STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	**39 EAST MOUNTAIN ROAD , HILLSBOROUGH, New Jersey, 08844**

(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 Complaint #: 2651044 Survey Dates: 5/15/26 to 5/28/26 Census: 163 Sample size: 32 + 3 closed records 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.	F0000		06/11/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary 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:	F0812	F812 CORRECTIVE ACTION PLAN Foothill Acres Rehabilitation & Nursing Center Survey Date: 05/15/2026 – 05/28/2026 Deficiency: F812 Food Procurement, Store, Prepare, Serve – Sanitary Purpose To ensure compliance with federal food safety regulations by implementing a comprehensive monitoring system addressing food labeling, dating, FIFO practices, unit pantry oversight, and sanitation standards. Immediate Corrective Actions ● All improperly labeled and undated food items were discarded. ● Expired items identified in unit pantries were discarded immediately. ● Staff food stored in resident refrigerators was removed. ● Ice machine dispenser was cleaned and sanitized. ● Dietary and Nursing staff were educated on facility policies regarding food dating, labeling, storage, FIFO rotation, and sanitation.	07/12/2026

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

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

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F0812 SS = F	Continued from page 1 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food-borne illness. This deficient practice was evidenced by the following: On 5/15/26 at 10:07 AM, the surveyor entered the facility's kitchen and conducted an interview with the U. S. FOIA (b) (2) who stated the food in the refrigerators and freezers should be sealed in an air-tight wrap and labeled with a use by date. The U. S. FOIA further stated the dietary staff were responsible for maintaining the nursing unit pantry inventory to ensure there were no expired items. At 10:29 AM, the surveyor, accompanied by the U. S. FOIA observed the following in the kitchen: In the Walk-In Freezer: 1. There was a two-inch steam pan of chicken parmesan that was sealed without a prepared or use-by date. The U. S. FOIA (b) discarded the chicken parmesan. 2. There was a 10.5 ounce (oz) bag of vegan chicken nuggets that was open and not resealed, leaving the contents of the bag exposed. The U. S. FOIA (b) discarded the bag of vegan chicken nuggets. On 5/21/26 at 11:02 AM, the surveyor, accompanied by U. S. FOIA (b) (2) #1, observed the following in the 200 Unit pantry: 1. In the freezer, there was a styrofoam cup that was not labeled. The U. S. FOIA (b) (2) removed it from the freezer to look inside the cup and an U. S. FOIA (b) (2) took the cup from her hand and began drinking from it. The U. S. F acknowledged that the cup belonged to him and the U. S. FOIA (b) (2) stated he should not store his food/drinks in the resident refrigerator. 2. In the refrigerator, there was a 15.2 oz bottle of juice with an expiration date of 3/20/26. The U. S. FOIA (b) (2) verified the juice was expired and discarded it.	F0812	Continued from page 1 Systemic Changes Implemented 1. Daily Kitchen Labeling/FIFO Audit Log 2. Twice-Daily Unit Pantry Monitoring Log 3. Staff education and competency validation 4. Ongoing supervisory audits by Food Service Director and Department Managers 5. Monthly review through QAPI Monitoring Plan Daily ● Kitchen Labeling & FIFO Audit completed by Cook Supervisor or Dietary Manager. ● Unit Pantry Monitoring completed twice daily by Dietary Aide or designee. Weekly ● U. S. FOIA (b) (2) reviews all logs for compliance. ● Corrective actions documented and staff re-educated as necessary. Monthly ● Results reported through QAPI for three months. ● Trends and opportunities for improvement identified and addressed.	07/12/2026

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F0812 SS = F	Continued from page 2 During an interview at that time, the U. S. FOIA (b) (2) stated the dietary staff were responsible for checking the pantry refrigerators for expired items and that the facility staff were not supposed to store their food/drinks in the resident refrigerators. On 5/21/26 at 11:13 AM, the surveyor, accompanied by Registered Nurse/Unit Manager (RN/UM) #1, observed the following in the 400 Unit pantry: 1. In the freezer, there was a previously opened container of ice cream that was labeled with a resident's name and room number, but did not include the date the ice cream was placed in the freezer or a use-by date. The U. S. FOIA (b) stated she would find out when the ice cream was placed into the freezer. 2. On the ice machine, there was a build up of a white substance along the ice dispenser. The U. S. FOIA (b) stated she would get someone to clean the ice machine. During an interview at that time, the U. S. FOIA (b) stated the dietary staff were responsible for checking the pantry refrigerators for expired items and that the ice machine was cleaned daily and should not have a build up of a white substance. The facility provided a copy of the 400 Unit ice machine maintenance log that revealed the ice machine was last cleaned 3/24/26. On 5/21/26 at 12:27 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that all food in the kitchen should be labeled with an expiration date, all food should be sealed properly, the food in the pantries should be stored under the facility's guidelines, and the ice machine should be clean. A review of the facility's "Dating and Labeling" policy, undated, included: Every food item that is prepared, opened, or removed from its original packaging must be labeled with:… the date the product was prepared or opened. All foods must be stored in food grade containers and tightly wrapped with a date and label… Do not	F0812		07/12/2026

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F0812 SS = F	Continued from page 3 leave open items in any storage areas (cold or dry). A review of the facility's "Food/Beverages from Outside" policy, revised 1/12/26, included: All food and beverage items that are brought into the facility must be labeled with the resident's name and date of delivery before being placed in refrigerators. All food items must be dated with receiving date and/or manufacturer's "use-by" date. All packaged/sealed food items will be discarded upon expiration date. A review of the facility's "Unit Pantries" policy, revised October 2025, included: Opened food items must be… labeled with opening date. Staff shall routinely inspect pantry items for expiration dates… Expired, spoiled, or contaminated food shall be discarded immediately. Resident-labeled food items shall be clearly identified and dated. Expired resident food items shall be discarded according to facility policy. Dietary department monitors food storage and sanitation compliance. A review of the facility's "Ice Machine" policy, revised January 2023, included: Ice machines shall be cleaned and disinfected:… immediately when visibly soiled… Cleaning shall include: interior surfaces, exterior surfaces,… gaskets and dispensers. The Infection Preventionist, Dietary Manager, or Maintenance Department shall inspect ice machines routinely for: mold or slime buildup… NJAC 8:39-17.2(g)	F0812		07/12/2026

