STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315196	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT MANCHESTER	**1770 TOBIAS AVENUE , MANCHESTER, New Jersey, 08759**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Survey Date: 8/27/24 Complaints: 399207, 399334, 399342, 399346, 399347, 257355 Census: 143 Sample Size: 28 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		09/05/2025
F0550 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 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.	F0550	F 0550 – Resident Rights Resident #2 & Resident # 95 had NJ Exec Order 26.4b1. Both care plans were updated to reflect their needs and their personal choices. All residents have the potential to be affected. Director of Nursing/ Designee immediately educated all staff on maintaining the dignity of our residents was completed. Social Service, or designee will conduct weekly audits of 4 residents for 4 weeks, then monthly x 2 months with the focus on dignity. All findings will be corrected immediately, if necessary, reported to the Administrator and reviewed at the facility's QAPI meeting for any appropriate action.	10/21/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315196	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

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F0550 SS = D	Continued from page 1 §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, record review, interview and review of pertinent facility documentation, it was determined that the facility failed to treat residents with respect and dignity. Specifically, by a.) staff failed to provide timely assistance to Resident #2, who was observed with [redacted] and an NJ Exec Order 26.4b1 [redacted] and [redacted] and b.) staff failed to provide [redacted] for Resident #95 during [redacted] care. This deficiency was identified in 2 of 2 residents (Resident #2 and Resident #95) reviewed for dignity and was evidenced by the following: 1.) Review of the Admission Record (AR), the Resident #2 was admitted to the facility with diagnoses including, but not limited to, NJ Exec Order 26.4b1 [redacted] A review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated [redacted], included a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating NJ Exec Order 26.4b1 [redacted]. Further review of the MDS revealed that Section NJ Exec Order 26.4b1 [redacted] revealed that NJ Exec Order 26.4b1 was coded as a [redacted] indicating the resident required NJ Exec Order 26.4b1 [redacted]. On 08/20/2025 at 10:52 AM, the surveyor observed	F0550		

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F0550 SS = D	Continued from page 2 Resident #2 seated in a wheelchair on the second-floor hallway with a bedside table in front of them, [redacted] on a sheet of paper. The resident had a [redacted]. Two facility staff members walked by without offering assistance or making any attempt to [redacted] from the resident's [redacted] On 08/21/2025 at 10:40 AM, the surveyor observed Resident #2 in the main dining room, seated in a wheelchair at a dining table, asleep while activity staff and other residents participated in an exercise activity. An [redacted] was observed [redacted]. The surveyor continued observing the resident for five minutes, during which time multiple staff members entered and exited the dining area. At no point did any staff offer or attempt to assist the resident in [redacted]. 2/) Review of the AR indicated that Resident #95 the was admitted to the facility with diagnoses which included but was not limited to [redacted]. A review of the resident's Admission MDS, an assessment tool used to facilitate care management, dated [redacted], included a BIMS score of [redacted] out of 15, indicating [redacted]. Further review of the MDS revealed that [redacted] revealed that [redacted] was coded as a [redacted] indicating the resident required [redacted]. On 08/21/2025 at 10:09 AM, the surveyor observed a [redacted] providing [redacted] care to Resident #95 in the bathroom of Room #[redacted] The resident had a [redacted], and the [redacted] was seen [redacted] the resident's [redacted] with [redacted] The bathroom door was left open during care, and Resident #95's [redacted] were [redacted] and visible from the bathroom. The resident's roommate was present in the shared bedroom, seated in a wheelchair near the bathroom entrance, watching television. The resident's comprehensive care plan, dated [redacted], included a focus area indicating that the resident has [redacted] The resident's comprehensive care plan, dated [redacted], included a focus area indicating that the resident has [redacted]	F0550		

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F0550 SS = D	Continued from page 3 During an interview with the surveyor on 08/21/2025 at 12:34 PM, the US FOIA (b)(6) stated that staff should have offered or assisted with NJ Exec Orde Resident #2 NJ Exec O their NJ Exec Ord and NJ Exec Ord During an interview with the surveyor on 08/27/2025 at 11:35 AM, the US FOIA (b)(6)) stated that staff should have offered assistance or helped Resident #2 NJ Exec Order 26.4b1 . The US FOIA (acknowledged that Resident #95 should have been provided privacy during NJ Exec Order 26.4b1 and confirmed that both residents should have been treated in a manner that maintained their dignity. A review of a facility policy undated titled, “Resident Rights”, revealed that, "The facility will treat you with dignity and respect in full recognition of your individuality.” N.J.A.C. 8:39-4.1(a)(16)	F0550		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to	F0582	F0582 – Medicaid/Medicare Coverage/Liability Notice Resident # 1,2, and 3 had NJ Exec Order 26.4b1 . Any resident who are to receive a Skilled Nursing Facility Advanced Beneficiary Notice has the potential to be affected. Education completed by US FOIA (b)(6) / Designee on the proper way to complete a Skilled Nursing Facility Advanced Beneficiary Notice with Social Service Team. The Director of Social Services / designee will conduct a random audit of 2 completed Skilled Nursing Facility Advanced Beneficiary Notices, dependent on Medicare discharges, weekly x 4 weeks and then monthly x 2 months. All findings will be corrected immediately, if necessary, reported to the Administrator and reviewed at the facility’s QAPI meeting for any appropriate action.	10/21/2025

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F0582 SS = D	Continued from page 4 residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to ensure the SNF ABN (skilled nursing facility advanced beneficiary notice) was complete and accurate which placed the residents and/or representatives at risk of not being fully informed. This was identified for 1 of 3 residents (Resident # 98) reviewed for SNF Beneficiary Protection and was evidenced by: A review of Resident #98's Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1 [redacted] Review of Resident #98's SNF Beneficiary Notification Review, which was provided by the facility, indicated the resident NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26. Continued review of Resident #98's "ABN" revealed "Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on NJ Exec Order 26.4 you may have to	F0582		

