STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE EDISON, NJ 08817**

(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
F 000	INITIAL COMMENTS	F 000		

Complaint #: NJ167098, 170018, 170644, 173721, 175243, 182121, 183380, 183805, 183871, 183873, 184237

Survey Date: 5/12/25

Census: 225

Sample: 35 + 3 closed records

A Recertification Survey was conducted at Embassy Manor at Edison Nursing and Rehabilitation from 4/29/25 to 5/12/25, to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.

During the survey, findings which constituted Immediate Jeopardy (IJ) were identified under 42 CFR 483.12(a)(1) F 600, F 609, and F 610, as the facility failed to ensure residents were free from NJ Ex Order 26.4(b)(1); all NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 including NJ Ex Order 26.4(b)(1) were reported to the New Jersey Department of Health (NJDOH); and all NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 including NJ Ex Order 26.4(b)(1) were thoroughly investigated.

Resident #381, a NJ Ex Order 26.4(b)(1) resident who had diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), reported to the Registered Nurse (RN #1) an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1). RN #1 documented in a progress note that the resident reported they were NJ Ex Order 26.4(b)1 of staff and the facility, and RN #1 endorsed it to the

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

Electronically Signed | 05/29/2025

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 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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F 000	Continued From page 1 Registered Nurse Supervisor (RNS #1) to follow-up. The NJ Ex Order 26.4(b)(1) was not investigated, the identified perpetrator was not suspended pending a thorough investigation, and it was not reported to the NJDOH per the facility's abuse policies. The Administration was informed of the F 600, F 609, and F 610 IJs, and was provided the IJ templates on 5/6/25 at 3:45 PM. Acceptable Removal Plans were received on 5/7/25 at 3:08 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the Certified Nursing Assistant (CNA #1) was immediately suspended, CNA #2 was terminated and last day of work was NJ Ex Order 26, and RNS #1 was educated on the abuse policy that included the seven components; screening, training, prevention, identification, investigation, protection and reporting. All NJ Ex Order 26.4(b)(1) residents or representatives were interviewed to verify that there were no allegations of abuse that were not investigated or reported. The abuse policy was reviewed by the U.S. FOIA (b) (6), U.S. FOIA (b) (6), Interdisciplinary team, Unit Managers, U.S. FOIA (b) (6), Social Workers, Activities, and the U.S. FOIA (b) (6) with no revisions made. All employees at the facility were educated on the abuse policy by the U.S. FOIA (b) U.S. FOIA (b) (6) Interdisciplinary team, Unit Managers, U.S. FOIA (b) (6) Social Workers, Activities, and U.S. FOIA (b) (6 The survey team verified the implementation of the Removal Plans on-site during the continuation of the survey, and determined the IJs for F 600, F	F 000		

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F 000	Continued From page 2 609, and F 610 were removed as of 5/7/25. The findings also constituted an IJ identified under 42 CFR 483.70 F 835 as the facility's Administrator failed to ensure policies and procedures were implemented for [NJ Ex Order 26.4] protecting all residents from [NJ Ex Order 26.4] investigating all [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4] and reporting all [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4] to the NJDOH. The Administration was notified of the F 835 IJ, and was provided the IJ template on 5/6/25 at 3:45 PM. An acceptable Removal Plan was received on 5/7/25 at 3:08 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the Regional Administrator educated the [U.S. FOIA (b)(6)] regarding role and responsibilities of the administrator and on the facility's abuse policy which included screening, training, prevention, identification, investigation, protection, reporting and response. The survey team verified the implementation of the Removal Plan on-site during the continuation of the survey, and determined the IJ for F 835 was removed as of 5/7/25.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		6/6/25

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F 550	Continued From page 3 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed a.) to treat each resident with respect and dignity and	F 550	Resident #206 did not have any [NJ Ex Order 26 4(b)] [redacted] The Certified Nursing Assistants were disciplined on 05/06/2025 due to the	

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F 550	Continued From page 4 b.) care for each resident in a manner and in an environment that promoted maintenance or enhancement of quality of life recognizing each resident's individuality. This deficient practice was identified for 1 of 35 residents reviewed for dignity (Resident #206), and was evidenced by the following: On 4/29/25 at 11:09 AM, during initial tour of the facility, the surveyor observed a Certified Nurse Aide (CNA #1) walking alongside Resident #206 in the hallway towards the [redacted] room. CNA #1 and Resident #206 entered the [redacted] room, and the door closed. The surveyor then heard Resident #206 [redacted] inside the [redacted] room. At that time, CNA #1 opened the door and asked for the facility's [redacted] to assist with [redacted] the resident's needs. The [redacted] entered the [redacted] room, and the surveyor observed the resident, who was still fully dressed, speaking with the [redacted] who then informed CNA #1 that the resident did not want to be [redacted] by him. At that time, CNA #2, who was a few doors down the hallway, came out of a resident's room and was [redacted] approaching CNA #1. CNA #2 stated, [redacted], "I told you [the resident] wasn't going to [redacted] At that time, CNA #1, CNA #2, and Resident #206 left the vicinity of the [redacted] room and escorted the resident back to their room. CNA #1 and CNA #2 then came out into the hallway, away from the resident's room, stood by the nurse's station and CNA #2 stated to CNA #1, "I told you" (the resident) "only [redacted] " That was when CNA #1 began to [redacted] the resident's [redacted] as the resident did in the [redacted] room, both CNA #1 and CNA #2 laughed and walked away from the nurse's station and continued with other duties.	F 550	behavior reported and educated about resident rights. All other residents under the care of these two Certified Nursing Assistants have the potential to be affected. Education on Resident Rights, Customer Service, and Professionalism in the workplace was given to staff members by Human Resources Director or Designee. Director of Quality Experience/designee will interview 20 random residents once a week for 4 weeks and then once per month for 2 months. Director of Quality Experience/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING / designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 550	Continued From page 5 On 4/29/25 at 11:13 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated Resident #206 refused NJ Ex Order 26.4(b) and only wanted their NJ Ex Order 26.4(b)(1) to provide NJ Ex Order 26.4(b) to them. On 4/29/25 at 11:15 AM, the surveyor interviewed CNA #2, who stated that she usually was assigned to care for Resident #206, but today she was not. On 5/6/25 at 1:39 PM, the surveyor interviewed CNA #2, who stated that she was provided training and education by the facility upon hire regarding resident rights, dignity, and respect. CNA #2 stated Resident #206 was NJ Ex Order 26.4(b)(1) at times, but was consistent with wanting only family to provide their NJ Ex Order 26.4(b CNA #2 stated that she informed CNA #1 that Resident #206 would refuse to be NJ Ex Order 26.4(b)(1) but CNA #1 NJ Ex Or that he could give Resident #206 NJ Ex Order 26.4(b)(1) . CNA #2 acknowledged that CNA #1 and CNA #2 laughed and stated it was because CNA #1 NJ Ex Order 26.4(b)(1) " and the resident refused to NJ Ex Order 26.4(b On 5/6/25 at 1:51 PM, the surveyor interviewed the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), who both acknowledged that all residents were to be treated with respect and dignity and for all staff to always respect their preferences. The surveyor informed them of the observation made of CNA #1 and CNA #2 with Resident #206, and both the U.S. FOIA (b and U.S. FOIA (b) (6) stated that was "absolutely not acceptable behavior and should not be tolerated." A review of the facility's "Dignity" policy with effective date of 2/1/24, included but was not	F 550		

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F 550	Continued From page 6 limited to: a facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality...	F 550		
F 578 SS=D	NJAC 8:39-4.1(a)(12) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		6/6/25

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F 578	Continued From page 7 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to obtain a physician's order to carry out a resident's wishes for NJ Ex Order 26.4(b)(1). This deficient practice was identified for 2 of 38 residents reviewed for NJ Ex Order 26.4(b)(1) and advanced directives (Residents #167 and #230), and was evidenced by the following: 1. On 4/29/25 at 12:34 PM, the surveyor reviewed Resident #167's electronic medical record (EMR). A review of the Admission Record face sheet (an admission summary) indicated that the resident was re-admitted to the facility with diagnosis which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1) [redacted]), and NJ Ex Order 26.4(b)(1) [redacted] A review of the New Jersey Practitioner NJ Ex Order 26.4 [redacted]) indicated the resident's wishes were to be NJ Ex Order 26.4(b)(1) [redacted]) and "NJ Ex Order 26.4(b)(1) [redacted]" and "NJ Ex Order 26.4(b)(1)) in the event	F 578	Resident #167 and #230 did not have NJ Ex Or [redacted] All other residents have the potential to be affected by this practice. An audit was completed on all NJ Ex Order 26.4(b)(1) orders and documentation. NJ Ex Order 26.4(b)(1) orders were updated on 05/01/2025 for this resident. Director of Nursing, Director of Social Services or Designee educated the nurses on Advance Directives orders and documentation. A weekly audit of Advance Directives to ensure that the orders and documentation is accurate will be conducted by DIRECTOR OF NURSING/designee. Director of Nursing/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING/designee will provide a report	

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F 578	Continued From page 8 the resident had [NJ Ex Order 26.4(b)(] and/or was [NJ Ex C] [redacted], which was signed and dated [NJ Ex Order 26.4(b)(] [redacted]. A review of the Physician Order Summary did not include a physician's order for the resident's code status to honor the resident's wish to be [NJ Ex Order] and [NJ Ex Orde] On 5/1/25 at 11:07 AM, the surveyor interviewed the Certified Nursing Aide (CNA #1), who stated she was not aware of Resident #167'2 [NJ Ex Order] [redacted] and that she would have to ask the nurse. On 5/1/25 at 11:20 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] [redacted]), who stated a physician's order was required in the resident's medical record to indicate the [NJ Ex Order 26.4(b)(1)] of the resident so that the nursing staff knew what to do to honor the wishes of the resident in the event of an emergency. On 5/1/25 at 11:44 AM, the [U.S. FOIA] [redacted] approached the surveyor, and stated that Resident #167's [NJ Ex Order 26.4(b)(1)] order was not in place previously, and she had since added it to the medical record after surveyor inquiry. The [U.S. FOIA] [redacted] stated whoever took the order did not enter it into the resident's EMR. On 5/1/25 at 11:47 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] [redacted]), who stated that when the [NJ Ex Order 26.4(] [redacted] form was completed with the resident's wishes for [NJ Ex Order] [redacted] and signed by the physician, the [NJ Ex Order] [redacted] should have been entered into the resident's EMR as a physician's order to be carried out. The [U.S. FOIA (b) (6)] [redacted] confirmed that there had not been an order for the resident's [NJ Ex Order 26.4(b)(1)] [redacted].	F 578	of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 578	Continued From page 9	F 578		

On 5/5/25 at 9:03 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that when the NJ Ex Order 26.4(form was completed for a resident, then a physician's order "should absolutely" be put in place and entered into the resident's EMR for NJ Ex Order 26.4(b)(1) identification.

2. The surveyor reviewed the closed medical record for Resident #230.

A review of the Admission Record face sheet indicated that Resident #230 was admitted to the facility with diagnosis which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(and was discharged due to NJ Ex Order 2 on NJ Ex Order 26.4

A review of the NJ Ex Order 26.4(which was completed and signed dated NJ Ex Order 26.4(, indicated that Resident #230's NJ Ex Order 26.4(b)(1) wishes were to be a NJ Ex Order 2 NJ Ex Orde and no NJ Ex Order 26.4(b)(1).

A review of the Physician Order Summary did not include a physician's order for NJ Ex Order 26.4(b)(1) to honor the resident's wish to be NJ Ex Order 2 NJ Ex Orde and no NJ Ex Order 26.4(b)(1).

A review of the Progress Notes included a Health Note dated NJ Ex Order 26 at 4:56 PM, that while doing rounds, CNA #2 reported to this writer that the resident was NJ Ex Order 26.4(b)(1). The writer attended to the room and found the resident NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The writer attempted to take vital signs, but was unable to obtain. The resident's NJ Ex Order 26.4(b)(1) was obtained, and the resident's NJ Ex Order 26 was NJ Ex Order and NJ Ex Orde The U.S. FOIA (b) (6)

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F 578	Continued From page 10 U.S. FOIA (b) (6) was called to the unit, and they NJ Ex Order 26.4b1 the resident at 4:05 PM. On 5/1/25 at 11:20 AM, the surveyor interviewed the U.S. FOIA (b who stated a physician's order was required in the resident's medical record to indicate the NJ Ex Order 26.4(b)(1) of the resident so that the nursing staff knew what to do to honor the wishes of the resident in the event of an emergency. On 5/1/25 at 11:47 AM, the surveyor interviewed the NJ Ex Order 26.4(b, who stated that when the NJ Ex Order 26.4(form was completed with the resident's wishes for NJ Ex Order 26.4(b)(1) and signed by the physician, the NJ Ex Order should have been entered into the resident's EMR as a physician's order to be carried out. On 5/5/25 at 9:03 AM, the surveyor interviewed the U.S. FOIA (b) who stated that when the NJ Ex Order 26.4(form was completed for a resident, then a physician's order "should absolutely" be put in place and entered into the resident's EMR for NJ Ex Order 26.4(b)(1) identification. A review of the facility's undated "Advance Directives" policy included but was not limited to: the director of nursing services or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care... NJAC 8:39-4.1(a)	F 578		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		6/6/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	10 BRUNSWICK AVENUE EDISON, NJ 08817

(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
F 600	Continued From page 11 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint # NJ182121 Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to implement their NJ Ex Order 26 policy to ensure residents were protected from NJ Ex Order 26.4(b)(1) after a NJ Ex Order 26.4(b)(1) resident (Resident #381) made an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 1 residents reviewed for NJ Ex Order 26 (Resident #381). A review of the Progress Note (PN) dated 12/28/24 at 9:16 AM, revealed that Resident #381, a NJ Ex Order 26.4(b)(1) resident, reported to the Registered Nurse (RN #1) that they were "NJ Ex Order 26.4 of staff and the facility due to an incident that had occurred NJ Ex Order 26.4(b)(1 prior NJ Ex Order 26.4(b)(1)). The resident reported that a Certified Nursing Assistant (CNA #1) NJ Ex Order 26.4(b)(1) the resident causing the resident's NJ Ex Order 26.4(b)(1) to have NJ Ex Order 26.4(b) RN #1 documented that Resident #381 had a NJ Ex Order 26.4(b)(1)	F 600	Resident #381 did not experience any NJ Ex Order 26.4(b)(1) and specifically stated to the US FOIA (b)(6) that NJ Ex Or did not feel NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(following the incident. NJ Ex Or chose to remain at the facility until NJ Ex Order 26.4(b)(1), before being discharged to NJ Ex Order 26.4(b)(1). All residents who report an allegation of abuse had the potential to be affected. All resident/ representatives were re-educated by the interdisciplinary team on abuse policy and to report immediately to staff any allegations immediately to the staff in person or via the feedback line. Abuse Policy and procedure were reviewed and all employees at the facility were educated on the policy that include the seven components, Screening, Training, prevention, identification, investigation, protection and reporting and response.	

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F 600	Continued From page 12 undetermined) around the area and that she administered the prescribed [NJ Ex Order] medication. RN #1 made the Registered Nurse Supervisor (RNS #1) aware of the resident's complaints and endorsed the resident's care and further follow-up of the [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4(b)(1)] to RNS #1, because RN #1 was being [NJ Ex Order 26.4(b)(1)]. An interview on 5/1/25, with RN #1, confirmed the [NJ Ex Order 26.4(b)(1)] was made, and she reported it to RNS #1. Interviews on 5/1/25, with RNS #1 and the [U.S. FOIA (b) (6)]), revealed that they both denied having knowledge of the [NJ Ex Order 26.4(b)(1)] and the [NJ Ex Order 26.4(b)(1)] was never investigated. The facility's failure to implement their [NJ Ex Order 26] policy including investigating all [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26] and protecting all resident from [NJ Ex Order 26] during an investigation, placed all residents at risk for [NJ Ex Order 26.4] This posed the likelihood of serious [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4(b)(1)], or [NJ Ex Order 26.4(b)(1)] which resulted in an Immediate Jeopardy (IJ) situation. The IJ began 12/28/24 at 9:16 AM, after Resident #381 made the [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4(b)(1)] to RN #1. The facility was notified of the IJ on 5/6/25 at 3:45 PM. The facility submitted an acceptable Removal Plan (RP) on 5/7/25 at 3:08 PM. The survey team verified the implementation of the RP on-site during the continuation of the survey on 5/7/25 at 3:40 PM. The evidence was as follows: Refer F 609, F 610 A review of the facility's "Abuse" policy dated	F 600	The Director of Nursing or designee will conduct weekly audits involving a random selection of 20 staff and residents weekly for 4 weeks and then monthly for 2 months to ensure compliance with the abuse policy. Director of Nursing/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING/designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 600	Continued From page 13 4/9/24, included that abuse and neglect exist in many forms and to varying degrees. Abuse includes verbal, sexual, physical, mental, involuntary seclusion, exploitation, misappropriation, mistreatment, neglect, intimidation and injury of unknown origin. The objective of the abuse policy is to comply with a seven-step approach to abuse and neglect detection and prevention...The seven steps include: 1.) Screening and verification of references, certification and verification of license and a criminal background check. 2.) Training of staff through orientation and on-going abuse and prohibition practices. 3.) Prevention: the facility is to prevent abuse by providing residents, family and staff with education on how and to whom to report concerns, incidences and grievances. 4.) Identification: All staff were to monitor residents and would know how to identify potential signs and symptoms of abuse. Occurrences, patterns and trends that may constitute abuse would be investigated. 5.) Investigation is the process used to try to determine what happened and the designated personnel would begin the investigation immediately and a root cause analysis would be completed. When an incident or suspected incident of abuse is reported, the Administrator or designee would investigate the incident with the assistance of appropriate personal to include who was involved, resident statement, roommate statements, involved staff and witness statements, a description of the residents behavior and environment at the time of the incident, any injuries and a resident assessment, and interview other residents who were cared for by the accused. All staff must cooperate during the investigation to assure the resident is fully protected. 6.) Protection procedure would include immediately upon	F 600		

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receiving a report of alleged abuse, the Administrator or designee would deliver appropriate medical and psychological care and attention, ensuring safety and wellbeing of vulnerable individuals. The alleged perpetrator would be immediately removed, and the resident would be protected. 7.) Reporting: the facility would ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin would be reported immediately to Administrator and state agencies to include the New Jersey Department of Health [NJDOH] and Ombudsman.