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F0697 SS = 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: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to meet the professional standards of practice by not appropriately assessing and documenting PRN (as needed) [NJ Exec] medications. This deficient practice was identified for 1 of 5 residents (Resident #41) reviewed for unnecessary medications and was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." On 5/15/2026 at 9:54 AM, during initial tour, the surveyor observed Resident #41 lying in bed with their [NJ Exec Order 26.4b1]. Resident #41 did not [NJ Exec Order 26.4b1] or [NJ Exec Ord] with the surveyor. On 5/18/2026 at 10:06 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #41. A review of the Admission Record, (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to: [NJ Ex Order 26, 4B1] A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the	F0697	PLAN OF CORRECTION: F0697 SS=E CFR(s): 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. CORRECTIVE ACTION(S): Nursing staff in-serviced by staff educator on pain management policy to include proper following parameters in pain medications ordered according to residents' pain level at time of administration. For residents who are cognitively impaired Nursing staff must then use signs and symptoms along with utilizing the Wong-Baker FACES scale for documenting pain levels. One to one education provided to nurse that administered prn medication outside parameters as per physician's orders. Resident #41 assessment by primary physician to ensure orders for prn medications are appropriate for resident #41 current status. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents taking pain medication have the potential to be affected by this practice. MEASURES PUT IN PLACE: Nursing will receive in-service by staff educator within 30 days on pain management policy to include proper following parameters in pain medications ordered according to residents' pain level at time of administration. For residents who are cognitively impaired Nursing staff must then use signs and symptoms along with utilizing the Wong-Baker FACES scale for documenting pain levels. MONITORING OF MEASURES:	07/12/2026

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F0697 SS = E	Continued from page 5 management of care, dated [redacted] included the resident had a Brief Interview for Mental Status (BIMS) [redacted] indicating that the resident was unable to [redacted] the [redacted] due [redacted]. Further review of the MDS revealed the resident was prescribed medications that included [redacted] A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated [redacted]. Interventions included: [redacted] assessments to administer [redacted] medications per physician orders. A review of the Physician Order Summary (POS), dated as of [redacted], included the following physician order (PO): [redacted]; Give [redacted] as needed for [redacted] A review of the [redacted] Medication Administration Record (MAR) revealed the resident was administered [redacted] for a [redacted] on the following days [redacted]. A review of the [redacted] revealed the resident was administered [redacted] for a [redacted] the following days: [redacted]. A review of the [redacted] revealed the resident was administered [redacted] or a [redacted] on the following days: [redacted] A review of the [redacted] revealed the resident was administered [redacted] for a [redacted] on the following days: [redacted] A review of [redacted] revealed the resident was administered [redacted] for a documented [redacted] on the following days: [redacted]	F0697	Continued from page 5 DON/Designee will randomly review 3 residents on prn pain medications to ensure pain medications are administered according to physician's ordered weekly x 4 weeks then monthly x 2 then quarterly x 2. DON/Designee will review Resident #41prn pain medications to ensure is administered per physician's ordered weekly x 4 weeks, then monthly x 2, then quarterly x 2. Audit findings will be reported to QA committee quarterly.	07/12/2026

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F0697 SS = E	Continued from page 6 On 5/19/2026 at 12:07 PM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) #2 who was aware of the medication errors. RN/UM #2 stated that there was one nurse that was chronically non-compliant with following the physician orders of pain level parameters. RN/UM #2 indicated that it has been addressed with the nurse on multiple occasions. A review of the facility's "Pain Management" policy with a review date of 1/25/2025, included, "The nurse assesses the resident for signs and symptoms of pain using either the pain assessment form for the cognitively impaired or the pain assessment record..." NJAC 8:39-27.1 (a)	F0697		07/12/2026
F0881 SS = E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record reviews, and a review of facility documentation, it was determined that the facility failed to consistently implement an [NJ Exec Order 26.4b] [redacted] The facility did not utilize standardized infection surveillance criteria to determine whether [NJ Exec Order 26] use was appropriate. This deficiency was identified in 3 of 6 residents reviewed for [NJ Ex Order 26, 4B] use (Resident #61, #74, and #154) and was evidenced by the following: 1.) A review of the Infection Control Case List (ICCL) in the electronic medical record (EMR) for [NJ Exec Order] revealed Resident #61 had a NJ Ex Order 26, 4B1 [redacted] with an onset date of [NJ Ex Order 26, 4B1] Further	F0881	PLAN OF CORRECTION: F0881 SS=E CFR(s): 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)(3) An antibiotic stewardship program that includes use protocols and a system to monitor antibiotic use. CORRECTIVE ACTION(S): Residents #61, #74, and #154 were assessed for appropriate [NJ Ex Order 26, 4B] use using [NJ Exec Order 26.4b] criteria. Nursing and medical staff in-serviced by staff educator on [NJ Exec Order 26] stewardship and utilizing [NJ Exec Order 26.4b] criteria when ordering any [NJ Exec Order 26.4b] to ensure and promote appropriate use of [redacted] and monitor prescribing practices. One to one education provided by DON to [U.S. FOIA (b)(6)] [redacted] on [NJ Exec Order 26] stewardship program, IP role and policy updated to include use of [NJ Exec Order 26.4b] criteria to ensure appropriate [NJ Exec Order 26] use and proper monitoring of prescribing practices. Use of [NJ Exec Order 26.4b] criteria also must be documented for anyone receiving antibiotics to ensure appropriate use of [NJ Exec Order 26.4b] has been met. IDENTIFICATION OF RESIDENTS WHO HAVE THE	07/12/2026

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F0881 SS = E	Continued from page 7 review of the ICCL indicated the resident was started on an [redacted] for the [redacted] on [redacted]. There was no evidence that standardized infection surveillance criteria were used to determine the appropriateness of the [redacted] prescribed. 2.) A review of the ICCL in the EMR for [redacted] revealed Resident #74 had [redacted] with an onset date of [redacted]. Further review of the ICCL indicated the resident was started on an [redacted]. There was no evidence that standardized infection surveillance criteria were used to determine the appropriateness of the [redacted] prescribed. 3.) A review of the ICCL in the EMR for [redacted] revealed Resident #154 had a [redacted], with an onset date of [redacted]. Further review of the ICCL indicated the resident was started on an [redacted] for the [redacted]. There was no evidence that standardized infection surveillance criteria were used to determine the appropriateness of the [redacted] prescribed. On 5/19/2026 at 11:40 AM, the surveyor interviewed the [redacted] who reported she has worked at the facility for [redacted] and had served in the [redacted] role since [redacted]. She indicated residents must meet criteria prior to initiation of [redacted] and that the facility utilized both the [redacted] and [redacted] for infection identification and [redacted] stewardship. The [redacted] further stated there was no formal checklist in place to ensure clinicians prescribed [redacted] in accordance with the [redacted]. She stated nursing staff notified her when a resident was started on [redacted] and she reviewed the criteria; however, this review was not documented. On 5/20/2026 at 10:04 AM, the surveyor interviewed the [redacted] who reported she had served as the [redacted] for [redacted]. The [redacted] indicated the facility utilized the [redacted], not the [redacted] for [redacted] surveillance. The [redacted] stated nursing staff were expected to be knowledgeable regarding the criteria utilized by the facility for [redacted] stewardship. She further confirmed the [redacted] should complete and document the [redacted] checklist rather than solely reviewing the criteria.	F0881	Continued from page 7 POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents taking antibiotic medications have the potential to be affected by this practice. MEASURES PUT IN PLACE: Nursing and medical staff will receive in-service by staff educator within 30 days on Antibiotic Stewardship policy to include use of McGeer's criteria to ensure and promote appropriate use of antibiotics. McGeer's criteria checklist will be utilized when any resident is prescribed an antibiotic by nursing staff. Infection Preventionist will ensure criteria checklist has been completed and documented to ensure appropriate use of antibiotics and refer to MD as needed. MONITORING OF MEASURES: DON/Designee will randomly review all residents on antibiotics to ensure proper assessment and documentation was performed by utilizing McGeer's criteria weekly x 4 weeks then monthly x 2 then quarterly x 2. DON/Designee will review Infection Preventionist documentation and audit logs to ensure antibiotic stewardship protocols are followed per policy weekly x 4 weeks, then monthly x 2 and then quarterly x 2. Audit findings will be reported to QA committee quarterly.	07/12/2026

