Ex Order 26. 4B1 because the NJ Ex Order 26. 4B1 had NJ Ex Order 26. 4B1 but she should have notified them.</p> <p>At 3:00 p.m., the surveyor reviewed a history and physical exam in Resident #3's MR completed by [his/her] Physician with an appointment date and time of NJ Ex Order 26. 4B1 at 08:00 a.m., which stated that Resident #3 reported [he/she] had NJ Ex Order 26. 4B1 when NJ Ex Order 26. 4B1 or NJ Ex Order 26. 4B1. In addition the Physician documented Resident #3 had no NJ Ex Order 26. 4B1 upon NJ Ex Order 26. 4B1 exam on NJ Ex Order 26. 4B1 at 08:00 a.m.</p>	A 357		

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A 735	<p>8:36-7.2(e)(1-5) Resident Assessments and Care Plans</p> <p>(e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following:</p> <ol style="list-style-type: none"> 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment. <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00188278</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop a Health Service Plan (HSP) for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 7/16/2025, the New Jersey Department of</p>	A 735		

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A 735	<p>Continued From page 9</p> <p>Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "Date of Event" [redacted], and a "Time of Event" of 12:55 p.m. The FRE revealed that a facility resident, Resident #3, was eating in the [redacted] and became [redacted]. The resident was assisted to another area in the facility for privacy to be assessed by the nurse. Resident #3 became [redacted] and [redacted] initiated and [redacted] called. Resident #3 was [redacted] by the Emergency Medical Technicians (EMTs).</p> <p>On 7/24/25 at 10:00 a.m., the surveyor reviewed the Medical Record (MR) of Resident #3 which revealed a [redacted].</p> <p>Review of a "Progress Note New (PNN)" dated [redacted] at 7:23 a.m., written by the Licensed Practice Nurse (LPN), revealed that Resident #3 had [redacted] upon [redacted] and was taking a [redacted] medication.</p> <p>Review of the Medication Administration Record (MAR) for Resident #3 revealed that Resident #3's Physician prescribed [redacted] to be given by mouth [redacted] a day, related to [his/her] [redacted] with a start date of [redacted] and a discontinue date of [redacted].</p> <p>Continued review of Resident #3's MR revealed that there was no documented evidence that a</p>	A 735		

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A 735	<p>Continued From page 10</p> <p>HSP was developed regarding [redacted] Resident #3 for signs and symptoms of [redacted] or interventions to follow if signs and symptoms of [redacted] occur.</p> <p>At 11:03 a.m., the surveyor interviewed a facility Licensed Practical Nurse (LPN) who stated that she was notified by a facility Care Manager (CM) that Resident #3 had NJ Ex Order 26. 4B1 upon [redacted] on the morning on [redacted]. The LPN also confirmed that this was a [redacted] to Resident #3's [redacted]. She also stated that she [redacted] Resident #3's [redacted] out with [redacted] and the [redacted] stopped. During continued interview with the LPN, she confirmed that she was aware that the RN and the Physician should have been notified of Resident #3's NJ Ex Order 26. 4B1.</p> <p>Surveyor review of an undated facility policy titled, "Assessing and Evaluating Residents" which revealed "Procedure: ...3. A Licensed Nurse (LN)/designee in collaboration with the interdisciplinary team (IDT) shall complete a comprehensive assessment...d. upon a significant change in condition...."</p>	A 735		
A 779	<p>8:36-7.5(c) Resident Assessments and Care Plans</p> <p>(c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care.</p>	A 779		

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A 779	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188278 Based on interview, and medical record review, it was determined that the facility's Licensed Practical Nurse (LPN) failed to notify the Registered Nurse (RN) of a resident's [redacted] for 1 of 3 residents reviewed, Resident #3. The deficient practice was evidenced by the following:</p> <p>On 7/24/25 at 10:00 a.m., the surveyor reviewed the Medical Record (MR) of Resident #3 which revealed a [redacted]</p> <p>[redacted]</p> <p>Review of a "Progress Note New (PNN)" dated [redacted] at 7:23 a.m., written by the LPN, revealed that Resident #3 had [redacted] upon [redacted] and was taking a [redacted] medication. Further review of the MR revealed that there was no documented evidence that the RN was notified of the resident's [redacted].</p> <p>At 11:03 a.m., the surveyor interviewed a facility LPN who stated that she was notified by a facility Care Manager (CM) that Resident #3 had [redacted] upon [redacted] on the morning on [redacted]. The LPN confirmed that this was a [redacted] Resident #3's [redacted]. She also stated that she [redacted] Resident #3's [redacted] out with [redacted] and the [redacted] stopped.</p> <p>In the same interview, when the surveyor asked</p>	A 779		

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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 779	Continued From page 12 the LPN if she notified the RN of Resident #3's NJ Ex Order 26. 4B1 , she stated that she didn't notify the RN because there was no further NJ Ex Order 26. 4B1 . The LPN continued to say that she was aware that the RN should have been notified of Resident #3's NJ Ex Order 26. 4B1 .	A 779		
A 781	8:36-7.5(d) Resident Assessments and Care Plans (d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any intervention by the physician shall be recorded. This REQUIREMENT is not met as evidenced by: Based on interview and medical record review, it was determined that the facility's Licensed Practical Nurse (LPN) failed to notify the Physician of a resident's NJ Ex Order 26. 4B1 for 1 of 3 residents reviewed, Resident #3. The deficient practice was evidenced by the following: On 7/24/25 at 10:00 a.m., the surveyor reviewed the Medical Record (MR) of Resident #3 which revealed a NJ Ex Order 26. 4B1 [REDACTED] [REDACTED]. Review of a "Progress Note New (PNN)" dated NJ Ex Order 26. 4B1 at 7:23 a.m. written by the LPN, revealed that Resident #3 had NJ Ex Ord [REDACTED] upon NJ Ex Order 26.4b1 and	A 781		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0L9278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/24/2025
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NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF MARLBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 3A SOUTH MAIN STREET MARLBORO, NJ 07746
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A 781	<p>Continued From page 13</p> <p>was taking a NJ Ex Order 26. 4B1 medication. Further review of the MR revealed that there was no documented evidence that the Physician was notified of the resident's NJ Ex Order 26. 4B1.</p> <p>At 11:03 a.m., the surveyor interviewed a facility LPN who stated that she was notified by a facility Care Manager (CM) that Resident #3 had NJ Ex Order 26. 4B1 upon NJ Exec Order 26.4b1 the morning of 7/13/25. The LPN confirmed that this was a NJ Exec Order 26. 4B1 Resident #3's NJ Ex Order 26. 4B1. She also stated that she NJ Ex Order 26. 4B1 Resident #3's NJ Ex Order 26. 4B1 out with NJ Ex Order 26. 4B1 and the NJ Ex Order 26. 4B1 stopped.</p> <p>In the same interview, when the surveyor asked the LPN if she notified the Physician of Resident #3's NJ Ex Order 26. 4B1, she stated that she didn't notify Resident #3's Physician because there was no further NJ Ex Order 26. 4B1. The LPN continued to say that she was aware that the Physician should have been notified of Resident #3's NJ Ex Order 26. 4B1.</p>	A 781		

POC # 5
Accepted
12/18/25



Sunrise Senior Living
Plan of Correction

Name of Facility: Sunrise Senior Living of Marlboro
Address of Facility: 3A South Main Street
License number: 0L9278
Inspection date(s): 07/24/2025

Name and Title of Legal Entity: Sunrise Senior Living of Marlboro NJ

Representative Signing the Plan of Corrections: [Redacted] NJ Exec Order 26.4b1

Signature of Sunrise Representative: [Redacted] NJ Exec Order 26.4b1

Date of Submission: 12/18/2025 [Redacted] - RN

A310, 8.36 -3.4 (a)(1) – Administration

Target Completion Date: 12/5/2025

1. Resident #3 [Redacted] NJ Exec Order 26.4b1. On 7/14/25, Regional Director of Resident Care and Executive Director conducted an immediate post-incident clinical and administrative review of the resident’s medical record to assess lapses in communication, documentation, and emergency response. The Licensed Practical Nurse who failed to report the [Redacted] NJ Exec Order 26.4b1 of the resident to the [Redacted] and Registered Nurse and Primary Care Physician received a [Redacted] NJ Exec Order 26.4b1 on [Redacted] NJ Exec Order 26.4b1 to report to the Registered Nurse and Primary Care Physician with [Redacted] NJ Exec Order 26.4b1 of residents. Written warning and re-training was completed by Regional Director of Resident Care.
2. All residents in the community have the potential to be affected by this deficient practice. Following the event, no other residents have been identified to have been affected by the deficient practice. On 9/25/2025, the Resident Care Director conducted an audit of incident reports from 7/18/2025 through 9/25/2025 to determine if the policy “Responding to Medical Emergencies” was adhered to. On

9/25/2025 the Resident Care Director found that incidents that were reported in the internal Patient Safety Work Product were in compliance with policy.

3. As of 9/1/2025 the Executive Director provided re-training to direct care staff, including care managers, certified medication managers, and licensed practical nurses on the community's current policies for "Resident's Rights", "Responding to Medical Emergencies", "Incident and Event Reporting", and "Individualized Service Plans". Training was concluded as of 9/25/25. These current policies address incident reporting, Registered Nurse and Primary Care physician notification, individualized service plans, and recognizing changes in condition and assessments, and how to respond during a change in condition. During the survey, the Executive Director inadvertently stated that the facility did not have a policy for Registered Nurse and Primary Care Physician notification. The existing policy "Responding to Medical Emergencies", most recently updated as of 4/24/2025, addresses reporting up to the Registered Nurse and Primary Care Physician during any changes in condition. The Regional Director of Operations retrained the Executive Director on 12/5/2025 to include that the existing "Responding to Medical Emergencies" policy states the Registered Nurse and Primary Care physician will be notified of any changes to a resident.
4. This plan of correction to ensure compliance of "Resident's Rights" and "Assessing and Evaluating Residents" policies will be discussed and evaluated quarterly for 2 quarters by the Executive Director or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If it is not effective, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violations do not occur again. The QAPI meeting discussion was initiated on 10/9/25 and will be reviewed for 2 quarters.
5. Target completion date: 12/5/2025

A313, 8.36 -3.4 (a)(4) – Administration

Target Completion Date: 9/25/2025

1. Resident #3 [NJ Exec Order 26.4b1] On 7/14/25, Regional Director of Resident Care and Executive Director conducted an immediate post-incident clinical and administrative review of the resident's medical record to assess lapses in communication, documentation, and emergency responses. The Licensed Practical Nurse, who failed to report the [NJ Exec Order 26.4b1] of the resident, received a [NJ Exec Order 26.4b1] and was [NJ Exec Order 26.4b1] to report to the Registered Nurse and Primary Care Physician with [NJ Exec Order 26.4b1] of residents. Written warning and re-training was completed by Regional Director of Resident Care.
2. All residents in the community have the potential to be affected by this deficient practice. Following the event, no other residents have been identified to have been affected by the deficient practice. On 9/25/2025, the Resident Care Director

conducted an audit of incident reports from 7/18/2025 through 9/25/2025 to determine if the policy "Responding to Medical Emergencies" was adhered to. On 9/25/2025, the Resident Care Director found that incidents that were reported in the internal Patient Safety Work Product were in compliance with the policy.

3. As of 9/1/2025 the Executive Director provided re-training to staff, including care managers, certified medication managers, and licensed practical nurses on facility's policies for "Resident's Rights", "Responding to Medical Emergencies," "Incident and Event Reporting" and "Individualized Service Plan" which was completed as of 9/25/25.
4. The Plan of Correction will be discussed and evaluated quarterly for 2 quarters by the Executive Director or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify that the violations do not occur again. The QAPI meeting initiated on 10/9/25 and will be reviewed for 2 quarters.
5. Target completion date: 9/25/2025

A357, 8.36 -4.1 (a)(2) – Resident's Rights

Completion Date: 9/25/2025

1. Resident #3 [NJ Exec Order 26.4b1] Regional Director of Resident Care and Executive Director conducted an immediate post-incident clinical and administrative review of the resident's medical record to assess lapses in communication, documentation, and emergency responses. The Licensed Practical Nurse, who failed to report the [NJ Exec Order 26.4b1] of the resident, received a [NJ Exec Order 26.4b1] report to the Registered Nurse and Primary Care Physician with [NJ Exec Order 26.4b1] of residents. Written warning and re-training was completed by Regional Director of Resident Care.
2. All residents in the community have the potential to be affected by this deficient practice. Following the event, no other residents have been identified to have been affected by the deficient practice. On 9/25/2025, The Resident Care Director conducted an audit of incident reports from 7/18/2025 through 9/25/2025 to determine if the policy "Responding to Medical Emergencies" was adhered to. On 9/25/2025, the Resident Care Director found that incidents that were reported in the internal Patient Safety Work Product were in compliance with the policy.
3. As of 9/1/2025 the Executive Director provided re-training to staff, including care managers, certified medication managers, and licensed practical nurses on facility's policies for "Resident's Rights", "Responding to Medical Emergencies,"

“Incident and Event Reporting”, and “Individualized Service Plan” which was completed as of 9/25/25. These current policies address incident reporting and changes in condition reporting to the Registered Nurse and Primary Care Physicians.

4. This Plan of Correction to ensure compliance of “Resident’s Rights” will be discussed and evaluated quarterly for 2 quarters by the Executive Director or designee and Coordinators at the Quality Management (QAPI) meeting to verify whether it is still effective. QAPI meeting initiated on 10/9/25 and will be reviewed for 2 quarters.
5. Completion date: 9/25/2025

A 735 , 8:36 – 7.2 (1-5)- Resident Assessments and Care Plans

Target Completion Date: 10/20/2025

1. Resident #3 [NJ Exec Order 26.4b1] Regional Director of Resident Care and Executive Director conducted an immediate post-incident clinical and administrative review of the resident’s medical record to assess lapses in communication, documentation, and emergency responses. The Licensed Practical Nurse who failed to report the [NJ Exec Order 26.4b1] of the resident received a written [NJ Exec Order 26.4b1] by the Regional Director of Resident Care on 7/14/25 with policy “Responding to Medical Emergencies” to include reporting to the Registered Nurse and Primary Care Physician with changes in condition of residents. Written warning and re-training was completed by Regional Director of Resident Care.
2. All residents in the community have the potential to be affected by this deficient practice.
3. On 9/1/2025 the Executive Director initiated an in-servicing to care managers, certified medication managers, and licensed practical nurses on facility’s policies for “Resident’s Rights”, “Responding to Medical Emergencies,” “Incident and Event Reporting”, and “Individualized Service Plan” which was completed as of 9/25/25. These policies address incident reporting, reporting changes in condition to the Registered Nurse and Primary Care Physician, service plans, and recognizing changes in condition and assessments, and timely notification of changes in condition. The Resident Care Director completed an audit for all current residents in the facility to identify residents currently on anticoagulation therapy. This audit was completed on 9/20/2025. The Resident Care Director also made care team aware of the residents currently using anticoagulation therapy verbally on 9/25/25 for immediate action. The Resident Care Director reviewed current service plans for residents who have been identified as receiving anticoagulation therapy and ensured that their care plans have been updated with interventions. These updates

were completed on 9/20/25. Registered Nurse was educated on contacting the Primary Care Physician for changes of condition of a resident. This education was completed by Executive Director on 9/25/25. Residents that are currently on an anticoagulant that may cause serious side effects have service plan updates. The Registered Nurse is instructed to notify the physician of potential bleeding/coagulation issues in a timely manner. The Registered Nurse is instructed to notify the resident and the resident's POA of the situation and explain what the next steps to take are (as provided by the physician) in a timely manner. This instruction was communicated by the Executive Director and Regional Director of Resident Care to the Registered Nurse on 9/25/25.

4. The Resident Care Director ran an audit from facility's pharmacy to identify residents on anticoagulation therapy that may cause serious side effects. This audit was initiated on 9/20/2025 and was performed weekly x 2 weeks then monthly x1 month with a completion date of 10/20/25 and as needed to ensure service plans reflect current treatment and interventions for existing and new residents. Residents who have been identified will be reviewed quarterly at QAPI meetings for 2 quarters.
5. Target completion date: 10/20/2025

A 779 , 8:36 – 7.5 (C) Resident Assessments and Care Plans

Target Completion Date: 10/20/2025

1. Resident #3 **NJ Exec Order 26.4b1** Regional Director of Resident Care and Executive Director conducted an immediate post-incident clinical and administrative review of the resident's medical record to assess lapses in communication, documentation, and emergency responses. The Licensed Practical Nurse who failed to report the **NJ Exec Order 26.4b1** of the resident received a written **NJ Exec Order 26.4b1** by the Regional Director of Resident Care on 7/14/25 with policy "Responding to Medical Emergencies" to include reporting to the Registered Nurse and primary care physician with **NJ Exec Order 26.4b1** of residents.
2. All residents in the community have the potential to be affected by this deficient practice. Changes of conditions will be reported to the Registered nurse promptly as well as reported to the Primary Care Physician. The Resident Care Director completed an audit from facility's pharmacy to identify residents on anticoagulation therapy. This audit was initiated on 9/20/2025. The Resident Care Director made care team aware of the residents currently using anticoagulation therapy verbally on 9/25/25.
3. An Audit was conducted by the Resident Care Director for residents receiving anticoagulant therapy. This audit was completed on 9/20/25 and was performed

weekly x2 weeks then monthly x1 month with a completion date of 10/20/2025. No other residents were identified as having delayed or undocumented notification of changes during the audit. Resident Care Director made care team aware of the residents currently using anticoagulation therapy verbally on 9/25/25. The Resident Care Director reviewed service plans for residents who have been identified as receiving anticoagulation therapy and ensured interventions were in place. This review was completed on 9/20/2025. As of 9/1/2025 the Executive Director provided an in-service to care managers, certified medication managers, and licensed practical nurses on community's policies for "Resident's Rights", "Responding to Medical Emergencies," "Incident and Event Reporting," and "Individualized Service Plans" which was completed as of 9/25/25. These policies address incident reporting, RN/MD notification, service plans, and recognizing changes in condition and assessments, and timely notification of changes in condition.

4. Audits of the service plans of residents receiving anticoagulation therapy was initiated by Resident Care Director on 9/20/2025 with a completion date of 10/20/25. The Plan of Correction and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for 2 quarters.

5. Target completion date: 10/20/2025

A 781 , 8:36 – 7.5 (D) Resident Assessments and Care Plans

Target Completion Date: 12/26/2025

1. Resident #3 **NJ Exec Order 26.4b1** Regional Director of Resident Care and Executive Director conducted an immediate post-incident clinical and administrative review of the resident's medical record to assess lapses in communication, documentation, and emergency responses. The Licensed Practical Nurse who failed to report the **NJ Exec Order 26.4b1** of the residents received a **NJ Exec Order 26.4b1** by the Regional Director of Resident Care on 7/14/25 with policy "Responding to Medical Emergencies" to include reporting to the Registered Nurse and Primary Care Physician with **NJ Exec Order 26.4b1** of residents.

2. All residents in the community have the potential to be affected by this deficient practice. All changes of conditions will be reported to the Primary Care Physician following a change of condition to residents.

3. No other residents were identified as having delayed or undocumented notification of condition changes. An internal audit was conducted on 9/25/25 by the Resident Care Director of all significant events from 7/18/25 - 9/25/25 to ensure Registered Nurse, Primary Care Physician, and responsible party were notified of event. Licensed Practical Nurse who failed to notify the Registered Nurse regarding the resident's change of condition has received a documented write up on 7/17/25. Regional Director of Resident Care retrained the Licensed Practical Nurse on 7/14/25 to include reporting changes of condition of a resident to the Registered Nurse and Primary Care Physician. As of 9/1/2025 the Executive Director provided re-training to care staff, including care managers, certified medication managers, and licensed practical nurses on facility's policies for "Resident's Rights", "Responding to Medical Emergencies," and "Individualized Service Plan" which was completed as of 9/25/25. For clarification, the audit was completed as of 9/25/25 and the re-training included notification of MD.
4. Resident Care Director or designee will review "Responding to Medical Emergencies" policy with Registered Nurse, Medication Care Managers, and Licensed Practical Nurses in the community monthly x3 months, which was initiated on 9/1/25 by Executive Director with a completion date of 12/26/25 and as needed, as well as reviewed quarterly at QAPI meetings for 2 quarters. The policy "Responding to Medical Emergencies" includes notification by the Licensed Practical Nurse/Team Member to the physician/healthcare practitioner, responsible party and any other state/province required documentation/notification. QAPI meeting initiated on 10/9/25 and will be reviewed for 2 quarters.
5. Target completion date: 12/26/2025

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 0L9278	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/18/2025
NAME OF FACILITY SUNRISE ASSISTED LIVING OF MARLBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 3A SOUTH MAIN STREET MARLBORO, NJ 07746

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0313	Correction	ID Prefix A0357	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-3.4(a)(4)	Completed	Reg. # 8:36-4.1(a)(2)	Completed
LSC	12/05/2025	LSC	09/25/2025	LSC	09/25/2025
ID Prefix A0735	Correction	ID Prefix A0779	Correction	ID Prefix A0781	Correction
Reg. # 8:36-7.2(e)(1-5)	Completed	Reg. # 8:36-7.5(c)	Completed	Reg. # 8:36-7.5(d)	Completed
LSC	10/20/2025	LSC	10/20/2025	LSC	12/26/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/24/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 0L9278	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/18/2025
NAME OF FACILITY SUNRISE ASSISTED LIVING OF MARLBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 3A SOUTH MAIN STREET MARLBORO, NJ 07746

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0313	Correction	ID Prefix A0357	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-3.4(a)(4)	Completed	Reg. # 8:36-4.1(a)(2)	Completed
LSC	12/05/2025	LSC	09/25/2025	LSC	09/25/2025
ID Prefix A0735	Correction	ID Prefix A0779	Correction	ID Prefix A0781	Correction
Reg. # 8:36-7.2(e)(1-5)	Completed	Reg. # 8:36-7.5(c)	Completed	Reg. # 8:36-7.5(d)	Completed
LSC	10/20/2025	LSC	10/20/2025	LSC	12/26/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/24/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		