The surveyor reviewed the closed medical record for Resident #381.

A review of the Admission Record face sheet (admission summary), reflected that Resident #381 was admitted to the facility with diagnoses that included but were not limited to; [redacted] and [redacted] (NJ Ex Order 26.4(b)(1) [redacted]).

A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating the resident was NJ Ex Order 26.4(b)(1). A further review of the MDS, revealed the resident required NJ Ex Order 26.4(b)(1) with activities of daily living and [redacted]

A review of the individual comprehensive care plan (ICCP) included a focus of area dated [redacted], for alteration in [redacted] due to [redacted] evidenced by [redacted] due to status [redacted]

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NJ Ex Order 26.4(b)(1)). Interventions included; to adjust NJ Ex Ord medication administration time to coincide with treatments, rehabilitation, and/or care, to administer NJ Ex Order 26.4(b)(1)) medication as ordered, and to maintain in the most NJ Ex Order 26.4(b)(1) which is per my request.

A review of a Progress Note (PN) dated NJ Ex Order 26.4b1 at 9:16 AM, revealed that Resident #381 was awake, NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 make their needs known. Resident #381 reported to RN #1 that they were NJ Ex Order 26.4b1 of staff and the facility due to an incident that had occurred two days prior (NJ Ex Order 26.4b1). The resident reported that a CNA (CNA #1) NJ Ex Order 26.4(b)(1) the resident causing the resident's already NJ Ex Order 26.4(b)(1) to have NJ Ex Order 26.4(b)(1) . RN #1 documented that Resident #381 had NJ Ex Order 26.4(b)(1) with NJ Ex Order 26 and that she administered the resident's prescribed NJ Ex Ord medication. The resident reported NJ Ex Order 26.4(b)(1) from the NJ Ex Ord medication. RN #1 made RNS #1 aware of the resident's complaints and endorsed the resident's care and further follow-up to RNS #1 because RN #1 was being NJ Ex Order 26.4(b)(1) .

A review of the NJ Ex Order 26.4(b)(1) , Medication Administration Record (MAR) between the dates the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) took place (NJ Ex Order 26.4(b)(through NJ Ex Order 26.4(b)( ) included a physician's order dated NJ Ex Order 26.4(b)(, for NJ Ex Order 26.4(b)(1)); give one tablet by mouth every six hours as needed for NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) . Resident #381 received NJ Ex Order 26.4(b)(1) on the following dates and times: NJ Ex Order 26.4(b)(1) at 8:00 PM, NJ Ex Order 26.4(b)(at 4:58 AM, NJ Ex Order 26.4(b)(1) at 8:04 PM, NJ Ex Order 26.4(b)(1) at 6:23 AM, NJ Ex Order 26.4(b)(at 8:23 AM, NJ Ex Order 26.4(b)(at 2:53 PM, and

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F 600	Continued From page 16 NJ Ex Order 26.4(b)(at 9:05 PM. On 5/1/25 at 9:16 AM, the surveyor conducted a telephone interview with RN #1, who had documented the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) for Resident #381 on NJ Ex Order 26.4(b)(at 9:16 AM. RN #1 identified herself as an NJ Ex Order 26.4b1, and stated that on NJ Ex Order 26.4(b)(, Resident #381 reported that they were NJ Ex Order 26.4(b)(1) by a CNA a couple days ago, during the 3:00 PM to 11:00 PM (3-11) shift around 9:00 PM. RN #1 stated that the resident requested to have their NJ Ex Order 26.4(b)(1) , and the CNA, without introducing herself and without explaining what she was going to do, NJ Ex Order 26. the resident NJ Ex Order 26.4(b)(1) that the resident NJ Ex Order 26.4(b)(1) . RN #1 stated that the resident used the word " NJ Ex Order 26.4(b)(1) when describing how it happened. RN #1 stated that the resident had complained of NJ Ex Order 26.4(b)(1) in the NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1) . RN #1 explained that she had administered the resident an as needed [prn] NJ Ex Ord medication at that time. RN #1 stated that she was going to call the physician to notify and to get NJ Ex Order 26.4(b)(1), however she was told by RNS #1 that she was being sent home. RN #1 stated that she had reported the NJ Ex Order 26.4(b)(1) of NJ Ex Order 2 to RNS #1, and RNS #1 told RN #1 that she would follow-up with the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4 RN #1 stated that Resident #381 provided her with the name of the NJ Ex Order 26.4(CNA (CNA #1), as well as the first names of the staff members the resident had notified about the NJ Ex Order 26.4(b)(1) RN #1 identified the staff as the U.S. FOIA (b and the U.S. FOIA (b) (6)) who still worked at the facility. On 5/1/25 at 9:51 AM, the surveyor interviewed the U.S. FOI who stated that he worked in Central	F 600		

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F 600	Continued From page 17 Supply in NJ Ex Order 26.4b1, and did not remember any resident reporting an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 to him. The NJ Ex O stated that he would have taken the allegation very seriously and would have reported it to the administration because it would have required a full investigation. The U.S. FO identified the alleged CNA reported to RN #1 by Resident #381 as CNA #1. On 5/1/25 at 9:59 AM, the surveyor conducted a telephone interview with RNS #1, who confirmed that she had worked the weekend of NJ Ex Order 26.4(b)(1) when the resident reported an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4 RNS #1 stated that she did not remember the event occurring or being told about the resident's complaints of NJ Ex Order 26.4(b)(1). RNS #1 stated that if the NJ Ex Order 26.4(b)(1) was reported to her, then she would have reported it to the administration and an investigation would have started. RNS #1 then instructed the surveyor to ask the U.S. FOIA (b for more information. On 5/1/25 at 10:50 AM, the surveyor interviewed CNA #1, who stated she might have worked the 3-11 shift on NJ Ex Order 26.4(b)(1, but did not remember any resident complaining about a CNA NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b) with Resident #381. On 5/1/25 at 11:01 AM, the surveyor interviewed the U.S. FOIA (b) who stated that she was in constant communication with Resident #381 when the resident was in the facility and did not remember the resident or any nurse informing her that a CNA was NJ Ex Order 26.4(b)(1) with Resident #381. At that time, the U.S. FOIA (b reviewed the PN dated NJ Ex Order 26.4(b)(1 at 9:16 AM, and confirmed that an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) was documented and it should have been reported to the administration and have been immediately investigated. The U.S. FOIA (b	F 600		

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stated that if it was reported to her at the time the event occurred, she would have interviewed the nurse and the resident, and removed the CNA from all resident care until an investigation was thoroughly completed. The [redacted] stated that the physician and family would have been notified and that the resident's [redacted] would have been monitored to assure that their [redacted] was being managed. The [redacted] also explained that she would have in-serviced all staff on repositioning and the handling of residents as well as [redacted] training. The [redacted] stated that if she had known, she would have reported the [redacted] to the New Jersey Department of Health (NJDOH).

On 5/1/25 at 11:09 AM, the surveyor interviewed the [redacted] in the presence of the [redacted] who explained that prior to completing any comprehensive admission assessment, she reviewed the resident's progress notes, interviewed the resident and staff, and looked at any documentation that was pertinent to the MDS assessment. The [redacted] stated that it would be important to review progress notes and extract pertinent information to develop a comprehensive assessment of the resident, and she reviewed the nursing progress notes going back seven days from the assessment reference date (ARD). The [redacted] explained that if Resident #381's MDS assessment's ARD was [redacted], she would have reviewed the progress notes from [redacted] until [redacted]. The [redacted] stated that she remembered reading the documentation regarding the resident's [redacted] of [redacted] and remembered that it was discussed at clinical morning meeting, however she did not remember who was there, but remembered there was enough management there to know that it needed

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F 600	Continued From page 19 to be followed-up with. On 5/5/25 at 11:38 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the nurse that cared for Resident #381 on NJ Ex Order 26.4(b)(1), did not report any incident related to NJ Ex Order 26.4(b)(1) to the administration. The U.S. FOIA (b) (6) stated that he reviewed the documentation minutes of the clinical morning meeting dated NJ Ex Order 26.4(b)(1), and there were no minutes pertaining to any resident NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated that the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) should have been reported by the U.S. FOIA (b) (6) who read the PN dated NJ Ex Order 26.4(b)(1), regarding the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) during Resident #381's admission assessment with the ARD of NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated the nurse should have reported it to the U.S. FOIA (b) (6) immediately. The U.S. FOIA (b) (6) continued to explain that the NJ Ex Order 26.4(b)(1) came into see Resident #381 on NJ Ex Order 26.4(b)(1), and the resident did not report NJ Ex Order 26.4(b)(1) and did not express any NJ Ex Order 26.4(b)(1) concerning their stay at the facility. The U.S. FOIA (b) (6) stated that he immediately started an investigation when he became aware of the NJ Ex Order 26.4(b)(1) and reported the incident to the NJDOH on 5/1/25 at 11:16 AM. On 5/6/25 at 11:20 AM, the surveyor interviewed the NJ Ex Order 26.4(b)(1) who reviewed the PN dated NJ Ex Order 26.4(b)(1), after surveyor inquiry. The NJ Ex Order 26.4(b)(1) stated that the RN/MDSC who read the note during the resident's assessment period, should have reported the NJ Ex Order 26.4(b)(1) to administration after reading the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) in the progress notes. The NJ Ex Order 26.4(b)(1) stated that based on the timesheets, CNA #2 worked the 3-11 shift on NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and cared for the resident. The NJ Ex Order 26.4(b)(1) reported that CNA #2 had not worked at the facility since NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1)	F 600		

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EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE EDISON, NJ 08817**

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F 600	Continued From page 20 At that time, the surveyor informed the U.S. FOIA (b that RN #1 identified the NJ Ex Order 26.4(CNA as CNA #1, and the U.S. FOIA (b was unsure of who that CNA was. A review of CNA #1's "Timecard Report" revealed that CNA #1 was working in the facility at the time of the NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1 during the 3-11 shift). On 5/7/25 at 11:17 AM, the surveyor interviewed the U.S. FOIA (b) (6 who stated that CNA #1 was suspended on NJ Ex Order 26 , pending outcome of the completed investigation and he had attempted to call RN #1, but received no answer. The U.S. FOIA (b) (alleged that he interviewed Resident #381 via telephone (no longer a resident in the facility) and the resident did not state that they were NJ Ex Order 26.4(during stay and NJ Ex Order 26.4(b) when they resided in the facility. The facility submitted an acceptable Removal Plan (RP) on 5/7/25 at 3:08 PM, indicating that the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include; CNA #1 was immediately suspended, CNA #2 was terminated and last day of work was NJ Ex Order 26.4 and RNS #1 was educated on the abuse policy that included the seven components; screening, training, prevention, identification, investigation, protection, reporting and response. All cognitively intact residents or representatives were interviewed to verify that there were no NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 that were not investigated or reported. The NJ Ex Order 26 policy was reviewed by the U.S. FOIA (b) U.S. FOIA (b) (6), Interdisciplinary team, Unit Managers, NJ Ex Order 26.4(b)(1), Social Workers, Activities, and U.S. FOIA (b) (with no revisions made. All employees at the facility were educated	F 600		

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	315279	A. BUILDING _____ B. WING _____	C 05/12/2025

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F 600	Continued From page 21 on the abuse policy by the [U.S. FOIA (b)] [NJ Ex Order 26.4(b)] [redacted] team, Unit Managers, NJ Ex Order 26.4(b)(1), Social Workers, Activities, and [NJ Ex Order 26.4(b)] The survey team verified the implementation of the RP on-site during the continuation of the survey on 5/7/25 at 3:40 PM.	F 600		
F 609 SS=J	NJAC 8:39-4.1(a)(5) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		6/6/25

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F 609	Continued From page 22 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ182121 Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to report within two hours to the New Jersey Department of Health (NJDOH) an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) for a NJ Ex Order 26.4(b)(1) resident (Resident #381) who reported being "NJ Ex Order 26.4(b)(1)" by a Certified Nursing Assistant (CNA #1). This deficient practice was identified for 1 of 1 residents reviewed for NJ Ex Order 26 (Resident #381). A review of the Progress Note (PN) dated NJ Ex Order 26.4(b)(at 9:16 AM, revealed that Resident #381, a NJ Ex Order 26.4(b)(1) resident, reported to the Registered Nurse (RN #1) that they were NJ Ex Order 26.4 " of staff and the facility due to an incident that had occurred NJ Ex Order 26.4(b)(prior (NJ Ex Order 26.4(b)(1). The resident reported that a Certified Nursing Assistant (CNA #1) NJ Ex Order 26.4(b)(1) the resident causing the resident's NJ Ex Order 26.4(b)(1) to have NJ Ex Order 26.4(. RN #1 documented that Resident #381 had a NJ Ex Order 26.4(b)(1)) around the NJ Ex Orde and that she administered the prescribed NJ Ex Ord medication. RN #1 made the Registered Nurse Supervisor (RNS #1) aware of the resident's NJ Ex Order 26.4(b)(1) and endorsed the resident's care and further follow-up of the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) to RNS #1, because RN #1 was being sent home early. An interview on 5/1/25, with RN #1, confirmed the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 was made, and she reported	F 609	Resident #381 did not experience NJ Ex Or and specifically stated to the NJ Ex Order 26.4(b)(1) that NJ Ex Or did not feel NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(following the incident. NJ Ex Ord chose to remain at the facility until NJ Ex Order 26.4(b)(1), before being discharged to NJ Ex Order 26.4(b)(1). All residents who report an allegation of abuse had the potential to be affected. All resident/ representatives were reeducated by the interdisciplinary team on abuse policy and to report immediately to staff any allegations immediately to the staff in person or via the feedback line. Abuse Policy and procedure were reviewed and all employees were educated on the policy that include the seven components, Screening, Training, prevention, identification, investigation, protection and reporting and response. The Director of Nursing (DIRECTOR OF NURSING) or designee will conduct weekly audits involving a random selection of 20 staff and residents weekly for 4 weeks and then monthly for 2 months to verify that all reportable incidents are properly identified and reported in accordance with facility policy and regulatory requirements. Director of Nursing/designee will coordinate the results of the weekly audit and review the	

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F 609	Continued From page 23 it to RNS #1. Interviews on 5/1/25, with RNS #1 and the U.S. FOIA (b) (6)), revealed that they both denied having knowledge of the allegation and the allegation was never investigated or reported to the NJDOH. The facility's failure to implement their abuse policy including reporting all NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 to the NJDOH placed all residents at risk for NJ Ex Order 26 which posed the likelihood of NJ Ex Order 26.4(. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began 12/28/24 at 9:16 AM, after Resident #381 made the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) to RN #1. The facility was notified of the IJ on 5/6/25 at 3:45 PM. The facility submitted an acceptable Removal Plan (RP) on 5/7/25 at 3:08 PM. The survey team verified the implementation of the RP on-site during the continuation of the survey on 5/7/25 at 3:40 PM. The evidence was as follows: Refer F 600, F 610 A review of the facility's "Abuse" policy dated 4/9/24, included that abuse and neglect exist in many forms and to varying degrees. Abuse includes verbal, sexual, physical, mental, involuntary seclusion, exploitation, misappropriation, mistreatment, neglect, intimidation and injury of unknown origin. The objective of the abuse policy is to comply with a seven-step approach to abuse and neglect detection and prevention...7.) Reporting: the facility would ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin	F 609	findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING/designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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would be reported immediately to Administrator and state agencies to include the NJDOH and Ombudsman.

The surveyor reviewed the closed medical record for Resident #381.

A review of the Admission Record face sheet (admission summary), reflected that Resident #381 was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)).