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F0582 SS = D	Continued from page 5 NJ Exec Order 26.4b1 for this care if you do not have other NJ Exec Order 26.4b1 ." Resident# 98's "ABN" noticed also documented " NJ Exec Order 26.4 and the reason listed was ' NJ Exec Order 26.4b1 ." The "Estimated Cost" was left blank. In addition, on the lower half of the page was an area with three boxes. The instructions read, “Check one box. We can’t choose a box for you”. All three option boxes were left blank. During an interview on 8/26/2025 at 9:07 AM, the Social Worker (SW#1), in the presence of of SW #2, stated that no estimated cost was not required as the business office would take care of the estimated cost and that the resident or representative “don’t always” check a box. During an interview on 8/26/2025 at 1:48 AM with the surveyor the US FOIA (b)(6) , in the presence of the US FOIA (b)(6)) acknowledged that one of the three options and that an estimated cost should have been filled in. The facility did not provide a policy referencing SNF ABN. NJAC 8:39-5.1(a)	F0582		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.	F0693	F0693 – Tube Feeding Management Resident #46 had NJ Exec Order 26.4b1 . All residents who have a gastrostomy have the potential to be affected. The nurse in question was re-educated and re-assessed by the Director of Nursing on management of g-tube, including checking for placement. Re-education was provided for all licensed nurses on properly administering enteral feeding and managing of gastrostomy tubes. The Director of Nursing or designee, will complete audit of one gastrostomy tube weekly for 4 weeks and then monthly for two months. All findings will be corrected immediately, if necessary, reported to the Administrator and reviewed at the facility’s QAPI meeting for any appropriate action	10/21/2025

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F0693 SS = D	Continued from page 6 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that appropriate care and services were provided to prevent complications of NJ Exec Order 26.4b1 [redacted]), by failing to check for proper placement of the NJ Exec Order [redacted] before administering the NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 1 resident (Resident #46) investigated for NJ Exec Order 26.4b1 and was evidenced by the following: On 8/21/25 at 9:15 AM, the surveyor reviewed the medical record for Resident #46. A review of the Admission Record (admission summary) reflected that Resident #46 was admitted to the facility with diagnoses that included but not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order, reflected that Resident #46 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated NJ Exec Order 26.4b1 [redacted]. Further review of Section [redacted] (NJ Exec Order 26.4b1 [redacted] revealed that Resident #46 had a NJ Exec Order 26.4b1 in place and received NJ Exec or more NJ Exec Order 26.4b1 [redacted] A review of the Order Summary Report of active orders as of NJ Exec Order 2 included a physician's order (PO) dated NJ Exec Order, for NJ Exec Order 26.4b1. The order directed staff to check the NJ Exec Order 26.4b1 for proper placement prior to each NJ Exec Order 2 NJ Exec O or medication administration at every shift. A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) for the physician's order dated NJ Exec Order 26 reflected that NJ Exec placement checks were documented as completed every shift, as ordered. A review of the Interdisciplinary Care Plan (IDCP) revealed a focus area, revised on NJ Exec Order, indicating that Resident #46 required NJ Ex Order 26.4(b)(1) due to NJ Exec [redacted] The IDCP included an intervention to NJ Exec Order 26.4b1 placement and assess NJ Exec Order 26.4b1 [redacted] in accordance	F0693		

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F0693 SS = D	Continued from page 7 with facility protocol and record. On 8/25/25 at 10:13 AM, the surveyor observed Resident #46 in [NJ Exec] room lying in bed. On 8/25/25 at 10:15 AM, the surveyor observed a [US FOIA (b)(6)]) attempting to [NJ Exec] Resident #46's [NJ Exec Order 26.4b1] without first verifying [NJ Exec] as required by facility policy. The surveyor interviewed the [US FO] who acknowledged that [NJ Exec Order 26.4b1] should be checked prior to administering [NJ Exec Order] and confirmed that this step had been missed. On 8/26/25 at 1:49 PM, in the presence of the survey team, the [US FOIA (b)(6)]) confirmed that the [US FO] should have checked the [NJ Exec Order 26.4b1] prior to administering [NJ Exec Order] The [US FOIA] stated that verifying [NJ Exec] placement was essential to ensure the [NJ Exec Order 26.4b1] was properly positioned and prevent potential complications. A review of the facility's "Bolus Nasogastric/Gastrostomy Tube-Feeding" policy, dated February 1, 2021, and revised on March 10, 2023, indicated the purpose as "to provide a means of feeding per tube to meet the nutritional requirements of residents who are unable or unwilling to take nutrients by mouth". NJAC 8:39-25.2(c)2,5	F0693		
F0761 SS = D	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. §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.	F0761	F0842 – Label/Store Drugs Resident #10 identified to have [NJ Exec Order 26.4] at the bedside. Residents had [NJ Exec Order 26.4b1]. The [NJ Exec Order 26.4] were immediately removed by Unit Manager. It was discovered that they [NJ Exec Order 26.4] were brought in by family. The Unit Manager called the resident's [NJ Exec Order 26] and educated her via phone, that any medication brought into the facility is to go through nursing first. All residents whose family member bring them in medications have the potential to be affected. Unit manager immediately educated Resident #10 to report to nurse if family brings in any medications. Administrator/ Designee immediately sent a letter to all families educating them to NOT bring any medications and if they do it MUST be given to the nursing staff. In addition, Unit Managers/ Designee educated Residents on the above process.	10/21/2025