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F0881 SS = E	Continued from page 8 On 5/20/2026 at 11:14 AM, the surveyor interviewed the U. S. FOIA (b) (2) via telephone, who reported the facility utilized the NJ Exec Order 26 Criteria for NJ Ex Order 26, 4B1, and that the criteria were reviewed monthly as part of her consultation process which included reviewing progress notes, laboratory results, and other clinical documentation to determine whether NJ Exec Order 26 Criteria were met. A review of the facility's "Antibiotic Stewardship Program" policy, dated 1/12/2026, included "The Antibiotic Stewardship Program (ASP) shall monitor compliance with evidence-based guidelines or best practices regarding antimicrobial prescribing which may include but not limited to the following activities in a manner needed to assure patient safety and met the new Centers for Medicare and Medicaid services requirement for stewardship." NJAC 8:39-19.4(d)	F0881		07/12/2026
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. §483.10(b) Exercise of Rights.	F0550	PLAN OF CORRECTION: F0550 SS=D CFR(s): 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 maintenenceor 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 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.	07/12/2026

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F0550 SS = D	Continued from page 9 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, record review, and review of facility documents, it was determined that the facility failed to treat each resident with respect and dignity in a manner that promotes his/her quality of life. This deficient practice was identified for one 1 of 32 residents (Resident #81) reviewed for resident rights. This deficient practice was evidenced by the following: On 5/15/26 at 12:08 PM, during the initial tour, the surveyor overheard a male voice speaking in a loud, firm tone to Resident #81, stating, "Are we on the same page? Do you understand what I'm saying?" To which the resident replied, "[redacted]" and the male voice responded, "Well, some people would disagree with that." When the surveyor approached the room, the man left the room and was wearing a sweatshirt with the facility's name on it. At that time, Resident #81 was sitting up in bed, [redacted] and told the surveyor that the man in the room was a [redacted]) and then reiterated the part of the conversation that the surveyor overheard. The resident stated he/she was [redacted] that he/she would not [redacted] be able to go [redacted] on [redacted] but that the [redacted] was always [redacted] to him/her. The surveyor reviewed the medical record for Resident #81.	F0550	Continued from page 9 CORRECTIVE ACTION(S): Resident #81 was immediately assessed and interviewed by admin; reportable event was completed. [redacted] was re-educated on resident rights and abuse/neglect policies and management of residents with behaviors by staff educator and facility administrator. Physical Therapist was removed from schedule and returned following a two-day suspension. All residents under the care of the physical therapist were interviewed regarding the physical therapist conduct, all reported positive experiences and denied any history of inappropriate behavior or abuse. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by this practice. MEASURES PUT IN PLACE: All staff will receive in-service by staff educator within 30 days on Resident Rights and management of residents with behaviors. All residents will receive education regarding Resident Rights and receive information on facility policy and procedures. DON/Admin/Designee will continue to monitor resident #81 to ensure all needs are met and resident rights are followed. MONITORING OF MEASURES: DON/Designee will randomly review 3 residents on	07/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0550 SS = D	Continued from page 10 According to the Admission Record, an admission summary, the resident had diagnoses which included, but were not limited to, NJ Ex Order 26, 4B1 [redacted] A review of the quarterly Minimum Data Set (MDS), dated [redacted], included the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident's NJ Ex Order 26, 4B1 A review of the individualized comprehensive care plan (ICCP), dated [redacted], included a focus that the resident had the potential to be NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 Interventions included: Assess the resident's [redacted] of the situation, allow time for the resident to [redacted] and [redacted] towards the situation, and when the resident becomes [redacted] intervene before NJ Exec Order 26.4b1, guide away from source of [redacted] engage [redacted] in [redacted] and if response is [redacted] staff to walk calmly away and reapproach later. On 5/15/26 at 12:49 PM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who explained that Resident #81 would sometimes [redacted], but that he never had any issues with the resident. On 5/15/26 at 12:52 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that Resident #81 could be NJ Ex Order 26, 4B1 towards staff, but that it was important to ensure the resident NJ Ex Order 26, 4B1. On 5/15/26 at 1:00 PM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) #1 who stated Resident #81 would complain about specific CNAs from time to time and that she would change the CNA assignment when that happened. The [redacted] further stated it was important to ensure the resident received the care they deserved and felt safe. On 5/15/26 at 1:02 PM, the surveyor observed the [redacted] enter Resident #81's room. The surveyor overheard the [redacted] to the resident and stated he should not have talked to him/her that way.	F0550	Continued from page 10 physical therapist assignment to ensure and promote Resident Rights are followed and maintain quality care weekly x 4 weeks then monthly x 2 then quarterly x 2. Audit findings will be reported to QA committee quarterly	07/12/2026