A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, indicating the resident was NJ Ex Order 26.4(b)(1). A further review of the MDS, revealed the resident required NJ Ex Order 26.4(b)(1) with activities of daily living and NJ Ex Order 26.4(b)

A review of the individual comprehensive care plan (ICCP) included a focus of area dated NJ Ex Order 26.4(b)(1), for alteration in NJ Ex Order 26.4(b) due to NJ Ex Ord evidenced by NJ Ex Order 26.4(b)(1) due to status NJ Ex Ord). Interventions included; to adjust NJ Ex Ord medication administration time to coincide with treatments, rehabilitation, and/or care, to administer NJ Ex Order 26.4(b)(1) medication as ordered, and to maintain in the most NJ Ex Order 26.4(b)(1) which is per my request.

A review of a Progress Note (PN) dated NJ Ex Order 26.4(b)(1) at 9:16 AM, revealed that Resident #381 was

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awake, NJ Ex Order 26.4(b)(1) and NJ Ex Ord to NJ Ex Order 26.4(b)(1) . Resident #381 reported to RN #1 that they were ' NJ Ex Order 26.4 of staff and the facility due to an incident that had occurred NJ Ex Order 26.4(b)(prior NJ Ex Order 26.4(b)(1) . The resident reported that a CNA (CNA #1) NJ Ex Order 26.4(b)(1) the resident causing the resident's NJ Ex Order 26.4(b)(1) to have NJ Ex Order 26.4(b)(1) . RN #1 documented that Resident #381 had NJ Ex Order 26.4(b)(1) around the NJ Ex Ord and that she administered the resident's NJ Ex Order 26.4(b)(1) medication. The resident reported some NJ Ex Order from the NJ Ex Ord medication. RN #1 made RNS #1 aware of the resident's NJ Ex Order 26.4(b)(1) and endorsed the resident's care and further follow-up to RNS #1 because RN #1 was being sent home early.

On 5/1/25 at 9:16 AM, the surveyor conducted a telephone interview with RN #1, who had documented the NJ Ex Order 26.4(b)(1) for Resident #381 on NJ Ex Order 26.4(b)(at 9:16 AM. RN #1 identified herself as NJ Ex Order 26.4b1 , and stated that on NJ Ex Order 26.4(b)(, Resident #381 reported that they were NJ Ex Order 26.4(b)(1) by a CNA a NJ Ex Order 26. ago, during the 3:00 PM to 11:00 PM (3-11) shift around 9:00 PM. RN #1 stated that the resident requested to have their NJ Ex Order 26.4(b)(1) , and the CNA, without introducing herself and without explaining what she was going to do, NJ Ex Order 26. the resident NJ Ex Order 26.4(b)(1) that the resident almost NJ Ex Order 26.4(b)(1) . RN #1 stated that the resident used the word ' NJ Ex Order 26.4(b)(1) when describing how it happened. RN #1 stated that the resident had NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) area due to being NJ Ex Order 26.4(b)(1) RN #1 explained that she had administered the resident an as needed [prn] NJ Ex Ord medication at that time. RN #1 stated that she was going to call the physician to notify and to get

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NJ Ex Order 26.4(b)(1), however she was told by RNS #1 that she was being sent home. RN #1 stated that she had reported the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 to RNS #1, and RNS #1 told RN #1 that she would follow-up with the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4 RN #1 stated that Resident #381 provided her with the name of the NJ Ex Order 26.4 CNA (CNA #1), as well as the first names of the staff members the resident had notified about the NJ Ex Order 26.4(b)(1) . RN #1 identified the staff as the U.S. FOIA (b and the U.S. FOIA (b) (6)) who still worked at the facility.

On 5/1/25 at 9:51 AM, the surveyor interviewed the U.S. FOI who stated that he worked in Central Supply in NJ Ex Order 26.4(b)(1), and did not remember any resident reporting an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 to him. The U.S. FO stated that he would have taken the NJ Ex Order 26.4(b)(1) very seriously and would have reported it to the administration because it would have required a full investigation. The U.S. FO identified the NJ Ex Order 26.4(CNA reported to RN #1 by Resident #381 as CNA #1.

On 5/1/25 at 9:59 AM, the surveyor conducted a telephone interview with RNS #1, who confirmed that she had worked the weekend of NJ Ex Order 26.4(b)(1) when the resident reported an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4 RNS #1 stated that she did not remember the event occurring or being told about the resident's complaints of NJ Ex Order 26.4(b)(1). RNS #1 stated that if the NJ Ex Order 26.4(b)(1) was reported to her, then she would have reported it to the administration and an investigation would have started. RNS #1 then instructed the surveyor to ask the U.S. FOIA (b for more information.

On 5/1/25 at 10:50 AM, the surveyor interviewed CNA #1, who stated she might have worked the

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F 609	Continued From page 27 3-11 shift on NJ Ex Order 26.4(b)(1, but did not remember any resident NJ Ex Order 26.4(b)(1) about a CNA being NJ Ex Order 2 or NJ Ex Order 26.4(b) with Resident #381. On 5/1/25 at 11:01 AM, the surveyor interviewed the U.S. FOIA (b) who stated that she was in constant communication with Resident #381 when the resident was in the facility and did not remember the resident or any nurse informing her that a CNA was NJ Ex Order 26.4(b)(1) with Resident #381. At that time, the U.S. FOIA (b reviewed the PN dated NJ Ex Order 26.4(b)(at 9:16 AM, and confirmed that an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) was documented and it should have been reported to the administration and have been immediately investigated. The U.S. FOIA (b stated that if she had known, she would have reported the NJ Ex Order 26.4(b)(1) to the NJDOH. On 5/1/25 at 11:09 AM, the surveyor interviewed the U.S. FOIA (b) (6)) in the presence of the U.S. FOIA (b) who explained that prior to completing any comprehensive admission assessment, she reviewed the resident's progress notes, interviewed the resident and staff, and looked at any documentation that was pertinent to the MDS assessment. The U.S. FOIA (b) (6) stated that it would be important to review progress notes and extract pertinent information to develop a comprehensive assessment of the resident, and she reviewed the nursing progress notes going back seven days from the assessment reference date (ARD). The U.S. FOIA (b) (6) explained that if Resident #381's MDS assessment's ARD was NJ Ex Order 26.4(b)(1) she would have reviewed the progress notes from NJ Ex Order 26.4(b)(until NJ Ex Order 26.4(b)(. The U.S. FOIA (b) (6) stated that she remembered reading the documentation regarding the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4 and remembered that it was discussed at clinical	F 609		

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morning meeting, however she did not remember who was there, but remembered there was enough management there to know that it needed to be followed-up with.

On 5/5/25 at 11:38 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the nurse that cared for Resident #381 on NJ Ex Order 26.4(b)(1) did not report any incident related to NJ Ex Order 26 to the administration. The U.S. FOIA (b) (stated that he reviewed the documentation minutes of the clinical morning meeting dated NJ Ex Order 26.4(b)(, and there were no minutes pertaining to any resident NJ Ex Order 26.4(b)(1) The U.S. FOIA (b) (stated that the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 should have been reported by the U.S. FOIA (b) (6) who read the PN dated NJ Ex Order 26.4(b)(, regarding the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 during Resident #381's admission assessment with the ARD of NJ Ex Order 26.4(b)(. The U.S. FOIA (b) (stated the nurse should have reported it to the U.S. FOIA (b) (immediately. The U.S. FOIA (b) (stated that he immediately started an investigation when he became aware of the NJ Ex Order 26.4(b)(1) and reported the incident to the NJDOH on 5/1/25 at 11:16 AM.

On 5/6/25 at 11:20 AM, the surveyor interviewed the U.S. FOIA (b) who reviewed the PN dated NJ Ex Order 26.4(b)(1) after surveyor inquiry. The U.S. FOIA (b stated that the NJ Ex Order 26.4(b)(1) who read the note during the resident's assessment period, should have reported the NJ Ex Order 26.4(b)(to administration after reading the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 in the progress notes. The U.S. FOIA (b stated that based on the timesheets, CNA #2 worked the 3-11 shift on NJ Ex Order 26.4(b)(1)) and cared for the resident. The U.S. FOIA (b reported that CNA #2 had not worked at the facility since NJ Ex Order 26.4(b) of NJ Ex Order 26 At that time, the surveyor informed the NJ Ex Order that

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F 609	Continued From page 29 RN #1 identified the [NJ Ex Order 26.4] CNA as CNA #1, and the [U.S. FOIA (b)] was unsure of who that CNA was. A review of CNA #1's "Timecard Report" revealed that CNA #1 was working in the facility at the time of the [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] during the 3-11 shift). On 5/7/25 at 11:17 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated that the [U.S. FOIA (b) (6)] was disciplined because she did not report the resident's [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4(b)(1)] after she read it in the progress note while performing the resident's admission assessment MDS. The [U.S. FOIA (b)] acknowledged that he was responsible to ensure [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26] were reported to the NJDOH and fully investigated. The [U.S. FOIA (b)] stated he was responsible to oversee this process and that it was done in accordance with the facility's [NJ Ex Order 26] policy. The facility submitted an acceptable Removal Plan (RP) on 5/7/25 at 3:08 PM, indicating that the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice which included; on 5/1/25 at 10:45 AM, the [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26] was reported to the NJDOH, the [U.S. FOIA (b)] and the [U.S. FOIA (b)] were educated by the [U.S. FOIA (b) (6)] on reporting [NJ Ex Order 26.4(b)(1)] to the NJDOH on 5/6/25, all [NJ Ex Order 26.4(b)(1)] residents or representatives were interviewed to verify that there were no [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26] that were not investigated or reported. The [NJ Ex Order 26] policy was reviewed by the [U.S. FOIA (b)] U.S. FOIA (b) (6), Interdisciplinary team, Unit Managers, [U.S. FOIA (b) (6)] Social Workers, Activities, and [U.S. FOIA (b)] with no revisions made. All employees at the facility were educated on the [NJ Ex Order 26] policy by	F 609		

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F 609	Continued From page 30 the [U.S. FOIA (b)] U.S. FOIA (b) (6), Interdisciplinary team, Unit Managers, U.S. FOIA (b) (6), Social Workers, Activities, and and [U.S. FOIA (b) (6)] that included the seven components screening, training, prevention, identification, investigation, protection, reporting and response. The survey team verified the implementation of the RP during the continuation on site survey on 5/7/25 at 3:40 PM.	F 609		
F 610 SS=J	NJAC 8:39-9.4(f) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ182121	F 610	Resident #381 did not experience [NJ Ex Or] and specifically stated to the [NJ Ex Order 26.4(b)(1)] that [NJ Ex Or] did not feel	6/6/25

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	315279	A. BUILDING _____ B. WING _____	C 05/12/2025

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F 610	Continued From page 31 Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to implement their NJ Ex Order 26 policy by thoroughly investigating an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) to a NJ Ex Order 26.4(b)(1) resident (Resident #381) who reported the NJ Ex Order 26.4(b)(1) to the Registered Nurse (RN #1) on NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 1 residents reviewed for NJ Ex Order 26 (Resident #381). A review of the Progress Note (PN) dated NJ Ex Order 26.4(b)(1) at 9:16 AM, revealed that Resident #381, a NJ Ex Order 26.4(b)(1) resident, reported to the Registered Nurse (RN #1) that they were NJ Ex Order 26.4 " of staff at the facility due to an incident that had occurred NJ Ex Order 26.4(b)(1) prior NJ Ex Order 26.4(b)(1). The resident reported that a Certified Nursing Assistant (CNA #1) NJ Ex Order 26.4(b)(1) the resident causing the resident's NJ Ex Order 26.4(b)(1) to have NJ Ex Order 26.4(b)(1). RN #1 documented that Resident #381 had NJ Ex Order 26.4(b)(1)) around the NJ Ex Order and that she administered the prescribed NJ Ex Order medication. RN #1 made the Registered Nurse Supervisor (RNS #1) aware of the resident's complaints and endorsed the resident's care and further follow-up of the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) to RNS #1, because RN #1 was being sent home early. An interview on 5/1/25, with RN #1, confirmed the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 was made, and she reported it to RNS #1. Interviews on 5/1/25, with RNS #1 and the U.S. FOIA (b) (6)), revealed that they both denied having knowledge of the NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) was never investigated. The facility's failure to implement their NJ Ex Order 26	F 610	NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(following the incident. NJ Ex Ord chose to remain at the facility until NJ Ex Order 26.4(b)(1) before being discharged to NJ Ex Order 26.4(b)(1) All residents who alleged abuse had the potential to be affected by this practice. All resident/ representatives were reeducated by the interdisciplinary team on abuse policy and to report immediately to staff any allegations immediately to the staff in person or via the feedback line. Abuse Policy and procedure were reviewed and all employees at the facility were educated on the policy that include the seven components, Screening, Training, prevention, identification, investigation, protection and reporting and response. The Director of Nursing or designee will conduct weekly audits a involving a random selection of 20 staff and residents weekly for 4 weeks and then monthly for 2 months to ensure that the facility is appropriately investigating, preventing, and correcting all alleged violations, including abuse, neglect, and misappropriation. Director of Nursing/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING or designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 610	Continued From page 32 policy by investigating all allegations of abuse placed all residents at risk for [NJ Ex Order 26] which posed the likelihood of NJ Ex Order 26.4(b)(1) and [NJ Ex Order 26.4(b)(1)] [redacted]. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began [NJ Ex Order 26.4(b)(1)] at 9:16 AM, after Resident #381 made the [NJ Ex Order 26.4(b)(1)] of NJ Ex Order 26.4(b)(1) to RN #1. The facility was notified of the IJ on 5/6/25 at 3:45 PM. The facility submitted an acceptable Removal Plan (RP) on 5/7/25 at 3:08 PM. The survey team verified the implementation of the RP on-site during the continuation of the survey on 5/7/25 at 3:40 PM. The evidence was as follows: Refer F 600, F 610 The facility's "Abuse" policy dated 4/9/24, included that abuse and neglect exist in many forms and to varying degrees. Abuse includes verbal, sexual, physical, mental, involuntary seclusion, exploitation, misappropriation, mistreatment, neglect, intimidation and injury of unknown origin. The objective of the abuse policy is to comply with a seven-step approach to abuse and neglect detection and prevention... 4.) Identification: All staff were to monitor residents and would know how to identify potential signs and symptoms of abuse. Occurrences, patterns and trends that may constitute abuse would be investigated. 5.) Investigation is the process used to try to determine what happened and the designated personnel would begin the investigation immediately and a root cause analysis would be completed. When an incident or suspected incident of abuse is reported the Administrator or designee would investigate the	F 610		

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F 610	Continued From page 33 incident with the assistance of appropriate personal to include who was involved, resident statement, roommate statements, involved staff and witness statements, a description of the residents behavior and environment at the time of the incident, any injuries and a resident assessment, and interview other residents who were cared for by the accused. All staff must cooperate during the investigation to assure the resident is fully protected... The surveyor reviewed the closed medical record for Resident #381. A review of the Admission Record face sheet (admission summary), reflected that Resident #381 was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, indicating the resident was NJ Ex Order 26.4(b)(1). A further review of the MDS, revealed the resident required NJ Ex Order 26.4(b)(1) with activities of daily living and NJ Ex Order 26.4(b)(1) A review of the individual comprehensive care plan (ICCP) included a focus of area dated NJ Ex Order 26.4(b)(1), for alteration in NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1) evidenced by verbalizing due to status NJ Ex Order 26.4(b)(1)). Interventions included; to adjust NJ Ex Order 26.4(b)(1) medication administration time to coincide with treatments,	F 610		

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F 610	Continued From page 34 NJ Ex Order 26.4(b)(1) and/or care, to administer NJ Ex Order 26.4(b)(1) medication as ordered, and to maintain in the NJ Ex Order 26.4(b)(1) which is per my request. A review of a Progress Note (PN) dated NJ Ex Order 26.4(b)(1) at 9:16 AM, revealed that Resident #381 was awake, NJ Ex Order 26.4(b)(1) and NJ Ex Ord to make their NJ Ex Order 26.4(b)(1). Resident #381 reported to RN #1 that they were 'NJ Ex Order 26.4 of staff and the facility due to an incident that had occurred NJ Ex Order 26.4(b)(prior (NJ Ex Order 26.4(b)(1). The resident reported that a CNA (CNA #1) NJ Ex Order 26.4(b)(1) the resident causing the resident's NJ Ex Order 26.4(b)(1) to have NJ Ex Order 26.4(b)(1) RN #1 documented that Resident #381 had NJ Ex Order 26.4(b)(1) and that she administered the resident's prescribed NJ Ex Ord medication. The resident reported some NJ Ex Order from the NJ Ex Ord medication. RN #1 made RNS #1 aware of the resident's complaints and endorsed the resident's care and further follow-up to RNS #1 because RN #1 was being sent home early. On 5/1/25 at 9:16 AM, the surveyor conducted a telephone interview with RN #1, who had documented the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) for Resident #381 on NJ Ex Order 26.4(b)(at 9:16 AM. RN #1 identified herself as an Agency nurse, and stated that on NJ Ex Order 26.4(b)(, Resident #381 reported that they were NJ Ex Order 26.4(b)(1) by a CNA a couple days ago, during the 3:00 PM to 11:00 PM (3-11) shift around 9:00 PM. RN #1 stated that the resident requested to have their NJ Ex Order 26.4(b)(1) changed, and the CNA, without introducing herself and without explaining what she was going to do, NJ Ex Order 26 the resident NJ Ex Order 26.4(b)(1) that the resident NJ Ex Order 26.4(b)(1) . RN #1 stated that the resident used the word 'NJ Ex Order 26.4(b)(1)	F 610		

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when describing how it happened. RN #1 stated that the resident had complained of NJ Ex Order 26.4(b)(1) in the NJ Ex Order 26.4(b)(1) due to being NJ Ex Order 26.4(b)(1) [redacted]. RN #1 explained that she had administered the resident an as needed [prn] NJ Ex Ord medication at that time. RN #1 stated that she was going to call the physician to notify and to get NJ Ex Order 26.4(b)(1), however she was told by RNS #1 that she was being sent home. RN #1 stated that she had reported the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 to RNS #1, and RNS #1 told RN #1 that she would follow-up with the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4 RN #1 stated that Resident #381 provided her with the name of the NJ Ex Order 26.4 CNA (CNA #1), as well as the first names of the staff members the resident had notified about the NJ Ex Order 26.4(b)(1) [redacted]. RN #1 identified the staff as the U.S. FOIA (b [redacted] and the U.S. FOIA (b) (6) [redacted] who still worked at the facility.

