

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0L9278</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUNRISE ASSISTED LIVING OF MARLBORO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3A SOUTH MAIN STREET MARLBORO, NJ 07746</b>
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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 #: NJ 00189448</p> <p>Date of Survey: 12/17/25</p> <p>CENSUS: 71</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.</p> <p>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) Administrator's Responsibilities</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

01/29/26

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189448</p> <p>Based on interview and record review, it was determined that the Administrator failed to ensure the implementation and enforcement of the facility policy titled, "Assistive Devices" for 1 of 3 residents, Residents #1. This deficient practice was evidenced by the following:</p> <p>On 12/17/25 at 9:45 a.m., the surveyor reviewed Resident #1's medical record (MR) which revealed that Resident #1 was admitted to the facility in [redacted], and with a diagnosis of [redacted].</p> <p>Further surveyor review of the MR revealed two (2) physician orders written for Resident #1 dated [redacted] which documented, "Wheelchair and [redacted] bed, [redacted] bed."</p> <p>At 10:05 a.m., the surveyor reviewed Resident #1's service plan (SP) written by the Director of Wellness (DOW) dated [redacted]. The surveyor observed that the SP was not updated to reflect the resident's use of a wheelchair and [redacted] bed until [redacted] after the resident's [redacted] on [redacted].</p> <p>At 12:59 p.m., the surveyor interviewed the DOW and inquired about Resident #1's SP not updated</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>until after the [redacted] on [redacted] The DOW confirmed that the SP was updated or [redacted] after Resident #1's [redacted] on [redacted] while the resident was in the [redacted]</p> <p>The surveyor reviewed the facility policy with a revision date of 7/17/25, titled, "Assistive Devices" which indicated, " ... 4. If it is determined that the use of an assistive devices is appropriate and ... the Resident Care Director (RCD) shall: ... d. The RCD/Licensed Nurse obtains the physician order which will include [must specify] the type of device used, reason for the device (for example bed mobility, repositioning, transfer assist, etc.), and documents the consultation in the progress notes and updates the resident service plan ..."</p>	A 310		
A 753	<p>8:36-7.3(c) General and Health Service Plans</p> <p>(c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189448</p> <p>Based on interview and record review, it was determined that the facility failed to develop and/or update a resident's Service Plan (SP) for 1 of 3 residents, Resident #1. This deficient</p>	A 753		

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A 753	<p>Continued From page 3</p> <p>practice was evidenced by the following.</p> <p>The Department of Health (DOH) received a Facility Reportable Event (FRE), (a form used by facilities to report events to the DOH) on [redacted] regarding Resident #1's [redacted] that occurred on [redacted]. According to the FRE, Resident #1 had an [redacted] which resulted in a [redacted].</p> <p>On 12/17/25 at 9:45 a.m., the surveyor reviewed Resident #1's medical record (MR) which revealed that Resident #1 was admitted to the facility in [redacted] and with a diagnosis of [redacted].</p> <p>Further surveyor review of the MR revealed two (2) physician orders written by the physician on [redacted] which documented, "Wheelchair and [redacted] bed [redacted] bed." And another physician order dated [redacted] which documented, "[redacted] and maintain [redacted]."</p> <p>At 10:05 a.m., the surveyor reviewed Resident #1's service plan (SP) provided by the Director of Wellness (DOW) dated [redacted]. Surveyor review of the SP did not reveal documented evidence that the SP was updated prior to Resident #1's [redacted] on [redacted] to reflect the use of a wheelchair, [redacted] bed and [redacted].</p> <p>At 12:59 p.m., the surveyor interviewed the DOW and inquired about Resident #1's SP not updated until after the [redacted] on [redacted] to reflect the use of a wheelchair, [redacted] bed and [redacted]. During the interview, the DOW confirmed that the SP was updated on [redacted] after Resident #1's [redacted] on [redacted] while the resident was in the hospital.</p>	A 753		