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F0550 SS = D	Continued from page 11 On 5/15/26 at 1:06 PM, the surveyor interviewed the [redacted]. When asked what the [redacted] was discussing with the resident, the [redacted] stated the resident told him that he does not say [redacted] things to the resident, which the [redacted] admitted was "a fair assessment." The [redacted] then acknowledged that, while he was trying to be [redacted] with the resident, his tone was [redacted] to the resident and was not [redacted]. The [redacted] further explained that it was important to maintain a safe space and to ensure the residents felt [redacted] On 5/15/26 at 1:23 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated Resident #81 had [redacted] towards staff, but that she would expect staff to respond to the resident in a respectful manner and reapproach the resident, if necessary, as it was sometimes difficult to [redacted] the resident's [redacted]. At that time, the surveyor described the interaction between the [redacted] and Resident #81, and the [redacted] confirmed that the interaction was not [redacted] or [redacted] to the resident. The [redacted] also stated that it was important to speak to residents [redacted] to ensure the residents were being properly cared for. On 5/15/26 at 1:33 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated it was important to speak to the residents [redacted] to ensure the dignity of the residents as the facility was their home. The [redacted] explained that Resident #81 could be NJ Ex Order 26, 4B1 towards staff, but that staff should try to talk through the situation with the resident or step away to get a supervisor. The [redacted] stated that staff should not [redacted] with the resident as they were expected to respond in a [redacted] manner. At that time, the surveyor described the interaction between the [redacted] and Resident #81, and the [redacted] confirmed that the [redacted] should not have responded to the resident in that manner, as the [redacted] was not [redacted] On 5/15/26 at 1:53 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated staff should speak to residents in a [redacted] way to honor the resident's rights. At that time, the surveyor described the interaction between the [redacted] and Resident #81, and the [redacted] confirmed that the [redacted] should have spoken to the resident in a more "[redacted]" manner, and that if the resident was NJ Ex Order 26, 4B1 towards the [redacted],	F0550		07/12/2026

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F0550 SS = D	Continued from page 12 he should have [NJ Exec Order 26.4b1] left the room and reapproached the resident later. A review of the "[NJ Exec Order 26.4b1] Job Description" signed by the [U.S. F] on [NJ Exec Order 2], included the following: Maintain professional relationships with co-workers, facility staff, patients, and patient families. Comply with all facility policies and procedures. Maintain a positive work atmosphere by demonstrating and communicating in a professional manner so as to foster positive relations with customers, clients, co-workers, and managers. Adhere to any and all other written and oral policies and procedures. A review of the facility's "Resident Rights" policy, revised 2/22/24, included, "Residents, visitors, and staff will be treated with dignity and respect," and that residents have the right: "To be treated with courtesy, consideration, and respect." NJAC 8:39-4.1(a)(12)	F0550		07/12/2026
F0569 SS = D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident	F0569	PLAN OF CORRECTION: F0569 SS=D CFR(s): 483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-(A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. 483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State Law. CORRECTIVE ACTION(S):	07/12/2026

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F0569 SS = D	Continued from page 13 with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of pertinent facility documents, it was determined that the facility failed to ensure that all residents that maintained a NJ Exec Order 26.4b1) received a written notification when approaching the limit that could jeopardize a resident's eligibility for NJ Exec Order 26.4b1 This deficient practice was identified for 5 of 5 residents (Resident #33, #111, #122, #163 and #164) reviewed for PNA and was evidenced by: On 5/15/26 at 11:25 AM, the U. S. FOIA (b) (2) provided the balances as of A review of the facility's "Patient Fund Balances" through revealed 5 residents had balances that ranged from NJ Ex Order 26, 4B1. On 5/19/2026 at 9:20 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that statements were handed out each quarter but at any time the residents could request it. The stated that some people did not spend their money and that either the Activities staff or herself contacted the resident or their representative to figure out how they could spend down the money. She then explained that the resident's should be under but was sure some residents were still over that amount. When asked if she provided a written notification or had documentation, the stated there was no documentation but moving forward she would provide documentation as there "probably" was a letter she could use. She further stated that it was important for the resident's to be under so they did not get "kicked off" The confirmed that when the resident reached they should be notified. On 5/21/2026 at 12:36 PM, the U. S. FOIA (b) (2) stated in the presence of the U. S. FOIA (b) (2) and the survey team that his expectation would be for a letter to be sent out. He stated that it	F0569	Continued from page 13 U.S. FOIA (b)(6) was re-educated on Personal Needs Account Policy to ensure all residents that maintain a Personal Needs Account receive a written notification when approaching the limit that could jeopardize a resident's eligibility for Medicaid and Supplemental Security Income (SSI). Residents #33, # 111, 122, 163 and #164 were reviewed, and notification of account balances were submitted to affected residents and/responsible parties. Residents #33, # 111, 163 and #164 were brought down to below limit. Resident #122 to make any purchases to , however stated that the made purchases and will be providing the receipts. Resident #122 was provided with a written notification letter informing resident #122 of the current balance on account and was notified that if account reaches $ than the resource limit, the resident may lose eligibility for . IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents with Personal Needs Account receiving Medicaid or Supplemental Security Income have the potential to be affected by this practice. MEASURES PUT IN PLACE: All Business Office Staff will receive in-service by staff educator within 30 days on Personal Need Account Policy and procedures. Business Office Manager will monitor Personal Needs Accounts monthly and send notifications as needed MONITORING OF MEASURES: DON/Admin/Designee will randomly review residents' Personal Needs Account balances to ensure all resident accounts are below the limit and	07/12/2026

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F0569 SS = D	Continued from page 14 was important for the resident or their representative to be notified as they could lose their [NJ Ex Order 26, 4B]. On 5/22/2026 at 9:37 AM, the [U. S. FOIA] stated in the presence of the [U. S. FOIA (b)] and the survey team that after surveyor inquiry the facility spoke with all the above-mentioned residents, and they brought their [NJ Exec O] down except Resident #122. She stated the resident [NJ Exec Order 2] but that the [NJ Exec O] made purchases but did not provide all the receipts. So, they sent another letter as Resident #122 was still above [NJ Ex Order 26, 4B1]. A review of the facility's "Resident PNA" policy dated 5/21/26, included, 3. This facility will notify each resident that receives Medicaid benefits: a.) when the amount in the resident's account reaches $200.00 less than the SSI resource limit for one person. b.) If the amount in the resident's account, reaches the SSI resource limit, the resident may lose eligibility for Medicaid or SSI. NJAC 8:39-9.5	F0569	Continued from page 14 to ensure those approaching $200 less than the SSI resource limit receive written notification of such monthly x 3 then quarterly x 2. Audit findings will be reported to QA committee quarterly.	07/12/2026
F0686 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, record review, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control practices and professional	F0686	PLAN OF CORRECTION: F0686 SS=D CFR(s): 483.25(b)(1)(i)(ii) Treatment/Services to Prevent/Heal Pressure UlcerCFR(s): 483.25(b) Skin Integrity. 483.25(b)(1) Pressure ulcers. Based on 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. CORRECTIVE ACTION(S): Resident #40 assessed to ensure proper [NJ Ex Order 26, 4B1] was performed and ensure resident was [NJ Exec] from [NJ Exec Order 26,4B1]. [U. S.] received one to one education regarding wound care policy and procedure, skill assessment performed for [NJ Exec Orde] care and hand hygiene.	07/12/2026