On 5/1/25 at 9:51 AM, the surveyor interviewed the U.S. FOI [redacted] who stated that he worked in Central Supply in NJ Ex Order 26.4(b)(1), and did not remember any resident reporting an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 to him. The U.S. FO [redacted] stated that he would have taken the allegation very seriously and would have reported it to the administration because it would have required a full investigation. The U.S. FO [redacted] identified the alleged CNA reported to RN #1 by Resident #381 as CNA #1.

On 5/1/25 at 9:59 AM, the surveyor conducted a telephone interview with RNS #1, who confirmed that she had worked the weekend of NJ Ex Order 26.4(b)([redacted], when the resident reported an NJ Ex Order 26.4(b)(1) [redacted] of NJ Ex Order 26.4 RNS #1 stated that she did not remember the event occurring or being told about the resident's complaints of NJ Ex Order 26.4(b)(1). RNS #1 stated that if the NJ Ex Order 26.4(b)(1) was reported to her,

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then she would have reported it to the administration and an investigation would have started. RNS #1 then instructed the surveyor to ask the U.S. FOIA (b) for more information.

On 5/1/25 at 10:50 AM, the surveyor interviewed CNA #1, who stated she might have worked the 3-11 shift on NJ Ex Order 26.4(b)(1), but did not remember any resident complaining about a CNA NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b) with Resident #381.

On 5/1/25 at 11:01 AM, the surveyor interviewed the U.S. FOIA (b) who stated that she was in constant communication with Resident #381 when the resident was in the facility and did not remember the resident or any nurse informing her that a CNA was NJ Ex Order 26.4(b)(1) with Resident #381. At that time, the U.S. FOIA (b) reviewed the PN dated NJ Ex Order 26.4(b)(1) at 9:16 AM, and confirmed that NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) was documented and it should have been reported to the administration and have been immediately investigated. The U.S. FOIA (b) stated that if it was reported to her at the time the event occurred, she would have interviewed the nurse and the resident, and removed the CNA from all resident care until an investigation was thoroughly completed. The U.S. FOIA (b) stated that the physician and family would have been notified and that the resident's NJ Ex Ord would have been monitored to assure that their NJ Ex Ord was being managed. The U.S. FOIA (b) also explained that she would have in-serviced all staff on NJ Ex Order 26.4(b)(1) and the handling of residents as well as NJ Ex Order 26 training.

On 5/1/25 at 11:09 AM, the surveyor interviewed the U.S. FOIA (b) (6) in the presence of the U.S. FOIA (b) who explained that prior to completing any

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comprehensive admission assessment, she reviewed the resident's progress notes, interviewed the resident and staff, and looked at any documentation that was pertinent to the MDS assessment. The U.S. FOIA (b) (6) stated that it would be important to review progress notes and extract pertinent information to develop a comprehensive assessment of the resident, and she reviewed the nursing progress notes going back seven days from the assessment reference date (ARD). The U.S. FOIA (b) (6) explained that if Resident #381's MDS assessment's ARD was NJ Ex Order 26.4(b)(1), she would have reviewed the progress notes from NJ Ex Order 26.4(b)(1) until NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated that she remembered reading the documentation regarding the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) and remembered that it was discussed at clinical morning meeting, however she did not remember who was there, but remembered there was enough management there to know that it needed to be followed-up with.

On 5/5/25 at 11:38 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the nurse that cared for Resident #381 on NJ Ex Order 26.4(b)(1), did not report any incident related to NJ Ex Order 26.4(b)(1) to the administration. The U.S. FOIA (b) (6) stated that he reviewed the documentation minutes of the clinical morning meeting dated NJ Ex Order 26.4(b)(1), and there were no minutes pertaining to any resident NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated that the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) should have been reported by the U.S. FOIA (b) (6) who read the PN dated NJ Ex Order 26.4(b)(1), regarding the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) during Resident #381's admission assessment with the ARD of NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated the nurse should have reported it to the U.S. FOIA (b) (6) immediately. The U.S. FOIA (b) (6) continued to explain that the U.S. FOIA (b) (6)

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came into see Resident #381 on [redacted], and the resident did not report [redacted] and did not express any [redacted] concerning their stay at the facility. The [redacted] stated that he immediately started an investigation when he became aware of the [redacted]

On 5/6/25 at 11:20 AM, the surveyor interviewed the [redacted] who reviewed the PN dated [redacted] after surveyor inquiry. The [redacted] stated that the [redacted] who read the note during the resident's assessment period, should have reported the [redacted] to administration after reading the [redacted] of [redacted] in the progress notes. The [redacted] stated that based on the timesheets, CNA #2 worked the 3-11 shift on [redacted]) and cared for the resident. The [redacted] reported that CNA #2 had not worked at the facility since [redacted]. At that time, the surveyor informed the [redacted] that RN #1 identified the [redacted] CNA as CNA #1, and the [redacted] was unsure of who that CNA was.

A review of CNA #1's "Timecard Report" revealed that CNA #1 was working in the facility at the time of the [redacted] during the 3-11 shift).

On 5/7/25 at 10:45 AM, the surveyor interviewed the [redacted] who stated that the nurse did not report the [redacted] of [redacted] or [redacted] at 9:16 AM, to the administration when the incident occurred, however after surveyor inquiry, the [redacted] started the investigation into the [redacted] of [redacted].

On 5/7/25 at 11:17 AM, the surveyor interviewed the [redacted] who stated that the [redacted] was disciplined because she did not report the resident's [redacted] of [redacted] after she

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F 610	Continued From page 39 read it in the progress note while performing the resident's admission assessment MDS. The [U.S. FOIA (b) (6)] acknowledged that he was responsible to ensure [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26] were reported to the NJDOH and fully investigated. The [U.S. FOIA (b) (6)] stated he was responsible to oversee this process and that it was done in accordance with the facility's [NJ Ex Order 26] policy. An acceptable Removal Plan was received on 5/7/25 at 3:08 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; the [U.S. FOIA (b) (6)] or designee immediately initiated an investigation; the [NJ Ex Order 26.4(b)(1)] was reported to the NJDOH; the [U.S. FOIA (b) (6)] and [U.S. FOIA (b)] were re-educated on Investigations/ Prevention/Correct Alleged Violations; and all staff were educated on the facility's abuse policies and procedures. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 5/7/25.	F 610		
F 656 SS=D	NJAC 8:39-4.1(a)(5) 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	F 656		6/6/25

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F 656	Continued From page 40 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). (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: Complaint #NJ183871, NJ183873	F 656	Resident # 73 and #531 did not have NJ Ex Order 26.4(b)(1). Resident #73 had	

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	315279	A. BUILDING _____ B. WING _____	C 05/12/2025

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F 656	Continued From page 41 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to develop and implement a comprehensive, person-centered care plan for a.) a resident who was receiving [redacted] treatments and b.) a resident with a [redacted]. This deficient practice was identified for 2 of 35 residents reviewed for care plans (Resident #73 and Resident #531), and was evidenced by the following: 1. On 4/29/25 at 12:13 PM, the Resident #73 was observed in bed with a blanket [redacted]. The resident did not want to be interviewed. The surveyor reviewed the medical record for Resident #73. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted], and [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] revealed that the resident had a Brief Interview of Mental Status score of [redacted] out of 15, meaning the resident had [redacted]. A review of Section [redacted], indicated the resident was receiving [redacted] treatments on admission to the facility. A review of the physician's orders included an active order dated [redacted] for [redacted] treatments	F 656	care plan updated immediately on 05/02/2025 to reflect [redacted] Resident #531 had care plan added immediately on 05/02/2025 relating to [redacted] All residents on Dialysis and/or have a surgical incision has the potential to be affected. An audit was completed to ensure that all Dialysis and Skin Care Plan for residents with surgical incisions has been completed. No other cases identified. Director of Nursing, or Designee educated the nurses on Care Planning for Dialysis and Skin related care plans. Director of Nursing, or Designee will complete a weekly audit/review on all dialysis patients to ensure that care plans are completed. Director of Nursing/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING/designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 656	Continued From page 42 every Tuesday, Thursday, and Saturday. A review of the resident's [NJ Ex Order 26.4(] communication book revealed that the facility completed the book every time Resident #73 went out to the [NJ Ex Order 26.4(] facility. A review of the individualized comprehensive care plan (ICCP) did not include a focus area for NJ Ex Order 26.4b1. On 5/6/25 at 1:22 PM, the surveyor interviewed the U.S. FOIA (b) (6) regarding care plans. The surveyor asked who was responsible for initiating and updating resident care plans, and the [U.S. FOIA] stated it was the responsibility of the Unit Manager. On 5/6/25 at 3:30 PM, the surveyor met with the U.S. FOIA (b) (6)) and the [U.S. FOIA (b) (6)] regarding care plans and who was responsible to initiate, revise, and update care plans on the sub-acute unit. The [U.S. FOIA (b) (] informed the surveyor that the U.S. FOIA (b) (6) was responsible. The [U.S. FOIA (b) (] said the U.S. FOIA (b) (6) shared the sub-acute unit and the second floor. 2. The surveyor reviewed the closed medical record for Resident #531. A review of the Face Sheet reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1)), [NJ Ex Order 26.4(b)(1)] and NJ Ex Order 26.4(b)(1). A review of the discharge MDS reflected under	F 656		

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F 656	Continued From page 43 Section NJ Ex Order 26.4(b)(1), the resident had a NJ Ex Order 26.4(b)(1). A review of the physician's orders included order dated NJ Ex Order 26.4(b)(1), for resident to follow-up with U.S. FOIA (b) (6) regarding NJ Ex Order 26.4(b)(1) A review of the ICCP did not include a focus area of NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) A review of the Progress Notes dated NJ Ex Order 26.4(b)(1) revealed that the resident was admitted from an acute care facility and had NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b)(1) covered with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) On 5/6/25 at 1:22 PM, the surveyor interviewed the U.S. FOIA regarding care plans. The surveyor asked who was responsible for initiating and updating resident care plans, and the U.S. FOIA stated it was the responsibility of the U.S. FOIA (b) (6). On 5/6/25 at 3:30 PM, the surveyor met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) regarding care plans and who was responsible to initiate, revise, and update care plans on the sub-acute unit. The U.S. FOIA (b) (6) informed the surveyor that the U.S. FOIA (b) (6) was responsible. The U.S. FOIA (b) (6) said the U.S. FOIA (b) (6) shared the sub-acute unit and the second floor. A review of the facility's undated "Care Plans" policy included that the resident's care plan was developed using the completed resident's comprehensive assessment using the Baseline Care Plan template and care plan were revised as changes in the resident's condition may dictate...	F 656		

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F 656	Continued From page 44 NJAC 8:39-27.1(a)	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure recommendations by the [redacted] care consultant were implemented to prevent [redacted] of [redacted]. This deficient practice was identified in 1 of 4 residents reviewed for [redacted] (Resident #333), and was evidenced by the following: The surveyor reviewed the medical record for Resident #333. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted], [redacted], and [redacted]	F 686	Resident # 333 did not have [redacted]. [redacted] applied immediately on 05/01/2025. All other residents who have a recommendation for an air mattress have the potential to be affected. An audit was completed and no other residents were identified. Director of Nursing, or Designee educated all nurses on Pressure Ulcer prevention policy and procedure and wound consultant recommendations. A weekly audit of new pressure injuries will be conducted by DIRECTOR OF NURSING/designee to ensure that	6/6/25

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F 686	Continued From page 45 A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26.4(], revealed the resident had a Brief Interview of Mental Status (BIMS) score of [NJ Ex] out of 15, meaning the resident was [NJ Ex Order 26.4(b)(1)]. A review of Section [NJ Ex Order 26.4(b)(1)], reflected that the resident had [NJ Ex Order 26.4(b)(1)] upon admission to the facility and used a [NJ Ex Order 26.4(b)(1)] [redacted] A review of the Nursing Admission Assessment dated [NJ Ex Order 26.4(], indicated that the resident had a sacral wound measuring [NJ Ex Order 26.4(b)(1)] [redacted]. A review of the individualized comprehensive care plan dated initiated [NJ Ex Order 26.4(b)(1] had a focus area of [NJ Ex Order 26.4(b)(1)] as evidenced by a [NJ Ex Order 26.4(b)(1)]. A review of the [NJ Ex Order 26.4(] Consultant Note dated [NJ Ex Order 26.4(], revealed the resident had an [NJ Ex Order 26.4(b)(1)] [redacted] with recommendations that included a [NJ Ex Order 26.4(b)(1)] to the resident's bed. On 4/30/25 12:16 PM, the surveyor observed Resident #333 in their room in a wheelchair visiting with family. The surveyor then asked the [US FOIA (b)(6)]) if the resident was on a [NJ Ex Order 26.4(b)(1)] for the [NJ Ex Order 26.4(b)(1] [redacted]. The nurse replied, "No, just a regular [NJ Ex Order 26.4(b)(1)] On 5/6/25 at 1:14 PM, the surveyor interviewed the [U.S. FOIA] regarding the residents with [NJ Ex Order 26.4(b)(1] [redacted] or potential to [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] informed the surveyor a '[NJ Ex Order 26.4(b)(1)]	F 686	residents have the appropriate equipment needed. Director of Nursing/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING/designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 686	Continued From page 46 NJ Ex Order 26.4(b)(1)) was done on admission which would indicate if a resident was at risk for a NJ Ex Order 26.4(b)(1). The surveyor asked who would need a NJ Ex Order 26.4(b)(1), and the U.S. FOIA stated if the NJ Ex Order 26.4(b)(1) classified them at risk for developing NJ Ex Order 26.4(b)(1) or a resident had a NJ Ex Order 26.4(b)(1), then the resident needed one. The surveyor asked if a NJ Ex Order 26.4(b)(1) were available, and she stated that they came from the maintenance department and were in the facility all of the time. On 5/7/25 at 12:15 PM, during an interview with the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) regarding Resident #333 and the NJ Ex Order 26.4(b)(1), the U.S. FOIA (b) (informed the surveyor, "I can't speak to why there was NJ Ex Order 26.4(b)(1) on the resident's bed." A review of the undated facility's "Prevention of Pressure Ulcers" policy included General Preventative Measures...2. determine if the resident needs a special mattress...	F 686		
F 697 SS=E	NJAC 8:39-27.1(e) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 697		6/6/25