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F0761 SS = D	Continued from page 8 §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, record review, interview, and pertinent facility documentation, it was determined that the facility failed to ensure that a medication was secured in a locked compartment accessible only to authorized personnel with a key. Specifically, the facility failed to secure medication that was left at a resident's bedside. This deficient practice was identified for 1 of 1 resident (Resident #10) and was evidenced by the following: On 08/21/2025 at 11:21 PM, the surveyor observed Resident #10 in their bedroom, seated in a wheelchair with a bedside table in front of them. On the table was a box containing a NJ Exec Order 26.4b1 [redacted] NJ Ex Order The resident stated that their NJ Exec Order 26 had brought the NJ Exe [redacted] because their NJ Exec sometimes feel NJ Exe Review of the electronic medical record on 08/20/2025 at 10:00 AM, revealed the following: A review of the Admission Record indicated that Resident # 10 was admitted to the facility with diagnoses that included but was not limited to, NJ Exec Order 26.4b1 [redacted]. A review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate care management dated NJ Exec Order 26.4b1, included a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, indicating NJ Exec Order 26.4b1 . A review of Resident #10's comprehensive care plan dated NJ Exec Order 26.4b1 included a focus area which indicated that the resident had NJ Exec Order 26.4b1. A review of the Medication Administration Record, dated as of NJ Exec Order 2, included the following physician orders (PO): a PO, dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 [redacted] in both NJ Exec every	F0761	Continued from page 8 The Director of Nursing, or designee, will audit 4 resident rooms weekly for 4 weeks and then monthly for 2 months to ensure no medications found.. All findings will be reported to the Administrator and reviewed at the facility's QAPI meeting for any appropriate action.	

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F0761 SS = D	Continued from page 9 4 hours as needed for [NJ Exec Order 2]; and a PO, dated [NJ Exec Order 26.4b1] for NJ Exec Order 26.4b1, to instill [redacted] as needed for [NJ Exec Order 2]. The surveyor conducted an interview on 08/21/2025 at 12:34 PM with the US FOIA (b)(6) [redacted] who stated that she was aware the resident had the [NJ Exec Order 26.4] at the bedside and that she would speak with the resident's family. She admitted that the resident should not have the [NJ Exec Order 26.4] at the bedside if she had not been assessed for safe [NJ Exec Order 26.4b1] administration. During an interview with the surveyor on 08/27/2025 at 11:40 AM, the US FOIA (b)(6) stated that Resident #10 should not have had [NJ Exec Order 26.4] at the bedside due to safety reasons. A review of the facility's undated policy, titled, "Storage of Medication", revealed that, "The nursing staff shall be responsible for maintaining medication storage." A review of the facility's undated policy, titled, "Administering Medications", revealed that, "Residents may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely." NJAC 8:39-29.2(d)	F0761		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F0842	F0842 – Resident Records MARS and TARS of resident #150 was identified with blank entries. Resident had [NJ Exec Order 26.4b1]. All residents who have blank entries on MARS & TARS have the potential to be affected. Director of Nursing/ Designee immediately gave re-education to all licensed nursing staff on the importance of completion of MARS and TARS in their entirety. The Director of Nursing, or designee will review MARS and TARS of all residents daily for one week and then weekly for the next 11 weeks auditing for missing documentation.	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315196	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT MANCHESTER	1770 TOBIAS AVENUE , MANCHESTER, New Jersey, 08759

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F0842 SS = D	Continued from page 10 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F0842	Continued from page 10 All findings will be reported to the Administrator and reviewed at the facility's QAPI meeting for any appropriate action	

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F0842 SS = D	Continued from page 11 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Complaint: NJ183978 Based on interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to maintain medical records accurately and completely in accordance with acceptable standards and practice. This identified for 1 of 46 residents (Resident # 150) reviewed medical records and evidenced by the following: A review of the Admission Record, an admission summary, revealed that Resident #150 had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1 [redacted] A review of the resident's individual comprehensive care plan (ICCP) had the following a focus areas, dated NJ Exec Order 26.4b1, that the resident had an NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 [redacted] for [signs/symptoms] of infection every shift and provide NJ Exec Order 26.4b1 care every shift; that the resident used NJ Exec Order 26.4b1 [related to] the management of NJ Exec Order 26.4b1 Interventions included, but not limited to, NJ Exec Order 26.4b1 medications as ordered by physician; that the resident has NJ Exec Order 26.4b1 [related to] NJ Exec Order 26.4b1 Interventions included, but not limited to, monitor/record/report to nurse my complaints of NJ Exec or requests for NJ Exec treatment; that the resident had a NJ Exec Order 26.4b1] of NJ Exec Order 26.4b1 Interventions included, but not limited to, NJ Exec Order 26.4b1 every] 8 hours. Record NJ Exec Ord if necessary; NJ Exec Order 26.4b1 every shift.	F0842		

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F0842 SS = D	Continued from page 12 A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated as of NJ Exec Order 26.4, included, but not limited to, the following physician orders (PO) and corresponding blank entries: A PO, dated NJ Exec Order 26.4, for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 give 1 capsule by mouth at bedtime related to NJ Exec Order 26.4b1. On NJ Exec Order 26.4b a blank space was observed. A PO, dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 to give 5 capsules by mouth at bedtime related to NJ Exec Order 26.4b1. On NJ Exec Order 26.4b a blank space was observed. A PO, dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 tablet by mouth two times a day (2pm and 9pm) for NJ Exec Order 26.4b1 *give with NJ Exec Order 26.4b1). On NJ Exec Order 26.4 a blank space was observed for the 9 PM entry. A PO, dated NJ Exec Order 26.4, for NJ Exec Order 26.4b1 to give 1 tablet by mouth two times a day (2pm and 9pm) for NJ Exec Order 26.4b1 *give with NJ Exec Order 26.4b1). On NJ Exec Order 26.4b a blank space was observed for the 9 PM entry. A PO, dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 to give 1 tablet by mouth every 12 hours for NJ Exec Or of NJ Exec Or. On NJ Exec Order 26.4b a blank space was observed. A PO, dated NJ Exec Order 26.4, for NJ Exec Order 26.4b1 to give 3 capsule by mouth three times (9am, 2pm, 9pm) a day for NJ Exec Order 26.4b1. On NJ Exec Order 26.4 a blank space was observed for the 9 PM entry. A PO, dated NJ Exec Order 26.4b, to monitor vital signs every shift for assessment. On NJ Exec Order 26.4 (second shift) and NJ Exec Order 26.4 (morning shift) did not have vital signs entered. On NJ Exec Order 26.4b (day), NJ Exec Order 26.4b (day), NJ Exec Order 26.4 (day) blank spaces were observed. A PO, dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 to apply to NJ Exec Order and NJ Exec Order 26.4b1 every day and evening shift for NJ Exec Order 26.4b1. A PO, dated NJ Exec Order 26.4, to monitor NJ Exec Order 26.4b1 for [signs/symptoms] of NJ Exec Order 2 every shift for NJ Exec Order 26 On NJ Exec Order 26.4 (day) and NJ Exec Order 26.4 (day) blank spaces were observed. A PO, dated NJ Exec Order 26.4b, to NJ Exec Order 26.4b1 when in bed every shift for prevention. On NJ Exec Order 26.4b (day) and	F0842		