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F0686 SS = D	Continued from page 15 standards during a NJ Ex Order 26, 4B1 for 1 of 3 residents (Resident #40) reviewed for NJ Ex Order 26, 4B NJ Ex Order 2 This deficient practice was evidenced by the following: On 5/20/26 at 10:34 AM, the surveyor observed Registered Nurse (RN) #1 perform a NJ Ex Order 26, 4B1 treatment on Resident #40. The U. S. FO performed hand hygiene using an alcohol-based hand rub (ABHR) and then donned gloves. She wiped down the overbed table with a disinfectant wipe, removed her gloves, used ABHR, and gathered her treatment supplies onto the overbed table, which included a NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1). The U. S. FO then donned gloves and a gown and entered the resident's room where two staff had already positioned the resident for the NJ Ex Order 26, 4B1. The U. S. FO removed the NJ Ex Order 26, 4B1 and disposed of it in a trash bag. With the same gloves, she then picked up a NJ Ex Order 26, 4B1 from the overbed table and NJ Ex Order 26, 4B1 bed, picked up NJ Exec Order 26.4b1 to pat dry the NJ Ex Order 26 bed, and measured the with a paper ruler, before removing her gloves and using ABHR. Afterwards, she packed the NJ Exec Orde with NJ Ex Order 26, 4B1 and covered the Order 26 with an undated/unlabeled NJ Exec Order 26.4b1. After the NJ Exec Order 26 was applied to the resident's NJ Ex Order 26, the then took a marker and wrote the date, time, and her initials on the middle of the NJ Exec Order 26.4b1. When the treatment was completed, the U. S. FO disposed of her gloves, gown, and single use treatment supplies. She brought the overbed table to the doorway where the treatment cart was and then washed her hands. Afterwards, she donned gloves and used a disinfecting wipe to wipe down the overbed table including the multi-use bottle of NJ Ex Order 26, 4B1, but did not designate the NJ Ex Order 26 as resident-specific for Resident #40 before returning it to the treatment cart. At 10:57 AM, the surveyor interviewed RN #1 who acknowledged that she should have removed her gloves and performed hand hygiene after discarding the NJ Ex Order 26, 4B1 purposes. The also stated she should have labeled the NJ Exec Order 26.4b1 before applying it to the	F0686	Continued from page 15 All nurses received skill assessments for NJ Exec Orde care and hand hygiene. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents with wound care needs have the potential to be affected by this practice. MEASURES PUT IN PLACE: All nurses will receive in-service on wound care and hand hygiene policy and procedure by staff educator within 30 days. MONITORING OF MEASURES: DON/Designee will randomly review 3 residents receiving wound care to ensure proper procedure is followed consistent with professional standards of practice weekly x4 weeks then monthly x 2 then quarterly x 2. Audit findings will be reported to QA committee quarterly.	07/12/2026

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F0686 SS = D	Continued from page 16 resident because it could have caused discomfort. The [U. S. FOIA (b)] also verified that multi-use bottles, such as the [NJ Ex Order 26, 4B1], should stay in the resident's room for infection control purposes. The surveyor reviewed the medical record for Resident #40. According to the Admission Record, an admission summary, the resident had diagnoses which included, but were not limited to, [NJ Ex Order 26, 4B1]. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26], included the resident had a Brief Interview for Mental Status score of [NJ Ex Order 26, 4B1] which indicated the resident's [NJ Ex Order 26, 4B1]. The MDS further included that the resident had a [NJ Ex Order 26, 4B1] that was present on admission. A review of the individualized comprehensive care plan (ICCP), revised [NJ Ex Order 26], included a focus area that the resident had [NJ Ex Order 26, 4B1] of a [NJ Ex Order 26, 4B1]. Interventions included: Administer treatment per physician orders. A review of the Order Summary Report, as of [NJ Ex Order 26], included the following physician's order (PO): A PO, dated [NJ Ex Order 26, 4B], to [NJ Ex Order 26, 4B1] with [NJ Ex Order 26] and cover with foam every day and evening shift. On 5/20/26 at 12:06 PM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) #1 who stated that during a [NJ Exec Order] care treatment, the nurse should remove their gloves and perform hand hygiene after removing the [NJ Exec Order 26.4b1] to prevent anything [NJ Exec Order 26.4b] from entering the [NJ Exec Order]. The [U. S. FOIA (b)] further stated that [NJ Exec Order 26.4b1] should be dated and initialed prior to applying the [NJ Exec Order 26] to the [NJ Exec Order] to prevent [NJ Exec O]. The [U. S. FOIA (b)] explained that if the [NJ Exec Order 26.4b1] was already applied, the nurse should label a piece of tape to apply to the [NJ Exec Order 26.4]. On 5/20/26 at 12:14 PM, the surveyor interviewed	F0686		07/12/2026

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F0686 SS = D	Continued from page 17 the[U. S. FOIA (b) (2)]) who stated that during a[NJ Ex Order 26, 4B1] gloves and performing hand hygiene after removing the[NJ Exec Order 26.4b1] to prevent any type of cross contamination. The[U. S. FOIA] further explained that the nurse should not label the[NJ Ex Order 2][NJ Ex Order 26, 4] after it was already applied to the resident because it could[NJ Ex Order 26, 4B1] when[NJ Ex Order 26, 4B1]. The[U.S. FOIA] also stated that multi-use bottles should not be brought into the resident's room, and if they were, the nurse would have to bag the bottle and designate it for the resident. The[U. S. FOIA] stated that multi-use items should be prepared prior to entering the resident's room and stored in the treatment cart. A review of the facility's[NJ Exec Order 26.4b1]" skill evaluation form used to evaluate RN #1 on[NJ Exec Order 2], included the following: Under the section titled "Remove[NJ Exec Order 26.4b1]:" c. Loosen the[NJ Exec Order 26.4b1] by holding the resident's[NJ Exec] and pulling the[NJ Exec O] or[NJ Exec Order 26] towards the[NJ Exec Orde] to protect new formed[NJ Exec Orde] and remove. d.1. Place the[NJ Exec Order 26.4b1] in the[NJ Exec Order 26.4b1] bag without touching the sides of the bag. f. Remove gloves and discard in prepared bag. Perform hand hygiene according to local requirements. Under the section titled "Prepare supplies using clean technique:" a.2.1. If a multi-use bottle is used; "lip" the liquid by pouring out a small of the liquid prior to dispensing. c. Prepare several lengths of tape in advance to secure the dressing. c.3. Include date, time, and nurse initials on one of the lengths of tape. A review of the facility's "Wound Care" policy, revised 5/7/19, did not include the steps for a wound care treatment. NJAC 8:39-27.1(a)	F0686		07/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	**39 EAST MOUNTAIN ROAD , HILLSBOROUGH, New Jersey, 08844**