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F 697	Continued From page 47 Complaint #NJ182121, NJ183873 Based on interview, record review, and other pertinent facility documents, it was determined that facility to failed to ensure residents received the appropriate [NJ Ex Ord] management by a.) administering [NJ Ex Ord] medications according to the physician's ordered [NJ Ex Order 26.4(b)(1)] parameters and b.) obtaining and administering [NJ Ex Ord] medications as ordered by the physician. This deficient practice was identified for 2 of 2 residents reviewed for [NJ Ex Ord] management (Residents #381 and Resident #531), and was evidenced by the following: 1. The surveyor reviewed the closed medical record for Resident #381. A review of the Admission Record face sheet (admission summary) reflected that Resident #381 was admitted to the facility with the diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) [NJ Ex Order 26.4(b)(1)] A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26.4(b)(1)], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Ex] out of 15, indicating the resident was NJ Ex Order 26.4(b)(1). A further review of the MDS revealed the resident required NJ Ex Order 26.4(b)(1) with activities of daily living and [NJ Ex Order 26.4(b)] A review of the individualized comprehensive care plan (ICCP) included a focus of area dated	F 697	Resident # 381 did not have [NJ Ex Or] Resident has been discharged since [NJ Ex Order 26.4(b)(1)]. All other residents requiring pain medication have the potential to be affected. Director of Nursing, or Designee educated all nursing staff on pain management policy and procedure and parameters. An audit was completed to ensure that all pain medications are administered as per doctor orders. A weekly audit of 20 random residents to ensure this practice is not present will be conducted by DIRECTOR OF NURSING/Designee weekly for 4 weeks and then monthly for 2 months. Director of Nursing/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING/designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 697	Continued From page 48 NJ Ex Order 26.4(b)(1), for alteration in NJ Ex Order 26.4(b) due to NJ Ex Ord evidenced by NJ Ex Order 26.4(b)(1) due to status NJ Ex Ord [redacted]. Interventions included: adjust NJ Ex Ord medication administration time to coincide with treatments, rehabilitation, and/or care, NJ Ex Order 26.4(b)(1) [redacted] as ordered, and maintain in most NJ Ex Order 26.4(b)(1) which is per my request. A review of the physician's order (PO) dated NJ Ex Order 26.4(b)(1), reflected an order for NJ Ex Order 26.4(b)(1) [redacted]); administer two tablets by mouth every eight hours as needed for NJ Ex Order 26.4(b)(1). A review of the PO dated NJ Ex Order 26.4(b)(1), reflected on order for NJ Ex Order 26.4(b)(1) [redacted] oral tablet, a NJ Ex Order 26.4(b)(1) medication, administer one tablet by mouth every six hours as needed for NJ Ex Order 26.4(The numerical NJ Ex Ord scale is as follows: [redacted] = NJ Ex Order 26.4(b)(1), 1-3 = NJ Ex Order 26.4(b)(1) 4-6 = NJ Ex Order 26.4(b)(1) and 7-[redacted] = NJ Ex Order 26.4(b)(1). A review of the Medication Administration Record (MAR) dated NJ Ex Order 26.4(b)(1), reflected that the following [redacted] medications were administered out of physician ordered NJ Ex Ord management levels: - On NJ Ex Order 26.4(b)(1) [redacted] at 10:53 PM, Resident #381 complained of NJ Ex Ord at a numerical level NJ Ex Ord scale of [redacted] which indicated NJ Ex Order 26.4(b)(1) and was administered NJ Ex Order 26.4(b)(1) [redacted]. The resident should have been administered NJ Ex Order 26.4(b)(1) for complaints of NJ Ex Order 26.4 [redacted] as ordered by the physician. - On NJ Ex Order 26.4(b)(1) [redacted] at 9:05 PM, the resident had complained of NJ Ex Ord at a NJ Ex Order 26.4(b)(1) of NJ Ex Ord	F 697		

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F 697	Continued From page 49 and was administered NJ Ex Order 26.4(b)(1). The resident should have received NJ Ex Order 26.4(b)(1) two tablets for NJ Ex Order 26.4(b)(1) as ordered by the physician. - On NJ Ex Order 26.4(b)(1) at 3:30 AM, the resident had complaints of NJ Ex Ord at a NJ Ex Order 26.4(b)(1) of NJ Ex Order 2 and was administered NJ Ex Order 26.4(b)(1). The resident should have received NJ Ex Order 26.4(b)(1) two tablets for NJ Ex Order 26.4(b)(1) as ordered by the physician. - On NJ Ex Order 26.4(b)(1) at 11:19 AM, the resident had complaints of NJ Ex Ord at a NJ Ex Order 26.4(b)(1) of NJ Ex Orde and was administered NJ Ex Order 26.4(b)(1). The resident should have received NJ Ex Order 26.4(b)(1) two tablets for NJ Ex Order 26.4(b)(1) as ordered by the physician. - On NJ Ex Order 26.4(b)(1 at 5:48 PM, the resident had complaints of NJ Ex Ord at a NJ Ex Order 26.4(b)(1) of NJ Ex Ord and was administered NJ Ex Order 26.4(b)(1). The resident should have received NJ Ex Order 26.4(b)(1) two tabs for NJ Ex Order 26.4(b)(1) as ordered by the physician. - On NJ Ex Order 26.4(b)(1) at 12:43 AM, the resident had complaints of NJ Ex Ord at a NJ Ex Order 26.4(b)(1) of NJ Ex O and was administered NJ Ex Order 26.4(b)(1). The resident should have received NJ Ex Order 26.4(b)(1) two tablets for NJ Ex Order 26.4(b)(1 as ordered by the physician. - On NJ Ex Order 26.4(b)(1 at 10:58 AM, the resident had complaints of NJ Ex Ord at a NJ Ex Order 26.4(b)(1) of NJ Ex Orde and was administered NJ Ex Order 26.4(b)(1). The resident should have received NJ Ex Order 26.4(b)(1) two tablets for NJ Ex Order 26.4(b)(1) as ordered by the physician.	F 697		

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F 697	Continued From page 50	F 697		

- On [redacted] at 4:00 AM, the resident had complaints of [redacted] at a [redacted] of [redacted] and was administered [redacted]. The resident should have received [redacted] two tablets for [redacted] as ordered by the physician.

- On [redacted] at 10:06 AM, the resident had complaints of [redacted] at a [redacted] of [redacted] and was administered [redacted]. The resident should have received [redacted] two tablets for [redacted] as ordered by the physician.

- On [redacted] at 4:00 PM, the resident had complaints of [redacted] at a [redacted] of [redacted] and was administered [redacted]. The resident should have received [redacted] two tablets for [redacted] as ordered by the physician.

On 5/1/25 at 11:41 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who stated that when a resident verbally complained of [redacted] that the nurse asked the resident what their [redacted] was according to numerical [redacted] scale ranging from [redacted] ([redacted] indicating [redacted] and [redacted] indicating [redacted]. The LPN stated that the numerical pain scale was [redacted]; 1-3 = [redacted]; 4-6 = [redacted]; and 7-[redacted] = [redacted]. At that time, the LPN reviewed Resident #381's physician's orders in the presence of the surveyor, and the LPN confirmed that [redacted] two tablets should be administered every eight hours for [redacted], and [redacted] should be administered every six hours for [redacted]. The LPN stated that if the resident had complained of [redacted], then the resident should have been

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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) COMPLETION DATE
F 697	Continued From page 51	F 697		

given the NJ Ex Order 26.4(b)(1) and if the resident complained of NJ Ex Order 26.4(b)(1) then the resident should have received NJ Ex Order 26.4(b)(1) . The LPN reviewed the MAR in the presence of the surveyor, and stated that when the resident complained of NJ Ex Order 26.4(b)(1), the resident should not have been administered the NJ Ex Order 26.4(b)(1) and should have received the NJ Ex Order 26.4 as ordered by the physician.

On 5/1/25 at 11:56 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that NJ Ex Ord medications should be administered as per the physician ordered NJ Ex Order 26.4(b)(1) parameters. The U.S. FOIA (b) (6) reviewed Resident #381's MAR and confirmed that the staff were not administering the NJ Ex Ord medications according to the physician's NJ Ex Ord parameters. The U.S. FOIA (b) (6) stated that the NJ Ex Order 26.4(b)(1) was only to be administered if the resident complained of NJ Ex Ord at a level of NJ Ex Order 2 not NJ Ex Ord which was NJ Ex Order 26.4(b)(1). the U.S. FOIA (b) (6) stated that it would be the same for the NJ Ex Order 26.4 and that it should only be given for NJ Ex Ord at NJ Ex Ord level of NJ Ex Ord or NJ Ex Order 26.4(b)(1) at a NJ Ex Ord level of NJ Ex O.

On 5/7/25 at 11:17 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who reviewed Resident #381's NJ Ex Order 26.4(b)(1) MAR in the presence of the surveyor and confirmed that the nurses were administering NJ Ex Ord medication out of the physician's ordered NJ Ex Ord level parameters.

A review of the facility's "Pain-Clinical Protocol" policy included that staff would use a standardized NJ Ex Ord assessment instrument appropriate for the resident's NJ Ex Order 26.4(b)(1). The staff and provider may identify the nature and

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F 697	Continued From page 52 NJ Ex Order 26.4(b) of NJ Ex Ord including characteristics NJ Ex Order 26.4(b)(1) , etc..).	F 697		

2. The surveyor reviewed the closed medical record for Resident #531.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(.

A review of the Minimum Data Set (MDS) list, a list of completed assessment tools, showed the resident had an entry MDS completed, and after a brief facility stay there was a discharge return not anticipated MDS completed. On the discharge MDS, Section NJ Ex Order 26.4(b)(1), was marked as "yes" that the resident was receiving a scheduled NJ Ex Ord medication regime.

A review of the Electronic Medical Record (EMR) revealed that Resident #531 arrived to the facility on NJ Ex Order 26.4(at 8:57 PM.

A review of the physician's orders reflected the following NJ Ex Ord medication orders on admission to the facility:

1. NJ Ex Order 26.4(b)(1) medication) NJ Ex Order 26.4(b)(1); give one tablet every three hours as needed for NJ Ex Order 26.4(b)(1) between NJ and NJ on a numeric NJ Ex Ord scale from 1 to 10) for five days. The order date was NJ Ex Order 26.4(.

2. NJ Ex Order 26.4(b)(1) tablet; give one tablet every three hours as needed for NJ Ex Order 26.4(b)(1)

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F 697	Continued From page 53 between [NJ] and [NJ Ex] on a numeric [NJ Ex Ord] scale from 1 to 10) for five days. The order date was [NJ Ex Order 26.4(b)(1)]. 3. NJ Ex Order 26.4(b)(1), a [NJ Ex Order 26.4(b)(1)] medication) [NJ Ex Order 26.4(b)(1)] tablet; give one tablet three times daily for [NJ Ex Order 26.4(b)(1)] (to be given around the clock). The order date was [NJ Ex Order 26.4(b)(1)]. 4. [NJ Ex Order 26.4(b)(1)] every six hours for [NJ Ex Order 26.4(b)(1)] between [NJ] and [NJ] on a numeric [NJ Ex Ord] scale from 1 to 10). A review of the Medication Administration Record (MAR) revealed that Resident #531 did not receive any [NJ Ex Order 26.4(b)(1)] during their stay at the facility. The [NJ Ex Order 26.4(b)(1)] orders were "pending confirmation". A further review of the MAR revealed that the [NJ Ex Order 26.4(b)(1)] was scheduled to be given at 8:00 AM, 12:00 PM, and 8:00 PM. The resident did not receive the [NJ Ex Order 26.4(b)(1)] the night of admission ([NJ Ex Order 26.4(b)(1)]) at 8:00 PM as scheduled. On [NJ Ex Order 26.4(b)(1)], the [NJ Ex Order 26.4(b)(1)] was not administered at 8:00 AM or 12:00 PM, and it was documented to "see progress notes." The surveyor reviewed the corresponding progress notes and there were no notes addressing the [NJ Ex Ord] medication. On [NJ Ex Order 26.4(b)(1)] at 8:00 PM, the medication was marked as not given and it was documented that the resident was sleeping. A review of the ICCP included a focus area for alteration in [NJ Ex Order 26.4(b)(1)] due to [NJ Ex Ord] evidenced by [NJ Ex Order 26.4(b)(1)] due to my diagnosis with [NJ Ex Order 26.4(b)(1)]. Interventions included to: adjust [NJ Ex Ord] medications as needed; administer [NJ Ex Order 26.4(b)(1)] as ordered; assess for continued need for [NJ Ex Order 26.4(b)(1)] and monitor effectiveness of [NJ Ex Ord]	F 697		

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F 697	Continued From page 54 medications and side effects. A review of the Physician Progress Note dated [NJ Ex Order 26.4(b)], included that per the resident, they are comfortable with [NJ Ex Order 26.4(b)(1)]. The physician's orders for [NJ Ex Order 26.4(b)] were discontinued as resident's [NJ Ex Ord] is [NJ Ex Order 26.4(b)(1)] at this time on current medications. On 5/6/25 at 1:35 PM, the surveyor interviewed LPN #2 regarding medication delivery, who stated that medications were delivered three times a day; morning, afternoon, and midnight. LPN #2 stated the facility did not have back-up medications, and "You just keep calling the pharmacy until you get it." The surveyor asked how a resident's [NJ Ex Ord] would be managed if the ordered medications were not available and she said, "We would just give them [NJ Ex Order 26.4(b)(1)] On 5/6/25 at 1:43 PM, the surveyor reviewed the resident's MAR for the time the resident was at the facility. The resident did not receive any [NJ Ex Ord] medications while waiting for the [NJ Ex Order 26.4(b)(1)] delivery, and their [NJ Ex Ord] level was documented as [NJ Ex Order] On 5/7/25 at 12:20 PM, during an interview with the [U.S. FOIA (b) (6)] regarding the delay in the [NJ Ex Ord] medications, the [U.S. FOIA (b) (6)] replied, "Same as the other resident." "We have requested a timeline from the pharmacy, but we have not received it." The surveyor was not provided any additional documentation from the facility. A review of the facility's undated "Delivery of Medications from Satellite (Back-Up) Pharmacy" policy included the purpose was to provide	F 697		

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F 697	Continued From page 55 medications in a timely manner by utilizing satellite (back-up) pharmacies to dispense medications that are needed by a facility sooner than the facility's regularly scheduled delivery...the facility may call the pharmacy and request a STAT (immediate) delivery, and the pharmacy had a 3-to-4-hour window to deliver a medication from their main location... NJAC 8:39-27.1(a)	F 697		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to administer ten doses of an NJ Ex Order 26.4(b)(1) medication (NJ Ex Order 26.4(b)(1) prescribed for NJ Ex Order 26.4(b) according to physician's orders. This deficient practice was identified for 1 of 35 residents reviewed for quality of care (Resident #47), and was evidenced by the following: On 4/29/25 at 11:324 AM, during initial tour of the facility, the surveyor observed Resident #47 lying in their bed with the bed NJ Ex Order 26.4(b)(1) with a NJ Ex [redacted] located at the side. On 4/30/25 at 10:49 AM, the surveyor reviewed the medical record for Resident #47. A review of the Admission Record face sheet (an admission summary) reflected that the resident	F 760	Resident #47 did not have NJ Ex Order 26.4(b)(1) [redacted]. Medication error form was completed with the nurses. All residents with anti-convalescent medications have the potential to be affected. An audit of all residents currently on anti-convalescent medications was conducted. Reeducation on the importance of adhering to medications to all nursing staff completed. A weekly audit of residents on anti-convalescent medications will be conducted by DIRECTOR OF NURSING/designee. Director of Nursing/designee will coordinate the	6/6/25

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F 760	Continued From page 56 was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)). A review of the most recent significant change Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, reflected the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated NJ Ex Order 26.4(b)(1) . A further review included the resident had an active diagnosis of NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1). A review of the Order Summary Report included a physician's order (PO) dated NJ Ex Order 26.4(b), for NJ Ex Order 26.4(b)(1)); administer one tablet by mouth one time a day for NJ Ex Order 26.4(b) A further review revealed a PO dated NJ Ex Order 26.4(b), for NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) oral tablet NJ Ex Order 26.4(b) administer one tablet by mouth two times a day for NJ Ex Order 26.4(b) A review of the individualized comprehensive care plan (ICCP) included a focus area date initiated on NJ Ex Order 26.4(b), that the resident has a NJ Ex Order 26.4 . Interventions included but were not limited to; give NJ Ex Order 26.4(medication as ordered by the doctor, NJ Ex Order 26.4(documentation, and NJ Ex Order 26.4(precautions. On 4/30/25 at 1:06 PM, the surveyor reviewed the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Medication Administration Records (MAR) which revealed the NJ Ex Order 26.4(b)(1) was not	F 760	results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING/designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 760	Continued From page 57	F 760		

administered on the following dates: NJ Ex Order 26.4(, NJ Ex Order 26.4(b), NJ Ex Order 26.4(, NJ Ex Order 26.4(, NJ Ex Order 26.4(, NJ Ex Order 26, NJ Ex Order 26, NJ Ex Order 26, NJ Ex Order 26, NJ Ex Order 26, and NJ Ex Order 26. A further review of the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) MAR revealed Resident #47 received the NJ Ex Order 26.4(b)(1) tablet by mouth two times a day for NJ Ex Order 26.4(as ordered by the physician.

On 5/1/25 at 12:23 PM, the surveyor reviewed the Progress Notes in the electronic medical record (eMR) which revealed the resident did not have any NJ Ex Order 26.4(activity during NJ Ex Order 26.4(b)(1) or NJ Ex Orde .

On 5/6/25 at 12:54 PM, the surveyor interviewed the Registered Nurse (RN #1), who stated medications were delivered three times a day. RN #1 further stated that the process when a medication was not delivered was to call the pharmacy, call the U.S. FOIA (b) (6)), complete a progress note and endorses it to the next shift. RN #1 acknowledged that the NJ Ex Order 26.4(b)(1) was not administered as ordered. RN #1 also confirmed that the resident did not have NJ Ex Order 26.4(b)(1) during that time.

On 5/6/25 at 1:00 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who stated medications delivery times vary but if a medication did not come in, the nurse should call the pharmacy to request it immediately (STAT). LPN #1 acknowledged that the resident did not receive the NJ Ex Order 26.4(b)(1) as ordered on NJ Ex Order 26.4(b)(LPN #1 further stated that the resident had not had NJ Ex Order 26.4(b)(1) during that time.