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F0842 SS = D	Continued from page 13 NJ Exec Order 26.4b (day) blank spaces were observed. A PO, dated NJ Exec Order 26.4, for NJ Exec Order 26.4b1 to apply to NJ Exec Order 26.4b1 every shift for NJ Exec Order 26.4b1 On NJ Exec Order 26.4 (day) and NJ Exec Order 26.4b (day) blank spaces were observed. A PO, dated NJ Exec Order 26.4b, to record NJ Exec Order 26.4b1 every shift for monitoring. On NJ Exec Order 26.4 (day) a blank space was observed. A PO, dated NJ Exec Order 26.4b, to render NJ Exec Order 26.4b1 care every shift for NJ Exec Order 26.4b1 On NJ Exec Order 26.4 (day) a blank space was observed. On 8/26/2025 at 8:41 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that upon administered medication and/or treatments the MAR/TAR should be checked off to show that it was given or completed. When asked what a blank box could mean, LPN #1 stated that the medication was not given or the treatment was not completed. On 8/26/2025 at 8:57 AM, the surveyor interviewed the US FOIA (b)(6)) who stated that physicians orders should be carried out as written and that there should never be blanks in the MAR/TAR. When asked what a blank could mean, the US FOIA (b)(6) responded that “it was not done”. During an interview on 8/26/2025 at 1:48 AM with the surveyor the US FOIA (b)(6) , in the presence of the US FOIA (b)(6) acknowledged that the MAR/TAR should be completed in its entirety upon completion of the order and that if it was not filled in it could mean that the order was not done. A review the undated facility policy titled, "Administering Medications" revealed the following under Policy Interpretation and Implementation: [...] 3. Medications must be administered in accordance with the orders, including any required time frame. [...] 11. The individual administering the medication must document in [electronic records] after giving each medication by clicking the "Y". [...] 13. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall click the "N" on the EMAR and then document as prompted by PCC. A review the undated facility policy titled, "Charting and Documentation" revealed the following under Policy	F0842		

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F0842 SS = D	Continued from page 14 Interpretation and Implementation: 1. All observations, medications administered, services performed, etc, must be documented in the resident's clinical record. NJAC 8:39- 23.2	F0842		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	F0880 - Infection Prevention & Control Resident #155 NJ Exec Order 26.4b1. All blood pressure cuffs currently in use were immediately cleaned, and disinfected according to facility protocol. Shower room on unit #1 was immediately cleaned and all linens properly stored. All other shower rooms checked with no concerns All residents who had their blood pressure checked by nurse #1 and those who use the shower room on unit #1 have the potential to be affected. The Infection Preventionist re-in serviced the nurse in question. In addition, the US FOIA (b)(6) conducted an in-service training on proper cleaning and disinfection of reusable medical equipment to all nursing staff. CNA i#1 was in serviced immediately on linen handling and infection control. Re-education provided to all nursing by the Infection Preventionist on proper linen handling and infection control practices. The Infection Preventionist/designee will conduct weekly audits for 4 weeks, then monthly for 2 months, observing blood pressure cleaning practices. All findings will be reported to the Administrator and reviewed at the facility's QAPI meeting for any appropriate action The Infection Preventionist or designee will conduct weekly rounds for 4 weeks, then monthly for 2 months, of shower rooms and utility areas for proper linen storage and handling. All findings will be reported to the Administrator and reviewed at the facility's QAPI meeting for any appropriate action.	10/21/2025

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F0880 SS = D	Continued from page 15 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. 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 a.) sanitize reusable medical equipment in between resident use during medication administration and b.) contain soiled laundry securely and transport to the designated holding area to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. This deficient practice was identified for 2 unsampled residents (Resident #81 and Resident #155) observed during medication administration and was evidenced by the following: Reference: “Contaminated textiles and fabrics often contain high numbers of microorganisms from body substances, including blood, skin, stool, urine, vomitus, and other body tissues and fluids. Disease transmission attributed to health-care laundry has	F0880		

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F0880 SS = D	Continued from page 16 involved contaminated fabrics that were handled inappropriately." "Contaminated textiles and fabrics are placed into bags or other appropriate containment in this location; these bags are then securely tied or otherwise closed to prevent leakage. " https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.html Reference: "Perform low-level disinfection for noncritical patient-care surfaces and equipment (e.g. blood pressure cuff) that touch intact skin." https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html#cdc_generic_section_9-4-7-noncritical-patient-care-equipment 1. On 8/25/2025 at 8:13 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 prepare to administer medications to Resident #155. LPN #1 sanitized their hands with alcohol-based sanitizer. LPN #1 proceeded to take the vital signs machine to the resident's bedside. The nurse applied the NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1. The surveyor observed the nurse touched the resident's right temple area with the NJ Exec Order 26.4b1. LPN #1 did not clean or sanitize the NJ Exec Order 26.4b1 prior to use and after using them. On 8/25/2025 at 9:57 AM, the surveyor observed LPN #1 prepare to administer medications to Resident #81. LPN #1 sanitized their hands with alcohol-based sanitizer. LPN #1 proceeded to take the vital signs machine to the resident's bedside. The nurse applied the NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1) on the resident's NJ Exec Order 26.4b1. The surveyor observed the nurse touched the resident's NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1. LPN #1 did not clean or sanitize the NJ Exec Order 26.4b1 to use and after using them. On 8/26/2025 at 1:49 PM, during an interview with the survey team, the US FOIA (b)(6)) stated that reusable medical equipment like the NJ Exec Order 26.4b1 should be cleansed after each use in between residents. A review of the facility-provided undated policy titled "Cleaning and Disinfection of Resident-Care Items and	F0880		

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F0880 SS = D	Continued from page 17 Equipment" included under Policy Interpretation and Implementation, 1.) …. c.2) Most non-critical reusable items can be decontaminated where they are used. 4.) Reusable resident care equipment will be decontaminated and/ or sterilized between residents according to manufacturer's instructions. 2.) On 8/26/2025 at 12:13 PM, the surveyor entered the nursing unit's shower room with Certified Nursing Assistant (CNA) #1. The surveyor observed a big pile of soiled linens, towels, and clothes in an opened plastic bag on the floor. One white wet towel was observed partly inside the plastic bag and partly on the floor. The surveyor asked CNA #1 if the soiled laundry should be sitting on the floor. CNA #1 stated that they should have been taken out to the dirty utility room because there are germs. CNA #1 also stated that nothing should be on the floor. CNA #1 was observed to put on gloves and transported the plastic bag of soiled laundry to the soiled utility room. On 8/26/2025 at 12:19 PM, Licensed Practical Nurse (LPN) #1 stated that dirty laundry should not sit on the floor. LPN #1 further stated that the dirty laundry should be bagged and put on the chute in the soiled utility room. On 8/26/2025 at 1:07 PM, the US FOIA (b)(6) stated that soiled laundry should be put in a bag, tied, and thrown in the soiled utility room. On 8/26/2025 at 1:50 PM, during an interview with the survey team, the US FOIA (b)(6) stated that soiled laundry should go to a bag and to the linen chute immediately. The US FOIA further stated that the soiled laundry should not sit on the floor in the shower room. A review of the facility-provided undated policy titled "Departmental (Environmental Services) – Laundry and Linen" included under General Guidelines, 3.) Consider all soiled linen to be potentially infectious. 5.) All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture. N.J.A.C. 8:39 – 19.4 (a); 21.1 (a)	F0880		
F0882 SS = D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist	F0882	F0882 - Infection Preventionist Role Resident #10 NJ Exec Order 26.4b1.	10/21/2025

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F0882 SS = D	Continued from page 18 The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure the Infection Preventionist actively performed responsibilities in accordance with her facility designated role. Specifically, by not administering an NJ Exec Order 26.4b1 to 1 of 5 residents reviewed for NJ Exec Order 26.4b1 (Resident #10). The deficient practice was evidenced by the following: On 08/25/2025 at 12:10 PM, the surveyor reviewed the electronic medical records of Resident #10, which revealed that the resident was admitted to the facility on NJ Exec Order 26.4b1, during the NJ Exec Order 26.4b1. Documentation showed that the resident signed an NJ Exec Order 26.4b1 consent form on NJ Exec Order 26.4b1 indicating agreement to receive the NJ Exec Order 2 However, the record also indicated that the last documented administration of the NJ Exec Order 26.4b1 was on NJ Exec Order 26.4b1, prior to the resident's admission to the facility, with no evidence that the NJ Exec Order was administered during the NJ Exec Order 26.4b1. Review of the admission record indicated that Resident #10 was admitted to the facility with diagnoses including, but not limited to, NJ Exec Order 26.4b1 .	F0882	Continued from page 18 All residents that accept the influenza vaccination have the potential to be affected. US FOIA (b)(6) was re-educated by the Director of Nursing, on the facility's vaccination policy, including timely offering, administration, and documentation of vaccines. The Director of Nursing, or designee, will review 4 resident's charts weekly for 4 weeks, then monthly for 2 months, to verify proper documentation of influenza vaccination or declination. All findings will be corrected immediately, if necessary, reported to the Administrator and reviewed at the facility's QAPI meeting for any appropriate action.	

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F0882 SS = D	Continued from page 19 A review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate care management dated NJ Exec Order 26.4b1, included a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, indicating NJ Exec Order 26.4b1 . A review of Resident #10's comprehensive care plan, dated NJ Exec Order 26.4b1, included a focus area indicating that the resident has NJ Exec Order 26.4b1. During an interview with the surveyor on 08/25/2025 at 1:10 PM, Resident #10 stated that she could not remember the last time she received an NJ Exec Order 26 On 08/27/2025 at 10:20 AM, the surveyor interviewed the US FOIA (b)(6) who stated that Resident #10 received an NJ Exec Order 26.4b1 at a pharmacy on NJ Exec Order 26.4b1, prior to admission, and was not due for another NJ Exec Order 26.4b1 until NJ Exec Order 26 On 08/27/2025 at 11:45 AM, the surveyor interviewed the US FOIA (b)(6) who stated that Resident #10 should had received an NJ Exec Order 26.4b1 between NJ Exec Order 26.4b1 , which was considered NJ Exec Order 26.4b1. She further stated that the facility did not administer NJ Exec Order 26.4b1 in NJ Exec Order 2 because it was outside of the NJ Exec Order 26.4b1. A review of the facility's undated policy, titled, "Influenza Vaccine", revealed that, "Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized." NJAC 8:39-19.1(b)	F0882		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61517	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		09/05/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was identified for a.) 4 day shifts and b.) 1 overnight shift out of 126 shifts reviewed, as evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift.	S0560	S0560 – Mandatory Access to Care Proactive review of the staffing schedule for the next 2 weeks through the next month. Nursing administration ensures on the units where needed. Resident had no adverse effect. All residents have the potential to be affected. Rates have been increased for CNA's and licensed/registered nursing staff. Recruitment ads were updated to reflect increases. Referral sign on bonuses offered. Payroll bonuses as needed. Agency staff pay reviewed and revised as necessary. The DON/designee and staff scheduler will have weekly meetings to determine upcoming schedules to determine needs. The Director of Nursing, or designee, will report the findings to the Administrator and monthly at the QAPI committee for action as appropriate.	10/21/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61517	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

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S0560	Continued from page 1 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. For the 2 weeks of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -08/03/25 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. -08/09/25 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. -08/10/25 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -08/16/25 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -08/16/25 had 9 total staff for 145 residents on the overnight shift, required at least 10 total staff. During an interview on 8/26/2025 at 1:48 AM with the surveyor the Licensed Nursing Home Administrator, in the presence of the Regional Clinical Director (RCD) and Director of Nursing, stated that he was aware of the staffing mandates and believed that the facility was meeting the requirements. A review the undated facility policy titled, "Staffing" revealed the following under Policy Interpretation and Implementation: 1. This facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met [...] 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan [...].	S0560		
S1690	Mandatory Nurse Staffing CFR(s): 8:39-25.2(d) In facilities with 150 licensed beds or more, there shall be an assistant director of nursing who is a registered professional nurse. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	S1690	S1690 – Mandatory Nurse Staffing 1. Facility has Director of Nursing Assistant with LPN license who is anticipating to take her Registered Nursing boards. Recruitment for Assistant Director of Nursing is ongoing. All residents have the potential to be affected.	10/21/2025

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S1690	Continued from page 2 Based on interview and review of pertinent facility documents, the facility failed to ensure there was an Assistant Director of Nursing (ADON) who was a registered professional nurse (RN). This deficient practice has the potential to affect all residents, and was evidenced by the following: During entrance conference on 8/20/2025 at 9:40 AM with the survey team coordinator, the Licensed Nursing Home Administrator (LNHA) stated that the facility had 165 licensed beds with a resident census of 143. On 8/27/2025 at 9:08 AM, during an interview with the surveyor, the LNHA confirmed that the facility is licensed for 165 licensed beds. On 8/27/2025 at 9:20 AM, the Chief Clinical Officer (CCO) stated to the survey team that the facility had an assistant to the Director of Nursing (DON) who was a Licensed Practical Nurse (LPN). The CCO further stated that the assistant to the DON was not the Assistant Director of Nursing (ADON). On 8/27/2025 at 10:00 AM, during an interview with the surveyor, the assistant to the Director of Nursing (DONA) stated that they were an LPN and that they assist the DON do their functions. A review of the DONA's active license confirmed that the DONA's license type was for a Licensed Practical Nurse - Single State (New Jersey). On 08/27/2025 at 10:22 AM, during an interview with the survey team, the LNHA confirmed that the facility did not have an Assistant Director of Nursing. A review of the facility-provided undated job description titled “Director of Nursing Services - Assistant” included under Education – Must possess a valid New Jersey Degree from an accredited college or university. N.J.A.C. 8:39 – 25.2 (d)	S1690	Continued from page 2 The Director of Nursing Assistant was in-serviced on the appropriate duties as per the dated job description by the Director of Nursing. Recruitment and the interview process to fill the position remains ongoing. The Director of Nursing will meet with the Director of Nursing Assistant to ensure that duties are met, as the recruitment and interview process continues for an Assistant Director of Nursing.	

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ARISTACARE AT MANCHESTER	**1770 TOBIAS AVENUE , MANCHESTER, New Jersey, 08759**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 10/22/2025 in relation to the 8/27/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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New Jersey State Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 10/22/2025 in relation to the 8/27/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/20/25 and 8/21/25. Aristacare at Manchester was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.	K0000		09/08/2025
K0222 SS = E	Egress Doors CFR(s): NFPA 101 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	K0222	K 0222 – Egress doors Facility immediately corrected this deficiency by removing the double keyed lock and installing a key pad lock only locking for entry to room. The Facility was inspected for any other areas affected by this deficiency with no other issues found. All residents on 3rd floor have the potential to be affected. The Maintenance Director/designee will inspect building monthly for 3 months to ensure facility is in compliance. The Maintenance staff were educated not to use double key bolt lock in resident areas. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee for any appropriate action.	09/19/2025

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

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K0222 SS = E	Continued from page 1 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 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 STANDARD is NOT MET as evidenced by: Based on observation and interview on 8/20/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined the facility failed to ensure doors within a required means of egress were not equipped with a latch or lock that required the use of a tool or key from the egress side in accordance with NFPA 101: 2012 Edition, Section 19.2 and 19.2.2.2.4. This deficient practice had the potential to affect 45 of 143 residents and was evidenced by the following: An observation at 11:12 AM of the 3rd floor sensory room, revealed the corridor door was equipped with a double-keyed bolt lock that would prevent egress from the room without a key. The door was the only way out of the room.	K0222		

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K0222 SS = E	Continued from page 2 In an interview at the time the [redacted] confirmed the observation. The facility's [redacted] were informed of the deficient practice at the Life Safety Code Exit conference on 8/21/25 at 3:15 PM. N.J.A.C. 8:39 - 31.2 (e)	K0222		
K0225 SS = E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 8/20/25 in the presence of the [redacted]), it was determined the facility failed to ensure listed items were identified by a label and labels on fire door assemblies were maintained in a legible condition in accordance with NFPA 101: 2012 Edition, Section 7.1.3.2, 7.2, 8.2, 8.3.3.2.3 and NFPA 80: 2010 Edition, Section 4.2, 4.2.1 to 4.2.3. This deficient practice had the potential to affect 27 of 143 residents and was evidenced by the following: Observations at 9:35 AM of the two stairwell doors in the lobby foyer, revealed the doors did not have the required fire rating label attached to the door or door assembly. One door went to the basement stairwell and the other door went to the 2nd and 3rd floor stairwell, providing egress from those locations out of the building. In an interview at the time the [redacted] confirmed the observations. The facility's [redacted] were informed of the deficient practice at the Life Safety Code Exit conference on 8/21/25 at 3:15 PM.	K0225	K 0225 – Stairways & Smokeproof Enclosures Facility contacted NJ Doorworks, a licensed vendor, to recertify & label the 2 stairwell doors in question. The Facility was inspected for any other areas affected by this deficiency with no other issues found. All residents have the potential to be affected. The Maintenance Director/designee will inspect building monthly for 3 months to ensure facility is in compliance. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee for any appropriate action.	10/21/2025

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K0225 SS = E	Continued from page 3 N.J.A.C. 8:39 - 31.2 (e) NFPA 80	K0225		
K0281 SS = E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 8/20/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined the facility failed to ensure required illumination was arranged so that the failure of any single lighting unit does not result in a below standard illumination level in any designated area in accordance with NFPA 101: 2012 Edition, Section 19.2.8, 7.8 and 7.8.1.4. This deficient practice had the potential to affect 47 of 143 residents and was evidenced by the following: An observation at 9:54 AM of the basement exterior exit by the phone room, revealed the exterior exit discharge was provided with a single light fixture with a single bulb. An observation at 10:11 AM of the basement exterior exit from the fire pump room, revealed the exterior exit discharge was provided with a single light fixture with a single bulb. An observation at 12:28 PM of the 1st floor exterior exit by room 113, revealed the exterior exit discharge was provided with a single light fixture with a single bulb. In interviews at the times, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code Exit	K0281	K 0281 – Illumination of means of Egress Facility purchased 3 more fixtures for the 3 areas identified requiring additional outdoor exit lighting. The Facility was inspected for any other areas affected by this deficiency with no other issues found. All residents have the potential to be affected. The Maintenance Director/designee will audit facility exterior exits for 3 months to ensure that facility is in compliance. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee for any additional recommendations.	10/21/2025

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K0281 SS = E	Continued from page 4 conference on 8/21/25 at 3:15 PM. N.J.A.C. 8:39 - 31.2 (e)	K0281		
K0341 SS = F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 8/20/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure fire alarm initiating devices were supported independently of their attachment to circuit conductors in accordance with NFPA 101: 2012 Edition, Section 19.3.4 and NFPA 72: 2010 Edition, Section 17.4.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:58 AM of the basement corridor ceiling smoke detector outside of the medical supply room, revealed the smoke detector was hanging down by its wires outside its electrical box. An observation at 10:00 AM of the basement generator room ceiling smoke detector by the transfer switch, revealed the smoke detector was hanging down by its wires outside its electrical box. In interviews at the times, the US FOIA (b)(6) confirmed the observations.	K0341	K 0341 – Fire Alarm System Facility immediately contacted Allied Fire & Safety who corrected the 2 hanging smoke detectors listed in the report. The Facility was inspected for any other areas affected by this deficiency and corrected if necessary. All residents have the potential to be affected. The Maintenance Director/designee will inspect the smoke detectors monthly for 3 months to ensure that facility is in compliance. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee x 3 months for any additional recommendations.	10/21/2025

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K0341 SS = F	Continued from page 5 The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code Exit conference on 8/21/25 at 3:15 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 72	K0341		
K0353 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 STANDARD is NOT MET as evidenced by: Based on observations and interviews on 8/20/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure sprinkler systems and their components were maintained in accordance with NFPA 101: 2012 Edition, Section 9.7 and NFPA 25: 2011 Edition, Section 5.2.1, 5.2.1.1.1, 5.2.1.1.2, and 5.2.1.1.3. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during a facility tour between 9:35 AM and 1:05 PM revealed the following: The basement small hallway had a sprinkler head with a	K0353	K 0353 Sprinkler System – Maintenance & Testing Facility immediately corrected all the broken tiles and escutcheons listed in the report. The Facility was inspected for any other areas affected by this deficiency and were immediately corrected if necessary. All residents have the potential to be affected. The Maintenance Director/designee will inspect the ceiling tiles & escutcheons at the building monthly for 3 months to ensure that facility is in compliance. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee x 3 months for any additional recommendations.	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315196	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT MANCHESTER	1770 TOBIAS AVENUE , MANCHESTER, New Jersey, 08759

(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
K0353 SS = F	Continued from page 6 space around it.The 3rd floor unit managers office had a 2-foot by 2-foot ceiling tile up, allowing the passage of smoke and hot gasses into the space above.The 1st floor porters closet by room 101 had ceiling tiles broken and space around where wires went through by the sprinkler head. The 1st floor shower room had a 5-inch by 4-foot ceiling tile missing along the wall where 2 pipes went through.Room 122 had 1 of 2 sprinklers with broken ceiling tiles and space around the sprinkler heads.The kitchen dietary office had 1 of 2 sprinklers that was missing the escutcheon.The kitchen dishwasher area had 2 sprinklers that were rusted. In interviews at the times, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code Exit conference on 8/21/25 at 3:15 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 25	K0353		
K0355 SS = F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 8/20/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure fire extinguishers not exceeding 40 pounds were installed so that the top of the fire extinguisher is not more than 5 feet above the floor in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition, Sections 6.1.3.8, 6.1.3.8.1 and 6.1.3.8.2. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 12:54 PM of the kitchen fire extinguishers revealed the following:The Class NJ Exec extinguisher by the dietary office was mounted	K0355	K 0355 – Portable Fire Extinguishers Facility immediately corrected the heights of the 3 fire extinguishers cited. The Facility was inspected for any other areas affected by this deficiency and were immediately corrected if necessary. All residents have the potential to be affected. The Maintenance Director/designee will inspect the fire extinguishers monthly for 3 months to ensure that there all is in compliance. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee for any additional recommendations.	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315196	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

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ARISTACARE AT MANCHESTER	1770 TOBIAS AVENUE , MANCHESTER, New Jersey, 08759

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K0355 SS = F	Continued from page 7 67-inches from the floor to the top.The Class K extinguisher by the dietary office was mounted 64-1/2 inches from the floor to the top.The Class NJ Exec extinguisher by the cooking line was mounted 66-inches from the floor to the top. In an interview at the time, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code Exit conference on 8/21/25 at 3:15 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 10	K0355		
K0363 SS = D	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 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.	K0363	K 0363– Corridor Doors Facility contacted NJ Doorworks, a licensed vendor, to replace the 3 doors – room 101, 122, 114 listed in the report. The Basement phone room door was repaired immediacy by director of Maintenance. The Facility was inspected for any other areas affected by this deficiency and corrected if necessary.Signed proposal included. All residents have the potential to be affected. The Maintenance Director/designee will inspect the corridor doors monthly for 3 months to ensure that there all is in compliance. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee for any additional recommendations.	10/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315196	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

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K0363 SS = D	Continued from page 8 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 STANDARD is NOT MET as evidenced by: Based on observations and interviews on 8/20/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure corridor doors resisted the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3. This deficient practice had the potential to affect 5 of 143 residents and was evidenced by the following: Observations during a facility tour between 9:35 AM and 1:05 PM revealed the following: Resident room 101 had a 3/4-inch space from the door face to the door stop and a 5/8-inch space from the door top to the top frame on the strike side of the door leaf. Resident room 122 had a 5/8-inch space from the door face to the door stop and a 3/8-inch space from the door top to the top frame on the strike side of the door leaf. Resident room 114 had a 3/4-inch space from the door face to the door stop and a 3/8-inch space from the door top to the top frame on the strike side of the door leaf. The basement phone room door stopped 3/4-inch from the closed position when tested and did not latch. In interviews at the times, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code Exit conference on 8/21/25 at 3:15 PM. N.J.A.C. 8:39 - 31.2 (e)	K0363		
K0541 SS = E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including	K0541	K 0541 –Rubbish Chutes Facility ordered & installed new trash chute to correct the area identified. The Facility was inspected for any other areas affected by this deficiency and were immediately corrected as necessary. All residents have the potential to be affected.	10/21/2025

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K0541 SS = E	Continued from page 9 pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 8/20/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined the facility failed to ensure all chute intake doors to a linen chute were provided with a positive latching frame in accordance with NFPA 101: 2012 Edition, Section 19.5.4, 9.5.2, 8.3 and NFPA 82: 2009 Edition, Section 5.2.1.1 and 5.2.3.3.2.1. This deficient practice had the potential to affect 41 of 143 residents and was evidenced by the following: An observation at 12:44 PM of the 1st floor laundry chute, revealed the chute door was not equipped with a latching mechanism. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code Exit conference on 8/21/25 at 3:15 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 82	K0541	Continued from page 9 The Maintenance Director/designee will inspect rubbish shuts at the facility monthly for 3 months to ensure facility is in compliance. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee x 3 months and as needed thereafter for any additional recommendations.	

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K0541 SS = F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not MET as evidenced by: Based on observations and interviews on 8/20/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined the facility failed to ensure ashtrays of non-combustible material and safe design and metal containers with self-closing cover devices into which the ashtrays can be emptied were available in all areas where smoking is permitted in accordance with NFPA 101: 2012 Edition, Section 19.7.4 (5)(6). This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 12:28 PM of the resident smoking area outside the exit by room 113, revealed the red metal can designated for smoking had a self-closing device	K0541 K0741	K 0741 – Smoking Regulations Facility immediately ordered and placed 2 required red metal cans with self-closing devices to correct the 2 smoking areas identified in the report. The Facility was inspected for any other areas affected by this deficiency. No other areas found. All residents have the potential to be affected. The Maintenance Director/designee will inspect the outside smoking areas monthly for 3 months to ensure that the facility is in compliance. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee and as needed thereafter for any additional recommendations.	10/21/2025

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K0741 SS = F	Continued from page 11 that did not work when tested and there were no ashtrays available. Observations at 12:39 PM of the courtyard off the dining room, revealed the courtyard was a designated smoking area and there was no metal can with a self-closing device available. In interviews at the times, the US FOIA (b)(6) confirmed the observations, and the US FO stated there was no courtyard metal can because it got destroyed and had to be thrown out. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code Exit conference on 8/21/25 at 3:15 PM. N.J.A.C. 8:39 - 31.2 (e), 31.6(e)	K0741		
K0911 SS = E Bldg. 01	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 8/20/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure the guarding of live electrical parts and controls within unlocked panels in resident accessible areas in accordance with NFPA 101: 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99: 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70: 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice had the potential to affect 76 of 143 residents and was evidenced by the following: An observation at 11:12 AM revealed the electrical panel in the 3rd floor sensory room was unlocked and	K0911	K 0911 – Electrical Systems Facility immediately locked the electrical box in the 2 areas listed. The Facility was inspected for any other areas affected by this deficiency and were immediately corrected if necessary. All smoking residents have the potential to be affected. Maintenance Director/designee will re-educate the dietary & maintenance departments to keep electrical panels locked at all times. Maintenance Director/designee will audit the electrical panel boxes monthly for 3 months to ensure facility is in compliance. Maintenance Director/designee will report any findings immediately to the administrator and to monthly QAPI committee x 3 months and as needed thereafter for any additional recommendations.	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315196	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

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K0911 SS = E Bldg. 01	Continued from page 12 open 7-inches. An observation at 10:24 AM revealed 1 of 4 electrical panels in the 1st floor corridor across from the employee lounge was unlocked. In interviews at the times, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code Exit conference on 8/21/25 at 3:15 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 99, 70	K0911		

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E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health on 8/21/25, the facility was found to be in substantial compliance with CFR 483.73, Requirements for Long Term Care Facilities.	E0000		09/08/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315196	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/13/2025 in relation to the 8/27/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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

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