(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 An offsite/desk review of the facility's Plan of Correction was conducted on 07/29/2026 in relation to the 06/01/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - FOOTHILL A... B. WING	(X3) DATE SURVEY COMPLETED 06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	39 EAST MOUNTAIN ROAD , HILLSBOROUGH, New Jersey, 08844

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K0000 Bldg. 03	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 5/28/26, 5/29/26, and 6/1/26. The facility was found to be in noncompliance 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. Foothill Acres Rehabilitation & Nursing Center is a two-story building with a basement built in 2010. It is composed of Type II (222) construction. The facility is divided into 11 - smoke zones. The 350 KW Diesel generator powers approximately 30 % of the building per U. S. FOIA (b) (2). The current occupied beds are 166 of 200.	K0000		06/30/2026
K0222 SS = F Bldg. 03	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	K0222	Recertification Survey: June 1, 2026 Plan of Correction: K222 NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13 Egress Deficiency SS=F Date of Completion: June1, 2026 Corrective Action(s): There was no harm to the residents due to the deficient practice. The thumb turn latch system was disabled by U. S. FOIA (b) (2) who removed the cam mechanism. This action rendered the locking function inoperable, thereby restoring the doors' ability to always open freely for emergency egress. Identifying Other Residents:	06/18/2026

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: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - FOOTHILL A... B. WING	(X3) DATE SURVEY COMPLETED 06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	39 EAST MOUNTAIN ROAD , HILLSBOROUGH, New Jersey, 08844

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K0222 SS = F Bldg. 03	Continued from page 1 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 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 5/28/26 in the presence of the[redacted] it was determined the facility failed to ensure doors in the 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 has the potential to affect all residents and was evidenced by the	K0222	Continued from page 1 All residents had the potential to be affected by the deficient practice. Measures Put Into Place: The Maintenance Dept updated policy to explicitly prohibit any locking devices on required means of egress doors that could interfere with emergency operation, in accordance with applicable NFPA 101 Life Safety Code requirements. Root cause analysis revealed the Maintenance Dept was unaware of the NFPA Life Safety Code prohibiting these locks. In-servicing of Maintenance personnel was held by the Administrator on June 1, 2026, reeducating staff of the requirement. Monitoring Measures: The Maintenance Director or designee will audit monthly for three months then quarterly to ensure no locks are installed on any of the emergency egress doors to ensure the facility meets NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13, with results of the audit to be brought to the QA Committee quarterly to ensure desired outcomes are met and sustained. video evidence was uploaded for all three doors.	06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING **03 - FOOTHILL A...** B. WING	(X3) DATE SURVEY COMPLETED **06/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	**39 EAST MOUNTAIN ROAD , HILLSBOROUGH, New Jersey, 08844**

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K0222 SS = F Bldg. 03	Continued from page 2 following: Observations on 5/28/26 at approximately 8:27 AM, of the front main entrance/exit revealed 2 sets of automatic sliding double doors with instructional signs on each door that stated IN EMERGENCY PUSH TO OPEN. The outer and the inner set of double doors were equipped with a thumb turn latch. During interviews at the time, the [redacted] confirmed the observations. Observations on 5/28/26 at approximately 10:08 AM, of the Ambulance entrance/exit revealed a set of automatic sliding double doors with instructional signs on each door that stated IN EMERGENCY PUSH TO OPEN. The set doors were equipped with a thumb turn latch. During interviews 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 6/1/26 at 1:30 PM. N.J.A.C 8:39-31.2 (e)	K0222		06/18/2026
K0345 SS = F Bldg. 03	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 STANDARD is NOT MET as evidenced by: Based on documents review and interviews on 5/29/2026 in the presence of the [redacted], it was determined the facility failed to ensure the fire alarm devices and all components were inspected, tested and maintained as one system in accordance with the requirements of NFPA 101: 2012 Edition, Section 9.7.5, 9.7.7 and 9.7.8, NFPA 72: 2010 Edition, Section 14.4.2.2,14.4.5.3.1. This deficient practice had the potential to affect all residents and was evidenced	K0345	Recertification Survey: June 1, 2026 Plan of Correction: K345 NFPA 101 Life Safety Code Standard Fire Alarm System – Testing and Maintenance SS=F Date of Completion: July 27, 2026 Corrective Action(s): There was no harm to the residents due to the deficient practice. Upon identification of the deficient practice, the [redacted] immediately contacted the facility's fire alarm vendor and coordinated the required testing of all fire alarm system interfaces and monitoring points. Testing was completed for the fire sprinkler monitoring points, elevator interface functions, door release output interface functions, HVAC and fire damper interface functions, and kitchen suppression system monitoring points. Documentation of the required testing was obtained and maintained on site. The required smoke detector sensitivity testing records	07/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - FOOTHILL A... B. WING	(X3) DATE SURVEY COMPLETED 06/01/2026

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K0345 SS = F Bldg. 03	Continued from page 3 by the following: A review of the facility fire protection system report dated March 17, 2026, at approximately 11:25 AM, on 6/1/2026 revealed the following: During component testing, fire sprinkler system monitoring points were not tested properly (simulation testing was not performed). Recommend coordinating trades for this testing work. During component testing, elevator interface functions were not tested. Recommend coordinating trades for this testing work. During component testing, door release output interface functions were not tested. Recommend coordinating trades for this testing work. During component testing, HVAC & fire damper interface functions were not tested, recommend coordinating trades for this testing work. During component testing, kitchen suppression system monitoring points were not tested (simulation testing could not be performed). Recommend coordinating trades for this testing work. A review of the facility fire protection system report dated October 24, 2025, at approximately 11:10 AM, on 6/1/2026 revealed the following: During component testing, fire sprinkler monitoring points were not tested properly. Recommend coordinating trades for this testing work. During component testing, elevator interface functions were not tested. Recommend coordinating trades for this testing work. During component testing, door release output interface functions were not tested. Recommend coordinating trades for this testing work. During component testing, kitchen suppression system monitoring points were not tested. Recommend coordinating trades for this testing work. Further documentation review at approximately 11:35 AM, revealed that the fire alarm smoke detector sensitivity test record was not among the documents provided for review.	K0345	Continued from page 3 were obtained and placed in the Life Safety compliance files. Identifying Other Residents: All residents had the potential to be affected by the deficient practice. Measures Put Into Place: The U. S. FOIA (b) (2) reviewed all fire alarm inspection, testing, and maintenance reports to ensure all required components and interfaces are tested in accordance with NFPA 72 requirements. Root cause analysis revealed that coordination between the fire alarm vendor and other applicable contractors was not consistently performed to ensure all integrated system functions were tested during annual and semi-annual inspections. In-service education was provided by the NJ Ex Order 26, 4B1 to the U. S. FOIA (b) (2) regarding the requirement to ensure all fire alarm system components, monitoring points, interfaces, and associated documentation are inspected, tested, and maintained as one integrated system in accordance with NFPA 72 requirements. The facility has coordinated and will complete testing with all required trades for the following integrated fire alarm system functions: Fire sprinkler system monitoring points Elevator recall and elevator interface functions Door release output interface functions HVAC shutdown interface functions Fire damper interface functions Kitchen suppression system monitoring points A tracking log was implemented to ensure all required trades are coordinated and all integrated system testing is completed and documented during future annual and semi-annual inspections.	07/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - FOOTHILL A... B. WING	(X3) DATE SURVEY COMPLETED 06/01/2026

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K0345 SS = F Bldg. 03	Continued from page 4 During interviews at the time, the [U. S. FO] confirmed the findings. The facility's [U. S. FOIA (b) (2)] and the [U. S. FO] were informed of the deficient practice at the Life Safety Code exit conference on 6/1/2026 at 1:30 PM. N.J.A.C 8:39-31.2 (e) NFPA 72	K0345	Continued from page 4 Monitoring Measures: The Maintenance Director or designee will audit all fire alarm inspection, testing, and maintenance reports monthly for three months and quarterly thereafter to ensure all required monitoring points, interface functions, sensitivity testing, and supporting documentation have been completed and maintained in accordance with NFPA 72 requirements. Results of the audits will be brought to the QA Committee quarterly to ensure desired outcomes are met and sustained.	07/27/2026
K0374 SS = F Bldg. 03	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 STANDARD is NOT MET as evidenced by: Based on observations and interviews on 5/28/2026 in the presence of the [U. S. FOIA (b) (2)] it was determined the facility failed to ensure that smoke barrier doors were able to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 8.5.4.1.This deficient practice had the potential to affect all residents and was evidenced by the following: Observations conducted on [NJ Ex Order 26, 4B] at approximately 8:17 AM, revealed that the smoke barrier doors located between the [NJ Ex Order 26, 4B] unit and the service corridor had an excessive gap at the meeting edge, which could compromise the doors' ability to resist the passage of smoke. Observations conducted on 5/28/2026 at approximately 11:142 AM, revealed that the smoke	K0374	Recertification Survey: June 1, 2026 Plan of Correction: K374 NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13 Subdivision of Building Spaces- Smoke Barrier Doors SS=F Date of Completion: June 18, 2026 Corrective Action(s): There was no harm to the residents due to the deficient practice. The smoke barrier doors located between the [NJ Ex Order 26, 4B] Unit and the service corridor, and the smoke barrier doors adjacent to the Physical Therapy gym, were immediately corrected by replacing the astragals on both door assemblies. Following installation, the [U. S. FOIA (b) (2)] verified that the meeting edge gaps were eliminated and that both smoke barrier door assemblies functioned properly to resist the passage of smoke. Identifying Other Residents: All residents had the potential to be affected by the deficient practice. Measures Put Into Place: The facility's preventative maintenance program has been revised to include inspection of all smoke barrier door assemblies during scheduled Life Safety	06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - FOOTHILL A... B. WING	(X3) DATE SURVEY COMPLETED 06/01/2026

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K0374 SS = F Bldg. 03	Continued from page 5 barrier doors located adjacent to the physical Therapy gym had a gap at the meeting edge. This condition could compromise the doors' ability to limit the passage of smoke and maintain the integrity of the smoke barrier. During interviews at the time, the [redacted] confirmed the finding. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 6/1/2026 at 1:30 PM. N.J.A.C 8:39-31.2 (e)	K0374	Continued from page 5 inspections. The inspection will verify that astragals are present and secure, meeting edge gaps are within NFPA requirements, and doors close properly to resist the passage of smoke. In-servicing of Maintenance personnel was held by the Administrator on June 1, 2026, reeducating staff of the requirement. Monitoring Measures: The Maintenance Director or designee will perform and document monthly inspections of all smoke barrier door assemblies for a period of three months. Inspection findings will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program. Any identified deficiencies will be corrected immediately, and additional monitoring will be implemented if indicated.to ensure desired outcomes are met and sustained.	06/18/2026
K0741 SS = F Bldg. 03	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.	K0741	Recertification Survey: June 1, 2026 Plan of Correction: K741 NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13 Smoking Regulations SS=F Date of Completion: June 8, 2026 Corrective Action(s): There was no harm to the residents due to the deficient practice. Upon identification of the deficiency, the [redacted] immediately obtained and installed the required smoking area signage and self-closing cover devices for the noncombustible ash trays in accordance with NFPA 101 Life Safety Code requirements. Identifying Other Residents: All residents had the potential to be affected by the deficient practice. Measures Put Into Place:	06/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - FOOTHILL A... B. WING	(X3) DATE SURVEY COMPLETED 06/01/2026

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K0741 SS = F Bldg. 03	Continued from page 6 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and interviews on 5/28/26 in the presence of the U. S. FOIA (b) (2)), it was determined the facility failed to ensure that metal containers with self-closing cover devices were readily available to all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:14 PM, revealed a metal container with a self-closing cover device into which ashtrays can be emptied was not provided or readily available to the smoking area. During an interview at the time, the U. S. FO confirmed the observation. The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference on 6/1/2026 at 1:30 PM. N.J.A.C 8:39-31.2 (e)	K0741	Continued from page 6 The U. S. FOIA (b) (2) replaced the missing smoking area signage and installed self-closing covers on the ash trays as required by NFPA 101 Life Safety Code requirements. A root cause analysis determined that Maintenance Department personnel were unaware of the requirement for designated smoking area signage and self-closing cover devices on noncombustible ash trays. On June 1, 2026, the NJ Ex Order 26, 4B1 provided in-service education to U. S. FOIA (b) (2) Department personnel regarding NFPA 101 Life Safety Code smoking area requirements, including the required signage and self-closing cover devices for ash trays. Monitoring Measures: The Maintenance Director or designee will audit monthly for three months then quarterly to ensure auto closer mechanisms are installed and in working order for all areas as required to ensure the facility meets NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13, with results of the audit to be brought to the QA Committee quarterly to ensure desired outcomes are met and sustained.	06/08/2026
K0918 SS = F Bldg. 03	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 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	K0918	Recertification Survey: June 1, 2026 Plan of Correction: K918 NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13 Electrical Systems- Essential Electrical Systems SS=F Date of Completion: June 1, 2026 There was no harm to the residents due to the deficient practice. Upon identification of the deficient practice, the U. S. FOIA (b) (2) conducted a review of all generator maintenance, testing, and fuel quality documentation. The diesel fuel quality analysis report was obtained from the vendor and placed in the facility's generator compliance records to ensure the documentation is readily available for review.	06/02/2026

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FOOTHILL ACRES REHABILITATION & NURSING CENTER	39 EAST MOUNTAIN ROAD , HILLSBOROUGH, New Jersey, 08844

(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
K0918 SS = F Bldg. 03	Continued from page 7 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 STANDARD is NOT MET as evidenced by: Based on documents review and interviews on 5/29/2026 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined the facility failed to ensure that the emergency and standby power generator was tested for diesel fuel quality and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's generator annual service reports (Critical Customer Support Agreement Inspection Report) dated 3/2/2026, provided by the U.S.F.P. [redacted], revealed no record that a diesel fuel sample analysis test had been conducted. No further documentation was provided regarding diesel fuel sample analysis testing had been conducted. During interviews at the time, the U.S.F.P. [redacted] confirmed the finding. The facility's U. S. FOIA (b) (2) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 6/1/2026 at 1:30 PM. N.J.A.C 8:39-31.2 (e)	K0918	Continued from page 7 Identifying Other Residents: All residents had the potential to be affected by the deficient practice. Measures Put Into Place: The U. S. FOIA (b) (2) [redacted] reviewed all generator maintenance, testing, and fuel quality records to ensure required documentation is maintained and readily available in accordance with NFPA 110 requirements. Root cause analysis revealed that generator compliance documentation was not being maintained in a centralized location, resulting in the diesel fuel quality analysis report not being readily available at the time of the survey. In-service education was provided by the U. S. FOIA (b) (2) [redacted] regarding the requirement to maintain all generator inspection reports, maintenance records, testing records, fuel quality analysis reports, and supporting documentation in a centralized compliance file readily available for survey review. A compliance tracking log was implemented to ensure all required generator documentation is received, reviewed, filed, and maintained in accordance with NFPA 110 requirements. Monitoring Measures: The Maintenance Director or designee will audit generator maintenance, testing, and fuel quality documentation monthly for three months and quarterly thereafter to ensure all required records are maintained, complete, and readily available for review. Results of the audits will be brought to the QA Committee quarterly to ensure desired outcomes are met and sustained.	06/02/2026
K0293 SS = E Bldg. 03	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.	K0293	Recertification Survey: June 1, 2026 Plan of Correction: K293 NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13 Exit Signage	07/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - FOOTHILL A... B. WING	(X3) DATE SURVEY COMPLETED 06/01/2026

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K0293 SS = E Bldg. 03	Continued from page 8 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observations and interview on 5/29/2026 in the presence of the[redacted]), it was determined the facility failed to ensure that exits were marked by an approved sign that was readily visible in accordance with NFPA 101: 2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect approximately 61 of 166 residents and was evidenced by the following Observation conducted on [redacted] at approximately [redacted], in the [redacted] enclosed courtyard revealed that the exit access door lacked the required exit signage, which could impede the identification of the means of egress during an emergency. Observation conducted on [redacted] at approximately [redacted], in the [redacted] enclosed courtyard revealed that the exit access door lacked the required exit signage, which could impede the identification of the means of egress during an emergency. During 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 6/1/2026 at 1:30 PM. N.J.A.C 8:39-31.2 (e)	K0293	Continued from page 8 SS=E Date of Completion: July 6, 2026 Corrective Action(s): There was no harm to the residents due to the deficient practice. The [redacted] obtained quotes from electricians for installation of missing exit signage and chose the vendor that provided the most competitive quote. The missing signage was installed and is fully functional. Identifying Other Residents: All residents had the potential to be affected by the deficient practice. Measures Put Into Place: The [redacted] inspected all exit doors in facility for appropriate signage, in accordance with applicable NFPA 101 Life Safety Code requirements. Root cause analysis revealed the Maintenance Dept was unaware of the missing signage. In-servicing of Maintenance personnel was held by the Administrator on June 1, 2026, reeducating staff of the requirement. Monitoring Measures: The Maintenance Director or designee will audit monthly for three months then quarterly to ensure no locks are installed on any of the emergency egress doors to ensure the facility meets NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13, with results of the audit to be brought to the QA Committee quarterly to ensure desired outcomes are met and sustained.	07/27/2026
K0321 SS = E Bldg. 03	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	K0321	Recertification Survey: June 1, 2026 Plan of Correction: K321 NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13 Hazardous Areas-Enclosure SS=E	06/29/2026

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K0321 SS = E Bldg. 03	Continued from page 9 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) 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 STANDARD is NOT MET as evidenced by: Based on observations and interview on 5/28/2026 in the presence of the U. S. FOIA (b) (2)), it was determined the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1,7.2.1.8,9.7 and 8.4. This deficient practice had the potential to affect 51 of 166 residents and was evidenced by the following: Observation on NJ Ex Order 26, 4B at approximately 10:14 AM, revealed that the door for linen room next to room NJ Ex O was not self- closing or automatic closing. Observation on 5/28/2026 at approximately NJ Ex Orde PM, revealed that the door for linen room next to room NJ Ex O was not self- closing or automatic closing.	K0321	Continued from page 9 Date of Completion: June 29, 2026 Corrective Action(s): There was no harm to the residents due to the deficient practice. The U. S. FOIA (b) (2) ordered automatic door closers for the Clean Linen closet next to room NJ Ex Orde and for the Clean Linen closet next to room NJ Ex Orde Identifying Other Residents: All residents had the potential to be affected by the deficient practice. Measures Put Into Place: The U. S. FOIA (b) (2) inspected all clean linen closets in the facility to be sure they met applicable NFPA 101 Life Safety Code requirements. Root cause analysis revealed the Maintenance Dept was unaware of the missing auto closing mechanisms for Clean Linen closet next to room NJ Ex O and for the Clean Linen closet next to room NJ Ex Orde In-servicing of Maintenance personnel was held by the U. S. FOIA (b) (2) on June 1, 2026, reeducating staff of the requirement. Monitoring Measures: The Maintenance Director or designee will audit monthly for three months then quarterly to ensure auto closer mechanisms are installed on all areas as required to ensure the facility meets NFPA 101 Life Safety Code Standard 2012 Edition NFPA 13, with results of the audit to be brought to the QA Committee quarterly to ensure desired outcomes are met and sustained.	06/29/2026

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K0321 SS = E Bldg. 03	Continued from page 10 During 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 6/1/2026 at 1:30 PM. N.J.A.C 8:39-31.2 (e)	K0321		06/29/2026

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH) on 5/28/2026, 5/29/2026, and 6/1/2026. Foothill Acres was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73.	E0000		06/11/2026

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: 315425	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - FOOTHILL A... B. WING	(X3) DATE SURVEY COMPLETED 08/11/2026

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K0000 Bldg. 03	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 8/11/2026 in relation to the 6/1/2026 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