On 5/6/25 at 2:35 PM, the U.S. FOIA (b) in the presence of the U.S. FOIA (b) (6) U.S. FOIA (b) (6), and the survey team,

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F 760	Continued From page 58 acknowledged that the NJ Ex Order 26.4(b)(1) was not administered as ordered. On 5/7/25 at 11:12 AM, the U.S. FOIA (b) (6) in the presence of the U.S. FOIA (b) (6) and survey team, could not provided any additional information. A review of the facility's "Orders and Transcription" policy undated, included 1. The nurse receiving the order must add it into [the electronic medical system] orders as a verbal order or telephone order. A review of the facility's "Delivery of Medications from Satellite (Back-Up) Pharmacy", revised 9/6/19, included Purpose: To provide medications in a timely manner by utilizing satellite (back-up) pharmacies to dispense medications that are needed by a facility sooner than the facility's regularly scheduled delivery ...1. The facility may call the pharmacy and request STAT delivery. Specialty Rx (prescription) has a 3-4-hour window to deliver a medication as a STAT from our main location.	F 760		
F 761 SS=D	NJAC 8:39-27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		6/6/25

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F 761	Continued From page 59 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) store all drugs and biologicals in locked compartments and b.) properly store medications and maintain clean and sanitary medication storage areas. This deficient practice was identified in 1 of 1 observed treatment cart and 2 of 6 observed medication carts, and was evidenced by the following: 1. On 4/30/25 at 12:12 PM, the surveyor observed a [redacted] treatment cart on the Second-floor nursing unit by the nurse's station in front of the elevators which was unattended and left unlocked. The surveyor remained near the treatment cart and observed two nursing staff members walk past the treatment cart and did not acknowledge or identify that the treatment cart was unsecured.	F 761	No residents had any adverse effects. All residents on the 2nd Floor has the potential to be affected. All medication carts were cleaned to ensure that there are no loose pills at the bottom of the drawers. Nurse on duty for Cart was educated to ensure that the treatment cart is locked when unattended. Director of Nursing or Designee educated the nurses on ensuring the med carts are cleaned routinely and making sure that the carts are locked when unattended. Director of Housekeeping reviewed the schedule of Medication cart deep cleaning, education was provide to the housekeeping staff about the appropriate process.	

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F 761	Continued From page 60 On 4/30/25 at 12:29 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that treatment carts contained medications and should be treated as medication carts and should always be locked when unattended by the nurse. At that time, the surveyor asked the U.S. FOIA (b) (6) if the treatment cart was unsecured, and the U.S. FOIA (b) (6) acknowledged that the treatment cart was left unattended and unlocked and that it should have been locked since it contained medications used for wound treatments and other medications. On 5/1/25 at 12:51 PM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that treatment carts should be treated as medication carts as they contained medications. The U.S. FOIA (b) further confirmed that treatment and medication carts should remain locked and secure when not attended to ensure residents cannot gain access to medications and potentially sharp objects that were stored in treatment carts. A review of the facility's undated "Storage of Medications" policy included compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if opened or otherwise potentially available to others... 2. On 5/1/25 at 11:30 AM, the surveyor, in the presence of the U.S. FOIA (b) inspected the "2B" nursing unit's medication cart labeled "2BC." The surveyor observed 17 unidentifiable loose medication pills of various shapes, colors, and	F 761	A weekly audit of Medication carts will be conducted by DIRECTOR OF NURSING/designee. Director of Nursing/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. DIRECTOR OF NURSING/designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate	

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F 761	Continued From page 61 sizes. At that time, the LPN confirmed that there should be no loose pills in the medication cart drawers, and all medications should be contained in the packaging as received from the pharmacy. On 5/1/25 at 12:17 PM, the surveyor, in the presence of the U.S. FOIA (b) (6)), inspected the "2B" nursing unit's medication cart labeled "2B." The surveyor observed 11 unidentifiable loose medication pills of various shapes, colors, and sizes. At that time, the U.S. FO confirmed that there should be no loose pills in the medication cart drawers, and all medications should be contained in the packaging as received from the pharmacy. On 5/1/25 at 12:42 PM, the surveyor interviewed the U.S. FOIA (b) (6), who confirmed that all medications in the medication carts should be kept in the pharmacy packaging and there should be no loose pills in the medication cart drawers. On 5/1/25 at 12:51 PM, the surveyor interviewed the U.S. FOIA (b, who stated that all nurses assigned to each medication cart were responsible to ensure the organization and cleanliness of the medication cart and that all medications should be stored in the pharmacy packaging and there should be no loose pills in the drawers. A review of the facility's undated "Storage of Medications" policy included drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received... NJAC 8:39-29.4(h)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		6/6/25

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F 812	Continued From page 62 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) maintain kitchen equipment in a clean and sanitary manner and b,) maintain 2 of 6 nourishment room refrigerators in a sanitary manner. The evidence was as follows: On 4/29/25 at 10:20 AM, in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) , the surveyor observed the following during kitchen tour: 1. The steamer unit floor drain was filled with debris and sediment. The U.S. FOIA acknowledge it was not properly cleaned according to facility	F 812	No resident sustained any adverse effects. All Kitchen equipment was cleaned on 04/29/2025 including the steamer, two convection ovens, floor trap screen, and the six burner stove top and oven. All residents who have food from the kitchen have the potential to be affected. Food Service Director, Dietician or designee educated the kitchen staff to ensure that cleaning schedules are followed. Food Services Director or designee will	

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	315279	A. BUILDING _____ B. WING _____	C 05/12/2025

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F 812	Continued From page 63 policy. 2. Two convection ovens were soiled with baked on brown coloring on the glass doors and interior of the unit. The [U.S. FOIA] acknowledged and stated, it was not cleaned according to facility policy. 3. Two steamer units were drained into a floor trap and the trap screen had debris covering it. The [U.S. FOIA] acknowledged and stated, it was not cleaned according to facility policy. 4. The six-burner stove top and oven were covered with cooked on grease and sediment crusted around the burners. The oven had food sediment and debris on the interior and the interior door. The catch tray that was lined with foil had burnt liquid, and food debris covering the entire tray and foil. The [U.S. FOIA] acknowledged and stated, it was not cleaned according to facility policy. On 5/6/25 at 1:31 PM, in the presence of the [U.S. FOIA (B)] the surveyor observed the nourishment rooms as evidence with the following ... 5. Both Unit 3A and 3B nourishment room refrigerators for resident use on the unit were observed to have discoloration and debris in the gaskets of the refrigerator door and freezer door. The [U.S. FOIA] acknowledged and stated it was not cleaned according to facility policy, and it was his departments responsibility to maintain or report any issues in the nourishment rooms. 6. In the 3A (locked unit) nourishment room microwaves had crusted brown colored debris stuck to the roof of the microwave. The [U.S. FOIA] acknowledged and stated, it was not cleaned	F 812	complete weekly kitchen sanitation audits. Food Service Director/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. Food Service Director /designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 812	Continued From page 64 according to facility policy, and it was his departments responsibility to maintain or report any issues in the nourishment rooms. 7. In all six nourishment rooms did not have properly documented temperatures for the freezer. The surveyor observed the temperatures to be in the correct range. The [U.S. FOIA] acknowledged the logs his staff were documenting on only had a date column, AM temp column, and PM temp column for only the refrigerator. On 5/6/25 at 1:36 PM, the surveyor interviewed the [U.S. FOIA (b)] who stated that he acknowledged that the equipment should have been cleaned and maintained in a sanitized way to prevent food borne illness and contamination for safety of our residents and staff. On 5/6/25 at 12:45 PM, the survey team met with the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)], who both acknowledged the surveyor's concerns. No additional information was provided. A review of the facility's undated, "Sanitation policy" included food service area shall be maintained in a clean and sanitary manner...all kitchens and kitchen area, shall be kept clean ...to protect from rodents, roaches, flies and other insects... A review of the facility's undated "Resident Rights handout" included the facility must provide a safe, clean, comfortable, homelike environment, allowing you the opportunity to use your personal belongings to the extent possible...	F 812		

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F 812	Continued From page 65 NJAC 8:39-17.2(g)	F 812		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #NJ182121 Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility's U.S. FOIA (b) (6) failed to ensure staff, as well as himself, implemented the facility's NJ Ex Order 26 policies and procedures to ensure resident safety and well-being by a.) protecting all residents from an NJ Ex Order 26.4(b)(1) pending a thorough investigation for an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1); b.) thoroughly investigating an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1); and c.) reporting an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) to the New Jersey Department of Health (NJDOH). This deficient practice was identified for 1 of 1 residents reviewed for NJ Ex Order 26 (Resident #381). Resident #381, a cognitively intact resident who had diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)), reported to the Registered Nurse (RN #1) an NJ Ex Order 26.4(b)(1) of	F 835	Resident #381 did not experience NJ Ex Or and specifically stated to the NJ Ex Order 26.4(b)(1) that NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(following the incident. NJ Ex Orc chose to remain at the facility until NJ Ex Order 26.4(b)(1), before being discharged to NJ Ex Order 26.4(b)(1). All residents who had an allegation of abuse had the potential to be affected. U.S. FOIA (b) (6) was educated by the Regional Administrator on the facility policies and reviewed Abuse Policy and procedure that include the seven components, Screening, Training, prevention, identification, investigation, protection and reporting and response. Administrator was terminated on 5/12/2025 and a new administrator of record was hired and started on 5/12/2025. On 5/12/2025 the Regional Administrator oriented the new administrator of record to his job description.	6/6/25

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F 835	Continued From page 66 NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1). RN #1 documented in a progress note that the resident reported they were 'NJ Ex Order 26.4 of staff and the facility, and RN #1 endorsed it to the Registered Nurse Supervisor (RNS #1) to follow-up. The NJ Ex Order 26.4(b)(1) was not investigated, the identified NJ Ex Order 26.4(b)(1) was not suspended pending a thorough investigation, and was not reported to the NJDOH per the facility's NJ Ex Order 26 policies. The facility's failure to ensure all staff, including the U.S. FOIA (b) (6 implemented their facility policies to ensure all residents were free from NJ Ex Order 26 by not NJ Ex Order 26.4(b)(1) residents from NJ Ex Order 26.4 not investigating or reporting an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) posed the likelihood of serious NJ Ex Order 26.4(b)(1). This resulted in an Immediate Jeopardy (IJ) situation. The IJ began 12/28/24 at 9:16 AM, after Resident #381 made the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) to RN #1. The facility was notified of the IJ on 5/6/25 at 3:45 PM. The facility submitted an acceptable Removal Plan (RP) on 5/7/25 at 3:08 PM. The survey team verified the implementation of the RP on-site during the continuation of the survey on 5/7/25 at 3:40 PM. The evidence was as follows: Refer to F 600, F 609, F 610. A review of the job description "Administrator" provided by the facility revealed the following: Position Summary: Direct day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long term care facilities to	F 835	The regional Administrator and/or designee will meet weekly with the new Administrator of Record weekly x 4 weeks and then monthly x 6 months to assure that processes and procedures are compliant with company policy. Administrator/designee will coordinate the results of the weekly audit and review the findings with the QUALITY ASSURANCE Committee weekly for 4 weeks then monthly for 2 more months. Administrator/designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	

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F 835	Continued From page 67 assure that the highest degree of quality of care can be always provided to residents. -Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities. -Develop and maintain written policies and procedures that govern the operation of the facility. -Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed. -Ensure that the resident rights to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights, including wage complaints are well established and always maintained. -Serve on various committees of the facility (i.e., Infection Control, Quality Assurance and Assessment, ect) and provide written/oral reports of such committee meetings to the governing board as directed. -Ensure that each resident receives the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan. -Maintains a liaison with the residents, their families, support personnel, ect., to assure that the residents' needs are continually met. A review of the facility's "Abuse" policy dated 4/9/24, included that abuse and neglect exist in many forms and to varying degrees. Abuse includes verbal, sexual, physical, mental, involuntary seclusion, exploitation, misappropriation, mistreatment, neglect, intimidation and injury of unknown origin. The objective of the abuse policy is to comply with a seven-step approach to abuse and neglect	F 835		

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F 835	Continued From page 68 detection and prevention...The seven steps include: 1.) Screening and verification of references, certification and verification of license and a criminal background check. 2.) Training of staff through orientation and on-going abuse and prohibition practices. 3.) Prevention: the facility is to prevent abuse by providing residents, family and staff with education on how and to whom to report concerns, incidences and grievances. 4.) Identification: All staff were to monitor residents and would know how to identify potential signs and symptoms of abuse. Occurrences, patterns and trends that may constitute abuse would be investigated. 5.) Investigation is the process used to try to determine what happened and the designated personnel would begin the investigation immediately and a root cause analysis would be completed. When an incident or suspected incident of abuse is reported, the Administrator or designee would investigate the incident with the assistance of appropriate personal to include who was involved, resident statement, roommate statements, involved staff and witness statements, a description of the residents behavior and environment at the time of the incident, any injuries and a resident assessment, and interview other residents who were cared for by the accused. All staff must cooperate during the investigation to assure the resident is fully protected. 6.) Protection procedure would include immediately upon receiving a report of alleged abuse, the Administrator or designee would deliver appropriate medical and psychological care and attention, ensuring safety and wellbeing of vulnerable individuals. The alleged perpetrator would be immediately removed, and the resident would be protected. 7.) Reporting: the facility would ensure that all alleged violations involving	F 835		

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F 835	Continued From page 69 abuse, neglect, exploitation or mistreatment including injuries of unknown origin would be reported immediately to Administrator and state agencies to include the New Jersey Department of Health [NJDOH] and Ombudsman. The surveyor reviewed the closed medical record for Resident #381. A review of a Progress Note (PN) dated [NJ Ex Order 26.4(b)(1)] at 9:16 AM, revealed that Resident #381 was awake, [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] to make their [NJ Ex Order 26.4(b)(1)]. Resident #381 reported to RN #1 that they were '[NJ Ex Order 26.4(b)(1)] of staff and the facility due to an incident that had occurred [NJ Ex Order 26.4(b)(1)] prior [NJ Ex Order 26.4(b)(1)]. The resident reported that a Certified Nursing Assistant (CNA #1) roughly [NJ Ex Order 26.4(b)(1)] the resident causing the resident's [NJ Ex Order 26.4(b)(1)] [redacted] to have [NJ Ex Order 26.4(b)(1)]. RN #1 documented that Resident #381 had a [NJ Ex Order 26.4(b)(1)] around the [NJ Ex Order 26.4(b)(1)] and that she administered the resident's prescribed [NJ Ex Order 26.4(b)(1)] medication. The resident reported some relief from the [NJ Ex Order 26.4(b)(1)] medication. RN #1 made RNS #1 aware of the resident's complaints and endorsed the resident's care and further follow-up to RNS #1 because RN #1 was being sent home early. On 5/1/25 at 9:16 AM, the surveyor conducted a telephone interview with RN #1, who had documented the [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4(b)(1)] for Resident #381 on [NJ Ex Order 26.4(b)(1)] at 9:16 AM. RN #1 identified herself as [NJ Ex Order 26.4b1], and stated that on [NJ Ex Order 26.4(b)(1)], Resident #381 reported that they were [NJ Ex Order 26.4(b)(1)] by a CNA a [NJ Ex Order 26.4(b)(1)] [redacted], during the 3:00 PM to 11:00 PM (3-11) shift around 9:00 PM. RN #1 stated that the resident requested to have their [NJ Ex Order 26.4(b)(1)]	F 835		

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NJ Ex Order 26.4(b)(1), and the CNA, without introducing herself and without explaining what she was going to do, NJ Ex Order 26 the resident NJ Ex Order 26.4(b)(1) that the resident NJ Ex Order 26.4(b)(1) . RN #1 stated that the resident used the word " NJ Ex Order 26.4(b)(1) when describing how it happened. RN #1 stated that the resident had complained of NJ Ex Order 26.4(b)(1) in the NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1) . RN #1 explained that she had administered the resident an as needed [prn] NJ Ex Ord medication at that time. RN #1 stated that she was going to call the physician to notify and to get a NJ Ex Order 26.4(b)(1), however she was told by RNS #1 that she was being sent home. RN #1 stated that she had reported the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 to RNS #1, and RNS #1 told RN #1 that she would follow-up with the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4 RN #1 stated that Resident #381 provided her with the name of the NJ Ex Order 26.4 CNA (CNA #1), as well as the first names of the staff members the resident had notified about the NJ Ex Order 26.4(b)(1) . RN #1 identified the staff as the U.S. FOIA (b and the U.S. FOIA (b) (6)) who still worked at the facility.

On 5/1/25 at 9:51 AM, the surveyor interviewed the U.S. FOI who stated that he worked in Central Supply in NJ Ex Order 26.4(b)(1) and did not remember any resident reporting an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 to him. The U.S. FO stated that he would have taken the NJ Ex Order 26.4(b)(1) very seriously and would have reported it to the administration because it would have required a full investigation. The U.S. FO identified the NJ Ex Order 26.4(CNA reported to RN #1 by Resident #381 as CNA #1.