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A 753	Continued From page 4  The surveyor reviewed a facility policy with a revision date of 5/15/25, titled, "Individualized Service Plan" which indicated, " ... 3. ISP is reviewed and updated: ... Additional revisions shall be made with changes in needs ..."	A 753		

POC # 1 Received 1/29/26.  
Acceptable POC letter  
sent 2/2/26



**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):** 12/17/2025

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

**Representative Signing the Plan of Corrections:** NJ Exec Order 26.4b1

**Signature of Sunrise Representative:**

**Date of  
Submission:**

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

Acceptable  
2/2/26

NJ Exec Order 26.4b1

**Target Completion Date:**

1.) Resident #1 experienced a [redacted] on [redacted] NJ Exec Order 26.4b1 and was transported to the hospital the same day for evaluation. Resident #1 was diagnosed with a [redacted] NJ Exec Order 26.4b1. Resident #1 did not return to the community following the hospitalization and was discharged from the community on [redacted] NJ Exec Order 26.4b1.

2.) All residents in the community who utilize assistive devices have the potential to be affected by this deficient practice. On 12/18/2025, the Resident Care Director completed an audit to verify that residents using assistive devices are accurately identified and that their service plans reflect the use of these devices.

3.) On 1/22/2026, the Regional Director of Operations reviewed the policies titled "Assistive Devices," "Individualized Service Plans," and "Resident's Rights" with the Executive Director. On 1/22/2026, the Executive Director reviewed these policies with the Resident Care Director to ensure understanding and proper implementation.

**CONFIDENTIAL**

4.) The Resident Care Director will complete a monthly audit x2 months of residents who are using assistive devices to ensure service plan updates are accurate. The first audit will be completed on 1/27/2026. This Plan of Correction to ensure compliance of "Assistive Devices" policy 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 will be initiated on 1/30/2026 and will be reviewed for 2 quarters.

**5.) Target Completion Date: 1/30/2026**

**A753 8:36-7.3(c)(16) General and Health Service Plans**

NJ Exec Order 26.4b Accepted  
2/2/26

**Target Completion Date: 01/21/2026**

1. Resident #1 experienced a NJ Exec on NJ Exec Order 26.4b1 and was transported to the hospital the same day for evaluation. Resident #1 was diagnosed with a NJ Exec Order 26.4b1. Resident #1 did not return to the community following the hospitalization and was discharged from the community on NJ Exec Order 26.4b1.
2. All residents in the community who utilize assistive devices have the potential to be affected by this deficient practice. On 12/18/2025, the Resident Care Director completed an audit to verify that residents using assistive devices are accurately identified and that their service plans reflect the use of these devices.
3. On 1/28/2026, the Resident Care Director will initiate re-training for care managers, Licensed Practical Nurses, Registered Nurses and Medication Care Managers on "Assistive Devices" and "Individualized Service Plans" policies with competition date of 1/30/2026.
4. The Resident Care Director will complete a monthly audit x2 months of residents who are using assistive devices to ensure service plan updates are accurate. The first audit will be completed on 1/27/2026. This Plan of Correction to ensure compliance of "Assistive Devices" policy 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 will be initiated on 1/30/2026 and will be reviewed for 2 quarters.

**5. Target Completion Date: 01/30/2026**

CONFIDENTIAL

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 0L9278	MULTIPLE CONSTRUCTION A. Building _____ B. Wing _____	DATE OF REVISIT 2/2/2026
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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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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 A0753	Correction	ID Prefix _____	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-7.3(c)	Completed	Reg. # _____	Completed
LSC _____	01/30/2026	LSC _____	01/30/2026	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 _____	_____
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 12/17/2025		<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 2/2/2026
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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 A0753	Correction	ID Prefix	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-7.3(c)	Completed	Reg. #	Completed
LSC	01/30/2026	LSC	01/30/2026	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	
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
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 12/17/2025	<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
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