On 5/1/25 at 9:59 AM, the surveyor conducted a telephone interview with RNS #1, who confirmed that she had worked the weekend of NJ Ex Order 26.4(b)(1)

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when the resident reported an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4 RNS #1 stated that she did not remember the event occurring or being told about the resident's complaints of NJ Ex Order 26.4(b)(1). RNS #1 stated that if the NJ Ex Order 26.4(b)(1) was reported to her, then she would have reported it to the administration and an investigation would have started. RNS #1 then instructed the surveyor to ask the U.S. FOIA (b) for more information.

On 5/1/25 at 11:01 AM, the surveyor interviewed the U.S. FOIA (b) who stated that she was in constant communication with Resident #381 when the resident was in the facility and did not remember the resident or any nurse informing her that a CNA was NJ Ex Order 26.4(b)(1) with Resident #381. At that time, the U.S. FOIA (b) reviewed the PN dated NJ Ex Order 26.4(b)(1) at 9:16 AM, and confirmed that an NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) was documented and it should have been reported to the administration and have been immediately investigated. The U.S. FOIA (b) stated that the NJ Ex Order 26.4(b)(1) should have been reported to the NJDOH.

On 5/1/25 at 11:09 AM, the surveyor interviewed the U.S. FOIA (b) (6) in the presence of the U.S. FOIA (b) who stated when doing Resident #381's admission assessment, she remembered reading the documentation regarding the resident's NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4 and remembered that it was discussed at clinical morning meeting. The U.S. FOIA (b) (6) did not remember who was there, but remembered there was enough management there to know that it needed to be followed-up with.

On 5/5/25 at 11:38 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the nurse that cared for Resident #381 on NJ Ex Order 26.4(b)(1), did not report any

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incident related to [NJ Ex Order 26] to the administration. The [U.S. FOIA (b)] stated that he reviewed the documentation minutes of the clinical morning meeting dated [NJ Ex Order 26.4(b)(1)], and there were no minutes pertaining to any resident [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)] stated that the allegation of abuse should have been reported by the [U.S. FOIA (b) (6)] who read the PN dated [NJ Ex Order 26.4(b)(1)], regarding the resident's [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26] during Resident #381's admission assessment with the assessment reference date (ARD) of [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)] stated the nurse should have reported it to the [U.S. FOIA (b)] immediately. The [U.S. FOIA (b)] continued to explain that the [U.S. FOIA (b) (6)] came into see Resident #381 on [NJ Ex Order 26], and the resident did not report [NJ Ex Order 26] and did not express any [NJ Ex Order 26] concerning their stay at the facility. The [U.S. FOIA (b)] stated that he immediately started an investigation when he became aware of the [NJ Ex Order 26.4(b)(1)] and reported the incident to the NJDOH on 5/1/25 at 11:16 AM.

On 5/6/25 at 11:20 AM, the surveyor interviewed the [U.S. FOIA (b)] who stated that the [U.S. FOIA (b) (6)] who read the note during the resident's assessment period, should have reported the [NJ Ex Order 26.4(b)(1)] to administration after reading the [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26] in the progress notes. The [U.S. FOIA (b)] stated that based on the timesheets, CNA #2 worked the 3-11 shift on [NJ Ex Order 26.4(b)(1)], NJ Ex Order 26.4(b)(1)) and cared for the resident. The [U.S. FOIA (b)] reported that CNA #2 had not worked at the facility since [NJ Ex Order 26.4(b)] of [NJ Ex Order 26] At that time, the surveyor informed the [U.S. FOIA (b)] that RN #1 identified the [NJ Ex Order 26.4(b)] CNA as CNA #1, and the [U.S. FOIA (b)] was unsure of who that CNA was.

A review of CNA #1's "Timecard Report" revealed that CNA #1 was working in the facility at the time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE EDISON, NJ 08817**

(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
F 835	Continued From page 73 of the [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] during the 3-11 shift). On 5/7/25 at 11:17 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated that CNA #1 was suspended on [NJ Ex Order 26.4(b)] pending outcome of the completed investigation and he had attempted to call RN #1, but received no answer. The [U.S. FOIA (b) (6)] alleged that he interviewed Resident #381 via telephone (no longer a resident in the facility) and the resident did not state that they were [NJ Ex Order 26.4(b)] during stay and [NJ Ex Order 26.4(b)] when they resided in the facility. The [U.S. FOIA (b) (6)] acknowledged that he was responsible to ensure [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4(b)] were reported and fully investigated. The [U.S. FOIA (b) (6)] stated he was responsible to oversee this process and that it was done in accordance with the facility's [NJ Ex Order 26.4(b)] policy. An acceptable Removal Plan was received on 5/7/25 at 3:08 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: the U.S. FOIA (b) (6) educated the [U.S. FOIA (b) (6)] regarding role and responsibilities of the administrator and on the facility's abuse policy which included screening, training, prevention, identification, investigation, protection, reporting and response. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey and determined the IJ for F 835 was removed on 5/7/25 at 3:40 PM. NJAC 8:39-9.2(a) NJAC 8:39-9.3(a) NJAC 8:39-27.1(a)	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE EDISON, NJ 08817**

(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
F 921	Continued From page 74	F 921		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documents, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment for residents. This deficient practice was identified for 4 of 5 observed resident pantry rooms as evidence by the following: On 5/6/25 at 1:00 PM, the surveyor toured the 1st floor Subacute unit pantry room in the presence of the U.S. FOIA (b) (6)). The surveyor observed the following: the counter around the sink and backsplash had black discoloration. The caulking was peeling and blackened along the edge of the sink, behind the sink, and around the faucet. On 5/6/25 at 1:11 PM, the surveyor toured the 2nd floor, 2A, and Chinese unit pantry room, in the presence of the U.S. FOIA (b The surveyor observed the following: the counter around the sink and backsplash had black discoloration and caulking was peeling and blackened along the edge of the sink, behind the sink, and around the faucet, and worn-down laminate countertops exposing the wood type surface under the laminate. On 5/6/25 at 1:23 PM, the surveyor toured the 3rd floor 3B unit, pantry in the presence of the U.S. FOIA (b The surveyor observed the following: the counter	F 921	No residents had any adverse effects. All residents have the potential to be affected. Administrator educated the U.S. FOIA (b) (6) on ensuring a safe/functional/sanitary/ comfortable environment. All countertops and pantries were addressed and fixed. Maintenance director or designee will complete weekly environmental audits to ensure this practice is not present. FSD/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QUALITY ASSURANCE Committee for 4 weeks then monthly for 2 more months. FSD/designee will provide a report of findings to the QUALITY ASSURANCE committee for action as appropriate.	6/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE EDISON, NJ 08817**

(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
F 921	Continued From page 75 around the sink and backsplash had black discoloration and caulking was peeling and blackened along the edge of the sink, behind the sink, and around the faucet. On 5/6/25 at 1:36 PM, the surveyor toured the 3rd floor 3A Indian unit pantry room in the presence of the [redacted] The surveyor observed the following: the counter around the sink and backsplash had black discoloration and caulking was peeling and blackened along the edge of the sink, behind the sink, and around the faucet. On 5/6/25 at 1:07 PM, the surveyor interviewed [redacted], who stated it was the nurse's responsibility to enter in electronic requisition system if they are told about an issue or notice an issue themselves. On 5/6/25 at 1:10 PM, the surveyor interviewed the[redacted]), who stated, "my staff and myself audit and make rounds daily to the pantry rooms". The [redacted] proceeded to say that his expectations of his staff were to report any issues noted during the audit directly to him. If other staff identify a concern, they should be putting it into the electronic system to generate a ticket requisition. The [redacted] confirmed he did not see any issues in the pantries, and there were not any request tickets for pantry room repairs. The [redacted] further stated the issue was not verbalized either. On 5/6/25 at 1:27 PM, the surveyor interviewed the [redacted] who stated the staff were required to report any issues on the unit verbally to the unit manager and enter a requisition in the facility's electronic maintenance program. The [redacted] further stated she had not entered a ticket for the black	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE EDISON, NJ 08817**

(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
F 921	Continued From page 76 discoloration in the pantry. On 5/6/25 at 1:54 PM, the surveyor interviewed the U.S. FOIA (b) (6) U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), who explained that the facility had an electronic request system in place that was monitored by maintenance staff. The surveyor confirmed that all staff have access to the electronic maintenance reporting system. They acknowledged the concerns of the surveyor and pictures visually provided. They had nothing further to provide the survey team regarding their concerns. A review of the facility's undated "Homelike Environment" policy included the residents are provided with a safe, clean, comfortable and homelike environment...clean, sanitary, and orderly environment... NJAC 8:39 -31.2(e)	F 921		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061205	A. BUILDING: _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND	10 BRUNSWICK AVENUE EDISON, NJ 08817

(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
S 000	Initial Comments THE FACILITY WAS 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for staffing for 14 of 49 days shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	All residents are potentially affected by this practice. Rates increased. Sign on with new agencies. Offer agency staff bonuses. Offer our staff bonuses. New retention and recruitment plan. Job Fair. Posting new ads around town and via social media.	6/6/25

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

Electronically Signed | 05/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061205	A. BUILDING: _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND	10 BRUNSWICK AVENUE EDISON, NJ 08817

(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
S 560	Continued From page 1 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 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. 1. For the week of Complaint staffing from 9/3/23 to 9/9/23, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -9/3/23 had 23 CNAs for 232 residents on the day shift, required at least 29 CNAs. -9/4/23 had 28 CNAs for 232 residents on the day shift, required at least 29 CNAs. -9/5/23 had 25 CNAs for 230 residents on the day shift, required at least 29 CNAs. -9/6/23 had 28 CNAs for 230 residents on the day shift, required at least 29 CNAs. 2. For the week of Complaint staffing from 5/12/24 to 5/18/24, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as	S 560	Referral bonuses for our staff. Referral bonuses for community. Sign on bonus. Utilizing nursing assistants. The Director of Nursing to have weekly meetings with staffing coordinator to determine upcoming schedules to anticipate needs. The DIRECTOR OF NURSING/designee will report findings to the administrator. The DIRECTOR OF NURSING/designee will aggregate findings from these rounds monthly and review the findings with the administrator quarterly on an ongoing basis the DIRECTOR OF NURSING/designee will provide a report of his/her findings to the QUALITY ASSURANCE committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061205	A. BUILDING: _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND	10 BRUNSWICK AVENUE EDISON, NJ 08817

(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
S 560	Continued From page 2 follows: -5/12/24 had 24 CNAs for 223 residents on the day shift, required at least 28 CNAs. 3. For the week of Complaint staffing from 6/30/24 to 7/6/24, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -7/1/24 had 26 CNAs for 225 residents on the day shift, required at least 28 CNAs. -7/5/24 had 27 CNAs for 227 residents on the day shift, required at least 28 CNAs. 4. For the week of Complaint staffing from 12/31/24 to 1/6/25, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -1/1/25 had 25 CNAs for 226 residents on the day shift, required at least 28 CNAs. -1/3/25 had 24 CNAs for 223 residents on the day shift, required at least 28 CNAs. -1/4/25 had 27 CNAs for 223 residents on the day shift, required at least 28 CNAs. -1/6/25 had 27 CNAs for 223 residents on the day shift, required at least 28 CNAs. 5. For the week of Complaint staffing from 2/9/25 to 2/15/25, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts and deficient in total staff for residents on 1 of 7 evening shifts as follows: -2/9/25 had 27 CNAs for 226 residents on the day shift, required at least 28 CNAs. -2/12/25 had 21 total staff for 224 residents on the evening shift, required at least 22 total staff.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061205	A. BUILDING: _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND	10 BRUNSWICK AVENUE EDISON, NJ 08817

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S 560	Continued From page 3 6. For the two weeks of staffing prior to survey from 4/13/25 to 4/26/25, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -4/13/25 had 23 CNAs for 232 residents on the day shift, required at least 29 CNAs. -4/20/25 had 24 CNAs for 232 residents on the day shift, required at least 29 CNAs. On 5/1/25 at 10:15 AM, the surveyor interviewed the Staffing Coordinator (SC), who was able to recite the state regulations and stated the schedule changed day to day. The SC stated that between the fifth and the 10th of every month, he began working on the next schedule, and if the schedule was short for CNAs, he called the supervisor's phone and got the "overtime books." The SC stated if no one picked it up, they reached out to Agency staff. When asked if the facility met the state regulations, he responded "Absolutely." A review of the facility's undated "Staffing" policy included that the facility provides adequate and competent staffing to meet needed care and services for our resident population...2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the residents comprehensive care plan...	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315279 Y1	A. Building B. Wing Y2	6/25/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	10 BRUNSWICK AVENUE EDISON, NJ 08817

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0550	Correction	ID Prefix F0578	Correction	ID Prefix F0600	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.12(a)(1)	Completed
LSC	06/06/2025	LSC	06/06/2025	LSC	06/06/2025
ID Prefix F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0656	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	06/06/2025	LSC	06/06/2025	LSC	06/06/2025
ID Prefix F0686	Correction	ID Prefix F0697	Correction	ID Prefix F0760	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(k)	Completed	Reg. # 483.45(f)(2)	Completed
LSC	06/06/2025	LSC	06/06/2025	LSC	06/06/2025
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0835	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70	Completed
LSC	06/06/2025	LSC	06/06/2025	LSC	06/06/2025
ID Prefix F0921	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/06/2025	LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON 5/12/2025

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061205 Y1	A. Building B. Wing Y2	6/25/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	10 BRUNSWICK AVENUE EDISON, NJ 08817

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/06/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/12/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING **01** B. WING _____	**05/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE** **EDISON, NJ 08817**

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/8/25, 5/9/25 and 5/12/25 and Embassy Manor at Edison Nursing and Rehab was found not to be in compliance with 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. Embassy Manor at Edison Nursing and Rehabilitation is a three-story building constructed in 1962. Residents are on all three floors with a behavior/dementia unit on the third floor. The facility has concrete flooring, concrete steel frame roofing and block bearing walls and brick facade exterior. Embassy Manor is noted to be a Type II (111) noncombustible construction. There is a complete fire sprinkler system and smoke detection in all corridors with battery operated smoke alarms in all resident rooms. The facility has a 113 KW (kilowatt) exterior diesel generator. The facility has 15 smoke zones. The facility has 225 occupied beds.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General	K 211		6/6/25

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

Electronically Signed | 05/29/2025

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING 01 B. WING _____	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	10 BRUNSWICK AVENUE EDISON, NJ 08817

(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
K 211	Continued From page 1 Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/8/25 in the presence of the Administrator, the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined the facility failed to ensure means of egress was continuously maintained free of all obstructions to full use in case of emergency in accordance with NFPA 101: 2012 Edition, Section 19.2 and 7.1.10.1. This deficient practice had the potential to affect 73 of 225 residents and was evidenced by the following: An observation at 12:20 PM of stairwell 5 ground level exterior exit door revealed the door was excessively hard to open. In an interview at the time, the U.S. FOI confirmed the observation. The facility's U.S. FOIA (b and the U.S. FOI were informed of the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The U.S. FOIA (b) (6) was unavailable for the exit conference.	K 211	The ground level exterior exit door by stairwell 5 was immediately lubricated so that the door opens as intended. 73 residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure means of egress are kept free from all obstructions. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter.	
K 222 SS=F	N.J.A.C. 8:39-31.2 (e) Egress Doors CFR(s): NFPA 101	K 222		6/6/25

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	315279	A. BUILDING **01** B. WING _____	**05/12/2025**

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EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE** **EDISON, NJ 08817**

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K 222	Continued From page 2 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected	K 222		

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K 222	Continued From page 3 throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/12/25 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to ensure doors in a required means of egress were not equipped with a lock or latch in accordance with NFPA 101: 2012 Edition, Section 7.2.1, 7.2.1.5.3, 7.2.1.6.1 and 19.2.2.2.4. This deficient practice had the potential to affect all 225 residents and was evidenced by the following: An observation at 11:48 AM of the front main entrance/exit revealed the automatic sliding double doors with instructional signs on each door that stated 'IN EMERGENCY PUSH TO OPEN" were equipped with a thumb latch lock in the path of egress to exit the building.	K 222	The handle on the thumb latch lock, located on the front main entrance/exit of the facility, was removed and the lock was disabled. All residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure egress doors are able to be opened without requiring use of a tool or key. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months	

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K 222	Continued From page 4 In an interview at the time, the [U.S. FOI] confirmed the observation. The facility's [U.S. FOIA (b)] and the [U.S. FOI] were informed of the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The [U.S. FOIA (b) (6)] was unavailable for the exit conference.	K 222	and on an as needed basis thereafter.	
K 271 SS=E	N.J.A.C. 8:39-31.2 (e) Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/8/25 in the presence of the Administrator, the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)], it was determined the facility failed to maintain a stable, level walking surface at exit discharge for 1 of 8 exterior exits in accordance with NFPA 101: 2012 Edition, Section 7.7, 7.1.6.2, 7.1.10.1 and 19.2.7. This deficient practice had the potential to affect 31 of 225 residents and was evidenced by the following: An observation at 11:30 AM of stair exit # 2 exit discharge, revealed the concrete walk from the exit to the public way posed a trip hazard in the	K 271	The concrete walkway located in the rear exterior of the building outside of stair exit #2 was repaired so that there is no trip hazard in the path of egress. 31 residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure that exit discharges maintain a stable, level, walking surface and are kept free from obstructions.	6/6/25

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K 271	Continued From page 5 path of egress for evacuation. There was a 1-1/4 inch lip across the path where the first concrete slab was raised above the next slab. In an interview at the time, the [U.S. FOI] confirmed the observation. The facility's [U.S. FOIA (b)] and the [U.S. FOI] were informed of the deficient practice at the Life Safety Code (LSC) exit conference on 5/12/25 at 1:25 PM. The [US FOIA (b)(6)] was unavailable for the LSC exit conference.	K 271	The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter.	
K 321 SS=F	N.J.A.C. 8:39-31.2 (e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		6/6/25

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K 321	Continued From page 6 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 5/8/25 in the presence of the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure hazardous area doors were self closing or automatic closing and provided with a device capable of keeping the door fully closed in accordance with NFPA 101: 2012 Edition, Section 19.3.2, 19.3.2.1.3 and 19.3.6.3.5. This deficient practice had the potential to affect all 225 residents and was evidenced by the following: Observations during a facility tour between 9:30 AM and 1:20 PM revealed: 1. The activities storage closet (D 393) was greater than 50 square feet and contained combustible storage. The door to the room was not equipped with a self-closing device. 2. The laundry dryer room door did not stay fully closed in it frame when released from its hold open device. The door bounced back open and remained 1-inch away from the door frame and the latch was stuck in the door. 3. The laundry washer room door did not close into its door frame when tested. The door's	K 321	A self-closing device was installed on the door of the activities storage closet (D 393). The laundry dryer room door was repaired so that it latches closed and the latch was repaired so that it does not get stuck in the door. The laundry washer room door was repaired so that the door closes properly. A self-closing device was installed on the door of the storage room by the kitchen. A self-closing device was installed on the door to the storage space located on the top landing of exit stairwell # 3. All residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure that doors to hazardous areas are equipped with self-closing or automatic-closing devices. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter.	

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K 321	Continued From page 7 leading edge hit the edge of the door frame and would not go into the frame. 4. The storage room by the kitchen had combustible storage and the door was not equipped with a self-closing device. 5. On the exit stairwell enclosure number 3 top landing, there was a 4-foot high by 28-inch wide door to a storage space that contained combustible storage and the door was not equipped with a self-closing device. The door was found in the open position. In interviews at the times, the U.S. FOIA (b) (6) the U.S. FOIA (b and the U.S. FOI confirmed the observations. The facility's U.S. FOIA (b and the U.S. FOI were informed of the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The U.S. FOIA (b) (6) was unavailable for the exit conference.	K 321		
K 345 SS=F	N.J.A.C. 8:39-31.2 (e) Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 345		6/6/25

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K 345	Continued From page 8 Based on observation, interview and record review on 5/9/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)) it was determined the facility failed to ensure the fire alarm system was inspected and tested and Maintained in accordance with NFPA 101:2012 Edition, NFPA 70:2011 Edition and NFPA 72:2010 Edition, Sections 3.3.106.4, 14.3, 14.3.1, Table 14.3.1, 14.4, 14.4.5, Table 14.4.5 14.4.2.2, Table 14.4.2.2. This deficient practice had the potential to affect all 225 residents and was evidenced by the following: A record review of the fire alarm system revealed the last inspection was dated 12/24/24. The previous inspection was 2/27/24, ten months earlier. Further review revealed the prior inspection was conducted 4/18/23, ten months prior to the 2/27/24 inspection. In an interview on 5/12/25 at 11:48 AM, the U.S. FOI confirmed the observations and record review. Observations on 5/8/25, 5/9/25 and 5/12/25 revealed the original fire alarm system panel was in trouble on all three days of survey (5/10 and 5/11 were not observed). Two trouble indicating lights that were ON were labeled: 1 B Wing/ Laundry room and Battery Trouble. In an interview on 5/12/25, the U.S. FOIA (b stated that an emergency call was placed to the service company. No further documentation was provided. The facility's U.S. FOIA (b and the U.S. FOI were informed of	K 345	An emergency service call was placed to the fire alarm company. The fire alarm company came on 5/12/2025 and made the necessary repairs to clear the trouble signals. All residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure that any troubles on the fire alarm panel are addressed. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter	

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K 345	Continued From page 9 the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The U.S. FOIA (b) (6) was unavailable for the exit conference. N.J.A.C. 8:39-31.1(c), 31.2 (e) NFPA 72	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/8/25 in the presence of the U.S. FOIA (b) (6) the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure fire sprinklers and their components were inspected and maintained in accordance with NFPA 101: 2012 Edition, Section	K 353	All holes were sealed up in the ceilings of the 3rd floor central supply storage room, 3rd floor medical records room, top of stairwell # 4, 3rd floor mechanical room, mechanical room 245.9, bottom of stairway #2, laundry washer room, 1st floor pantry, and the medical records	6/6/25

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K 353	Continued From page 10 9.7 and NFPA 25: 2011 Edition. This deficient practice had the potential to affect all 225 residents and was evidenced by the following: Observations during a facility tour between 9:30 AM and 1:20 PM revealed: 1. The 3rd floor central supply storage had 2 holes in the ceiling tiles of the drop ceiling smoke barrier membrane. One measured 3-inches by 7-inches and the other measured 3-inches by 8-inches. Fire sprinklers were installed in the plane of the ceiling. 2. The 3rd floor medical records room had 2 holes in the drop ceiling tiles. One was a 2-inch diameter hole and the other measured 4-inches by 7-inches. 3. In the top of stairwell number 4, there was a 4-inch by 1-1/2 inch hole next to a smoke detector. 4. The 3rd floor mechanical room had a 6-inch diameter hole in the plaster ceiling. 5. In the cultural storage room, a fire sprinkler head had no escutcheon. 6. In the 3rd floor porters closet, the escutcheon was 3/4 of an inch down from the ceiling exposing a space through the membrane. 7. In room 350, one fire sprinkler head had a space on the side of the escutcheon and the escutcheon was down 3/4 of an inch on the other sprinkler head. 8. The Room 323 bathroom sprinkler head had	K 353	room by the kitchen. New sprinkler escutcheons were installed in the cultural storage room, 3rd floor porters closet, room 350, room 323, storage room (#339), 2nd floor stationary supply room, 2nd floor shower room, storage room 279, nurses station staff bathroom (#221.1), and the mens rest room by the kitchen. All residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure that there are no openings by the fire sprinklers. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter.	

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K 353	Continued From page 11 no escutcheon. 9. The storage room (#339) sprinkler head by stair 3 had no escutcheon. 10. The 2nd floor stationary supply room sprinkler head was missing the bottom part of the escutcheon. 11. The 2nd floor shower room (by the staff room) sprinkler head had no escutcheon. 12. The Mechanical room 245.9 had a 5-inch by 5-inch penetration with wires going through the hard ceiling. 12. The bottom of stairway #2 was missing a 2-foot by 4-foot ceiling tile. 13. In storage room 279, two sprinkler heads were missing the bottom piece of their escutcheon exposing a space through the ceiling. 14. In the nurses station staff bathroom number 221.1, the sprinkler head had no escutcheon. 15. In the laundry washer room, a 1-foot by 3-foot piece of ceiling tile was missing. 16. In the 1st floor pantry across from the nurses station, there was a space in the drop ceiling 3/4-inch by 2-inches on the side of the smoke detector. 17. The sprinkler head in the men's rest room by the kitchen sprinkler was missing the bottom escutcheon piece. 18. The medical records room by the kitchen had	K 353		

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K 353	Continued From page 12 a 2-foot by 4-foot and a 1-foot by 2-foot ceiling tile missing and a hole in another tile. In interviews at the times the U.S. FOIA (b) (6) the U.S. FOIA (b) and the U.S. FOI confirmed the observations. The facility's U.S. FOIA (b) and the U.S. FOI were informed of the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The U.S. FOIA (b) (6) was unavailable for the exit conference. N.J.A.C. 8:39-31.1(c), 31.2 (e) NFPA 13, 25	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363		6/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING 01 B. WING _____	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	10 BRUNSWICK AVENUE EDISON, NJ 08817

(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
K 363	Continued From page 13 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 5/8/25 in the presence of the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) it was determined the facility failed to ensure corridor doors would resist the passage of smoke and have positive latching hardware for 4 of 18 corridor doors observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3, 19.3.6.3.5. This deficient practice had the potential to affect 10 of 225 residents and was evidenced by the following: Observations during a facility tour between 9:30 AM and 1:20 PM revealed: 1. The Room 364 door was difficult to latch. 2. In Room 304, the top of the door edge hit the door frame preventing the door from closing.	K 363	The doors of room 364, 304, 327, 227, and 279.1 were all repaired so that they close and latch properly. 10 residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure that corridor door can properly close. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING **01** B. WING _____	**05/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE** **EDISON, NJ 08817**

(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
K 363	Continued From page 14 3. In Room 327, the door did not latch. 4. In Room 227, the door does not close all the way to latch because it hit on the bottom leading edge and door stop. 5. The Soiled utility room (279.1) door did not latch. In interviews at the times, the U.S. FOIA (b) (6) the U.S. FOIA (b and the U.S. FOI confirmed the observations. The facility's U.S. FOIA (b and the U.S. FOI were informed of the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The U.S. FOIA (b) (6) was unavailable for the exit conference. N.J.A.C. 8:39-31.1(c), 31.2 (e)	K 363		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced	K 374		6/6/25

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	315279	A. BUILDING 01 B. WING _____	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	10 BRUNSWICK AVENUE EDISON, NJ 08817

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K 374	Continued From page 15 by: Based on observation and interview on 5/8/25 in the presence of the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) it was determined the facility failed to ensure that doors in smoke barriers closed the opening, leaving only the minimum clearance necessary for proper operation for 2 of 18 double smoke barrier doors in accordance with NFPA 101:2012 Edition, Section 8.5.4.1 and NFPA 105. This deficient practice had the potential to affect 57 of 225 residents and was evidenced by the following: An observation at 9:55 AM revealed that the right leaf of the double smoke barrier doors on the third floor by the porter's closet did not close into its frame when tested. The right leaf hit the leading edge of the left leaf and stopped. An observation at 11:35 AM revealed that the right leaf of the double smoke barrier doors on the second floor by room 246 did not close into its frame when tested. The right leaf hit the bar from the door leaf delay hardware and stopped approximately 7-inches from its place in the door frame. In interviews at the times, the U.S. FOIA (b) (6) the U.S. FOIA (b) and the U.S. FOI confirmed the observations. The facility's U.S. FOIA (b) and the U.S. FOI were informed of the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The U.S. FOIA (b) (6) was unavailable for the exit conference. N.J.A.C. 8:39-31.1(c), 31.2 (e)	K 374	The double smoke barrier doors by the 3rd floor porters closet and on the 2nd floor outside room 246 were repaired so that they fully close as intended. 57 residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure that any troubles on the fire alarm panel are addressed promptly. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter.	

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	315279	A. BUILDING 01 B. WING _____	05/12/2025

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K 914	Continued From page 16	K 914		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 5/8/25, 5/9/25 and 5/12/25 in the presence of the U.S. FOIA (b) (6) the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure non-hospital grade outlets in patient care rooms were tested annually in accordance with NFPA 99: 2012 Edition, Section 6.3.3, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect all 225 residents and was evidenced by the following:	K 914	An electrical testing company performed testing on all non-hospital grade outlets in patient care rooms. All residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure that the facility maintains records of annual testing for non-hospital grade outlets in patient	6/6/25

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	315279	A. BUILDING **01** B. WING _____	**05/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE** **EDISON, NJ 08817**

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K 914	Continued From page 17 Observations during a facility tour on 5/8/25 between 9:30 AM and 1:20 PM revealed the resident rooms were provided with non-hospital grade outlets. A record review on 5/9/25 revealed the annual electrical inspection report dated 4/23/25 did not include testing: physical integrity, continuity, polarity and blade tension for non-hospital grade outlets in patient care rooms for the last 12 months. In an interview on 5/12/25 at 11:48 AM, the U.S. FOI confirmed the observations and record review. The facility's U.S. FOIA (b and the U.S. FOI were informed of the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The U.S. FOIA (b) (6) was unavailable for the exit conference. N.J.A.C. 8:39-31.2 (e) NFPA 99	K 914	care rooms. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		6/6/25

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K 918	Continued From page 18 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and record review on 5/9/25 and 5/12/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure: 1.) the diesel power generator was exercised at 30% or greater of its nameplate rating during the monthly load tests or that a 90 minute load bank test was conducted, 2.) the generator was tested once every 36 months for 4 continuous hours and 3.) the generator transferred power within 10 seconds, in accordance with NFPA 110: 2010 Edition, Section 4.1 to 4.4, 8.3.4, 8.4, 8.4.2(2), 8.4.2.3 and 8.4.9. This deficient practice has the potential to affect all 225 residents and was evidenced by the	K 918	The U.S. FOIA (b) (6) was in-serviced by the Regional Maintenance Director that the percentage of load must be recorded on the monthly test logs. A generator company was contracted and performed the 4 hour load bank test. The Maintenance Director was in-serviced by the Regional Maintenance director that the transfer time must be recorded on the monthly load test logs. All residents have the potential to be affected. The Maintenance Director will conduct	

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EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE** **EDISON, NJ 08817**

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K 918	Continued From page 19 following: A record review on 5/9/25 of the facilities generator service reports and monthly and weekly generator test logs revealed: 1. There was no value recorded, or place on the log to have recorded the percent of load the generator was run under during the monthly full load exercises for the last 12 months. Further review of the service records verified there was no record that an annual 90 minute load bank test was performed in the last 12 months, which would have been required if the monthly load values were under 30% of the nameplate rating. 2. There was no documentation that a 4 hour load or load bank test was performed in the last 36 months. 3. The transfer time from primary to secondary power in seconds was not recorded for the last 9 monthly load tests. The generator log had a place to record transfer time that was blank. In an interview on 5/12/25 at 12:50 PM, the U.S. FOI and the U.S. FOIA (b confirmed the record review. The facility's U.S. FOIA (b and the U.S. FOI were informed of the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The U.S. FOIA (b) (6) was unavailable for the exit conference. N.J.A.C. 8:39-31.2 (e) NFPA 99, 110	K 918	weekly audits for 4 weeks then monthly audits for 2 months to ensure that the facility maintains records of the transfer time and load percentage for monthly load tests, and the 4 hour load bank test once every 36 months. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101	K 921		6/6/25

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	315279	A. BUILDING 01 B. WING _____	05/12/2025

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K 921	Continued From page 20 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 5/8/25, 5/9/25 and 5/12/25 in the presence of the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure that all Patient Care	K 921	The U.S. FOIA (b) (6) was in-serviced by the regional maintenance director that the hospital beds are required to be inspected and tested. The maintenance department inspected and tested each bed missing an inspection	

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K 921	Continued From page 21 Related Electrical Equipment (PCREE) was inspected, tested and maintained (ITM) in accordance with NFPA 99 :2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8 including resident beds. This deficient practice had the potential to affect all 225 residents and was evidenced by the following: An observation on 5/8/25 at 10:40 AM of room 353 revealed the resident's electric hospital bed had no inspection sticker. The U.S. FOI confirmed the observation. In an interview at the time, the surveyor asked about the facilities policy for the electric beds and PCREE inspections, tests and maintenance. The U.S. FOI stated that an outside service company manages the beds and PCREE for the facility. A record review on 5/9/25 of the PCREE service reports dated 3/14/24, 9/24/24 and 4/3/25, revealed resident electric hospital beds were not included in the reports. In an interview on 5/12/25 at 12:53 PM, the U.S. FOI and the U.S. FOIA (b confirmed the record review. The facility's U.S. FOIA (b and the U.S. FOI were informed of the deficient practice at the Life Safety code exit conference on 5/12/25 at 1:25 PM. The U.S. FOIA (b) (6) was unavailable for the exit conference. N.J.A.C. 8:39-31.2 (e) NFPA 99	K 921	sticker. All residents have the potential to be affected. The Maintenance Director will conduct weekly audits for 4 weeks then monthly audits for 2 months to ensure that the electric hospital beds have been inspected. The results of these audits will be reported at the monthly QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT meetings for 3 months and on an as needed basis thereafter.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315279 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/25/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	10 BRUNSWICK AVENUE EDISON, NJ 08817

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	06/06/2025	LSC K0222	06/06/2025	LSC K0271	06/06/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	06/06/2025	LSC K0345	06/06/2025	LSC K0353	06/06/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	06/06/2025	LSC K0374	06/06/2025	LSC K0914	06/06/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	06/06/2025	LSC K0921	06/06/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/12/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO