

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER STARS ADULT MEDICAL DAY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1470 HADDON AVENUE CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments Type of Survey: Monitoring/Follow-up to the 8/8/2024 audit survey conducted by the Office of the Inspector General. Census: (2) Morning Sessions: 53 Sample Size: 3 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 377	8:43F-5.4(b) Participant Assessment and Plan of Care The interdisciplinary plan of care shall be based on the comprehensive assessments provided by nursing, dietary, activities, and social work staff; and when ordered by the physician, advanced practice or physician assistant, other health professionals, including pharmacy consultation, shall also provide assessments. The plan of care shall include measurable objectives with interventions based on the participant's care needs and means of achieving each goal. The complete plan of care shall include, if appropriate, rehabilitative/restorative measures, preventive intervention, and training and teaching of self-care.	M 377		

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

TITLE

(X6) DATE

10/14/25

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M 377	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that during the 9/2/25 and the 8/8/24 Office of the Inspector General (OIG) surveys, the facility failed to ensure a participant's Plan of Care (POC) was reviewed and revised at least quarterly for 1 of 3 participants reviewed, Participant #3. This deficient practice was evidenced by the following: 1. On 9/2/25, the surveyor reviewed the Medical Record (MR) of Participant #3, which revealed an NJ Ex Order 26. 4B1 The surveyor did not observe any quarterly updated POC for NJ Ex Order in Resident # 3's MR. At 11:38 a.m., the surveyor interviewed the Director of Nursing (DON) and asked about the location of the updated NJ Ex Order POC for Participant #3. The DON reviewed the MR and was unable to provide them. The DON stated that she did not know if the quarterly updates were completed and requested additional time to locate them. At 12:25 p.m., the surveyor interviewed the Director of Operations (DOO) and asked if she was aware that Participant #3's POC had not been updated quarterly in NJ Ex Order. The DOO stated that she was not aware but explained that the facility conducted monthly Interdisciplinary Team (IDT) meetings to update the POC as needed and acknowledged that the POC should be updated quarterly. At 3:39 p.m., the surveyor did a follow up	M 377		

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M 425	Continued From page 3 by: Based on interview and review of pertinent facility documents, during the NJ Ex Order 26 and the NJ Ex Order 26 Office of the Inspector General (OIG) surveys, it was determined that the facility failed to designate in writing a registered professional nurse to act in the absence of the Director of Nursing (DON), as evidenced by the following: During the 8/8/24 survey, the facility stated that they did not have an alternate DON, when the DON was not there, they hired temporary nurses through a staffing agency. On 9/2/25 at 11:49 a.m., the surveyor interviewed the DON and asked who was the Alternate Director of Nursing (ADON). The DON stated that she did not know who the ADON was and explained that the facility used a nursing agency service, and a Registered Nurse (RN) always came in her absence. At 12:25 p.m., the surveyor interviewed the Director of Operations (DOO) and asked who was the ADON. The DOO stated that the facility used a nursing agency service and gave the surveyor a nursing agency contract for review and explained that she did not have an ADON designated in writing, but that the nursing agency always provided a Registered Nurse (RN) in the absence of the DON. Surveyor review of an undated facility policy titled, "Designation of Director of Nursing Services," N.J.A.C. 8:43F-7.1," Accountable to: Administrator revealed, a registered nurse has been designated in writing as the Director of Nursing Services ... A registered professional nurse shall be designated in writing to act in the director's absence."	M 425		

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M 481	8:43F-8.2 Medical Services A physician shall be designated to serve as the facility's medical consultant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that a physician was designated to serve as the facility's medical consultant. This deficient practice was evidenced by the following: During the 8/8/24 survey, the facility stated that they did not have a medical consultant on file because the previous one moved out of state and the facility used different consultants until a new one was hired. On 9/2/25, the surveyor reviewed a facility document titled, "Professional Credentialing Process." Profession: Medical Consultant. The document revealed that the facility medical consultant's license expired on NJ Ex Order 26, 4B. At 12:25 p.m., the surveyor interviewed the Director of Operations (DOO) about the designated Medical Consultant (MC), the DOO stated that the facility had a designated MC and that she would provide a copy of the physician's contract, license, and insurance. At 3:01 p.m., the DOO gave the surveyor a facility document for review titled, "Professional Credentialing Process." Profession: Medical Consultant that revealed the facility medical	M 481		

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M 481	Continued From page 5 consultant contract started on [NJ Ex Order 26. 4B] and the license had an expiration date of [NJ Ex Order 26. 4B]. When the surveyor inquired who was the MC prior to the new contract on [NJ Ex Order 26. 4B], the DOO explained that the facility did not have a MC because the prior MC [NJ Ex Order 26. 4B1], but they could still contact her via telephone and explained she could not locate a copy of the prior MC information. On 9/4/25, at 11:45 a.m., the surveyor contacted the facility DOO via telephone to request documentation of a designated MC prior to the [NJ Ex Order 26. 4B] contract date. On 9/5/25, the surveyor reviewed a document submitted by the facility Administrator via email titled, "Medical Consultant Agreement." The document revealed that the facility medical consultant contract started on [NJ Ex Order 26. 4B]. The MC Physician license was also dated with an expiration date of [NJ Ex Order 26. 4B1]. The surveyor also reviewed a letter from the same MC dated 10/31/20 that revealed the MC would [NJ Ex Order 26. 4B1] onsite in New Jersey as of [NJ Ex Order 26. 4B1] but would remain available by telephone until the facility acquired a Medical Consultant, which was not contracted until [NJ Ex Order 26. 4B]. Surveyor review of an undated facility policy titled, "8:43F-8.2 Designation of Medical Consultant", "...A Physician shall be designated to serve as the facility's medical consultant ... Surveyor review of an undated facility policy titled, "Mandatory Staffing Requirements," 8:43F-3.6 (a) 1 revealed, the facility shall have adequate staff capability to provide services and supervision to the participants... At a minimum the facility shall	M 481		

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M 689	Continued From page 7 Procedures Binder (EPB). The surveyor then requested the records of annual drills for review. At 10:15 a.m., the surveyor reviewed the EPB provided by the DOO. Record review of the EPB, the surveyor observed that quarterly fire drills were conducted during 2023, however, the surveyor did not observe any documentation in the records to indicate that a disaster drill was conducted in 2023. At 10:50 a.m., the surveyor interviewed the DOO and asked if she could provide any documentation that a disaster drill was completed during 2023, the DOO stated that the 2023 annual disaster drill was completed but could not provide any documentation. Surveyor review of an undated facility policy titled, "Orientation." The Policy Interpretation and Implementation section revealed, The following drills will be conducted by our facility in preparing for emergency or disaster situations that could occur ... b. Other Emergency - Flood, Bomb, Storm, etc. (annually) Surveyor review of an undated facility policy titled, "Emergency Drills." The Policy Interpretation and Implementation section revealed, At least one drill per year shall be due to another type of emergency such as a storm, flood, other natural disaster, bomb threat, or nuclear accident.	M 689		
M 701	8:43F-15.3(a)(1) Medical Records (a) The participant's complete medical record shall include, but not be limited to, the following: 1. Participant identification data, including	M 701		

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M 701	Continued From page 8 name, date of admission, address, date of birth, race, religion (optional), sex, referral source, payment plan, marital status, and the name, address, and telephone number of the person(s) to be notified in an emergency, and travel directions to the participant's home. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that participant medical records contained complete and current identification data, including emergency contact information and addresses, for 2 of 3 participants reviewed, Participant #s 2 and 3. This deficient practice was evidenced by the following: On 8/8/24, the surveyor reviewed the Medical Record (MR) of Participant #2, which revealed an NJ Ex Order 26. 4B1 [REDACTED]. Review of an undated facility document titled, "Participant Emergency Contact Form", did not reveal an emergency contact phone number. The surveyor also reviewed the MR of Participant #3, which revealed an NJ Ex Order 26. 4B1 [REDACTED]. Review of an undated "Participant Emergency Contact Form" did not reveal an emergency contact address, and the directions to	M 701		

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M 701	Continued From page 9 Participant #3's home were outdated. The surveyor observed the directions were from [REDACTED], although the participant's [REDACTED] was changed in [REDACTED] as noted on the face sheet. On 9/2/25 at 11:38 a.m., the surveyor interviewed about how often emergency contact information and participants' addresses were updated, the Director of Nursing (DON) stated that all emergency contact forms had recently been updated, and that participants' [REDACTED] were updated whenever they [REDACTED]. At 12:25 p.m., the surveyor interviewed the Director of Operations (DOO) and asked if she was aware of when the emergency contact forms were updated. The DOO stated that she was not aware of the policy or of when the forms were updated. The surveyor also reviewed an undated facility policy titled, "Designation of Director of Nursing Services" indicated Administrative responsibilities included: "...7. Procedures for maintaining records as required by the facility..."	M 701		
M 805	8:43F-16.5(a)(b)(c) Infection Control, Santation, Housekeeping (a) The facility shall provide and maintain a sanitary and safe environment for participants. (b) The facility shall provide housekeeping and pest control services. (c) Written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for housekeeping, sanitation, and safety services shall be developed	M 805		

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M 805	Continued From page 10 and implemented. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, during the 9/2/25 survey and the 8/8/24 Office of the Inspector General (OIG) survey, it was determined that the facility failed to maintain a sanitary and safe environment for all participants. This deficient practice was evidenced by the following: During the 8/8/24 survey, the surveyors observed the following: water damage on ceiling tiles and missing ceiling tiles, water leaks from an outside awning, first aid cabinets with expired medications, unlocked and open medication storage areas. On 9/2/25 at 9:38 a.m., during a tour of the facility, the surveyor observed eight (8) ceiling tiles with stains and seven (7) damaged, misaligned and missing ceiling tiles throughout the building. The specific locations were: a) Two stained ceiling tiles in the front vestibule. b) Three stained ceiling tiles and one missing tile in the reception area. c) One stained ceiling tile in the Social Worker's office. d) One stained ceiling tile in the nursing station. e) Two damaged ceiling tiles and five ceiling tiles pushed in, misaligned, missing framing in the	M 805		

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M 805	Continued From page 11 Activity Room. At 10:50 a.m., the surveyor interviewed the Director of Operations (DOO) and asked about ceiling tiles that were stained, pushed in, missing, misaligned and missing framing. The DOO stated that she was not aware of the ceiling tiles that were stained, pushed in, missing, misaligned and missing framing and explained that the facility had recently completed a roof repair and was replacing tiles as needed. On 9/2/25 at 10:24 a.m., the surveyor observed a first aid cabinet in the Recreation area that contained expired supplies. At 10:30 a.m., the surveyor observed two first aid cabinets in the Nursing Station. One contained expired supplies, while the other housed an Automatic Electronic Defibrillator (AED) with no pads. At 11:38 a.m., the surveyor interviewed the Director of Nursing (DON) and asked about the first aid cabinets in the Nursing Station. The DON stated that she used the supplies in the first aid cabinet and also used the cabinet for storage. The DON also stated that she checked the first aid cabinet last month and did not realize that the supplies were expired and then she explained that the facility no longer had a contract with the vendor responsible for replacing supplies. In the same interview, the surveyor asked the DON about the AED in the first aid cabinet on the wall without pads, the DON stated that another working AED was available. The surveyor asked how staff would know which AED to use in an emergency since the non-working AED was mounted on the wall while the working AED was	M 805		

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M 805	Continued From page 12 located on the countertop behind the sink. The DON replied that she did not know, but she can place a sign on the non-working AED. At 12:25 p.m., the surveyor interviewed the DOO and asked if she was aware of the expired supplies in the Recreation and Nursing Station first aid cabinets. The DOO stated that she was not aware and that the facility no longer had a contract for servicing the cabinets. She then stated, that she would have the cabinets removed. The surveyor then asked the DOO about the AED without pads in the first aid cabinet mounted to the wall in the Nursing Station, the DOO stated that, she did not know the AED did not work and would have it was removed. Surveyor review of an undated facility policy titled, "Maintenance Services," revealed, 1. A building inspection is conducted monthly...2. The building shall be kept in good repair and free of hazards ..." Surveyor review of an undated facility policy titled, "Quality Assurance/Improvement Program," revealed, ... 9. Periodic evaluations of sanitation ...10. quarterly evaluation of safety equipment ...12. Periodic evaluation of maintenance.	M 805		
M 813	8:43F-16.7(a)(1-23) Infection Control, Santation, Housekeeping (a) The following housekeeping, sanitation, and safety conditions shall be met: 1. The facility and its contents shall be free of dirt, debris, and insect and rodent harborages;	M 813		

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M 813	Continued From page 13 2. Nonskid wax shall be used on all waxed floors; 3. All rooms shall be ventilated to help prevent condensation, mold growth, and noxious odors; 4. All participant areas shall be free of noxious odors; 5. Throw rugs or scatter rugs shall not be used in the facility; 6. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Equipment shall be kept covered to protect from contamination and accessible for cleaning and inspection. Broken or worn items shall be repaired, replaced, or removed promptly; 7. All equipment shall have unobstructed space provided for operation; 8. All equipment and materials necessary for cleaning, disinfecting, and sterilizing shall be provided; 9. Thermometers which are accurate to within three degrees Fahrenheit shall be maintained in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration; 10. Pesticides shall be applied in accordance with N.J.A.C. 7:30; 11. Articles in storage shall be elevated from	M 813		

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M 813	Continued From page 14 the floor and away from walls; 12. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room that is used for no other purpose; 13. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement; 14. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in closed metal cabinets or containers; 15. Unobstructed aisles shall be provided in storage areas; 16. A program shall be maintained to keep rodents, flies, roaches, and other vermin out of the facility; 17. Toilet tissue, soap dispenser, paper towels or air dryers, and waste receptacles shall be provided in each bathroom at all times; 18. All solid or liquid waste that is not regulated medical waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey Department of Environmental Protection and the New Jersey Department of Health and Senior Services. Solid waste shall be stored in insect-proof, rodent-proof, and fire-proof, non-absorbent, watertight containers with tight-fitting covers and collected from storage areas regularly, so as	M 813		

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M 813	Continued From page 15 to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24; 19. Garbage compactors shall be located on an impervious pad that is graded to a drain. The drain shall be unobstructed and connected to the sanitary sewage disposal system; 20. Plastic bags shall be used for solid waste removal. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal; 21. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof; 22. Wastebaskets and ashtrays shall be made of noncombustible materials; 23. Latex foam pillows shall be prohibited.	M 813		

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M 813	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other pertinent facility documents, during the 9/2/25 survey and the 8/8/24 Office of the Inspector General (OIG) survey, it was determined that the facility failed to maintain a safe environment for residents by using throw rugs in participant areas and the improper storage of flammable materials. This deficient practice was evidenced by the following: During the 8/8/24 survey, the surveyors observed throw rugs in the entrance area and improper storage of flammable materials in an unlocked storage area. On 9/2/25 at 9:38 a.m., during tour of the facility the surveyor observed two throw rugs in the resident-use areas creating a potential tripping hazard and flammable materials were observed improperly stored on the shelf and floor of an unlocked storage room, creating a risk of fire and unsafe conditions for participants. At 12:25 p.m. the surveyor interviewed the Director of Operations (DOO) and asked why the two throw rugs were in resident-use area and she stated that the rugs were there in case it rained or snowed to prevent falls and she would remove them as she did not know that they could not use them. In the same interview, when the surveyor asked why the storage room door that contained the hot water heater was propped open with flammable materials on the floor and shelf, the DOO explained that the door was propped open as the staff checked the hot water heater every morning and that she was not aware that the flammable	M 813		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER STARS ADULT MEDICAL DAY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1470 HADDON AVENUE CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 813	Continued From page 17 materials were left on the floor and shelf, and stated that she would have them removed from the storage room to a locked metal storage cabinet. Surveyor review of an undated facility policy titled, "Housekeeping, Sanitation and Safety," that revealed, ...Maintenance Services ...8. Throw rugs or scatter rugs shall not be used in the facility. 13. Articles in storage shall be elevated from the floor and away from walls ...14. All poisonous and toxic materials shall be identified, labeled and stored in a locked cabinet or room that is not used for any other purpose ...15. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater ...16. Paints, varnishes, lacquers, thinners and all other flammable materials shall be stored in closed metal cabinets." Surveyor review of an undated facility policy titled, "Ingestion of Poisons," revealed, Policy Statement: It is the policy of [facility] to identify, label and store in a locked cabinet, used for no other reason or storage, all poisonous and/or toxic materials."	M 813		



POC # 3

Accepted
12/5/25

Tel: 856-203-3548 Fax: 856-203-3582 •

• 1470 HADDON AVE. CAMDEN, NJ 08103

December 4, 2025

PLAN OF CORRECTION

FOR DOH SURVERY CONDUCTED SEPTEMBER 2, 2025

M377 (8:43F-5.4B) Participant Assessment and Plan of Care

1. Participant #3 identified as not having a Plan of Care for [REDACTED] in the Medical Record (MR). The administrator retrieved the POC from the file storage unit which was misplaced in a thinned chart and returned it to participant #3 Medical Record (MR) on [REDACTED] NJ Ex Order 26.4B1. Participant #3 is actively attending the facility and is [REDACTED] NJ Ex Order 26.4(b)(1).
2. All participants may be affected by this practice.
3. The Administrator created a Medical Record Audit form on 10/1/25 and the Director of Nursing (DON), Social Worker (SW), and Director of Operations (DO), were trained on 10/1/25, on the Medical Record Audit form procedure. The Administrator created an online, monthly reminder system on 10/1/25 through Microsoft Outlook calendar, and linked the alert to the Administrator's phone and computer. On 10/1/25, the Administrator scheduled the system to alert her phone and computer calendar monthly. The alert system was created and implemented on 10/1/25 for the Director of Nursing (DON), Social Worker (SW), and the Director of Operations (DO) through their emails. Additionally, on 10/1/25 the Administrator created and implemented a (12) twelve-month Binder where the list of Medical Records (MR) reviewed each month will be filed by the Administrator. In the Administrator's absence, the Director of Nursing (DON), or Social Worker (SW) will file the list in its respective month after the Medical Record Audit process has been completed.

4. The Administrator, Director of Nursing (DON) and Social Worker (SW) reviewed all the Medical Records (MR) reviews started on 10/1/25 and completed on 10/31/25. Medical Records (MR) due for a Quarterly update each month, will be reviewed for completeness by the Director of Nursing (DON) and Social Worker (SW) to ensure they are complete. The list of audited Medical Records will be filed in the binder labeled Medical Record Audit, located in the Administrator's office. The Medical Record (MR) audit reviews are ongoing monthly and upon admission.

Completion Date: 10/31/25 and Ongoing

M425 (8:43F-7-7.1(a) Nursing Services

1. The Facility has hired a Per Diem Registered Professional Nurse on 11/17/25 to act in the director's absence.
2. All participants may be affected by a staff shortage.
3. The Administrator will continue to procure a Qualified, Professional Registered Nurse from our contracted Staffing Agencies, in the event the Director of Nursing or Alternate Registered Professional Nurse is not available.
4. The Administrator will monitor staffing levels weekly beginning on 11/17/2025 with the Director of Nursing and Alternate Registered Professional Nurse to confirm availability.

Completion Date: 11/17/2025 and Ongoing

M481 (8:43F-8.2) Medical Services

1. The Administrator contracted A Medical Consultant on NJ Ex Order 26, 4B1 and all credentials are up to date.
2. All participants may have been affected by the lack of a Medical Consultant.

3. The Administrator created and implemented a calendar alert tracking system, on 9/28/25 through Microsoft Outlook Calendar to track all Consultants' credentials. The Administrator started and completed the monthly review on 9/28/25. The Administrator trained the Social Worker (SW) and the Director of Operations (DO) on the process and procedure for the tracking system on 10/27/25. In the Administrator's absence, the Social Worker (SW) or the Director of Operations (DO) will perform this task. The Administrator reviewed and updated the Policy and Procedure (P&P) manual on 9/28/25; the review and updates are ongoing.
4. The Administrator implemented and completed the monthly tracking form on 9/28/25 to ensure all Consultants' credentials are up to date. The Administrator will review monthly on an ongoing basis.

Completion Date: 9/28/2025 and Ongoing Monthly

M689 (8:43F-14.7(f)(g) Physical Plant Requirements

1. The Social Worker conducted an emergency flood drill on 9/6/24 and a gas leak drill on 6/13/2025. The emergency drills commenced on 9/6/24. Both records were filed in the Emergency Services & Procedures binder.
2. All participants may have the potential to be affected.
3. The Facility Administrator updated and distributed the yearly Fire & Emergency Drill schedule form on January 2, 2025, to all department personnel. The Social Worker filed the completed Emergency drill form in the Emergency Services Procedures Binder on 6/13/2025.
4. The Administrator started coordinating the emergency drills on 9/6/24 with the Director of Nursing (DON), Social Worker (SW), and Director of Operations (DO). These emergency drills will be conducted once a year starting on 9/6/24 and three fire drills as per regulations. The drills will be ongoing quarterly.

Completion Date: 9/3/2025 and Ongoing Quarterly

M701 8:43F-15.3(a)(1) Medical Records

1. Identified participant #2 missing emergency contact number. The Administrator updated the Medical Record (MR) on [REDACTED] Participant #3 missed emergency contact number and travel directions home. The Director of Nursing updated emergency contact information/directions in Medical Record (MR) on 9/3/25. Participants #2 and #3 are [REDACTED] and actively attending the facility.
2. All participants may have been affected by this lack of information in Medical Record (MR).
3. The Administrator reviewed procedures for maintaining medical records with the Director of Nursing (DON) on 10/1/25. The Administrator and the Director of Nursing (DON) reviewed all Medical Records which began on 10/1/25 and were completed on 10/14/25 to ensure that all emergency contact information and travel directions are in all Medical Records (MR). The Administrator created and implemented a change of address/directions form on 10/14/2025. The Administrator trained the Director of Nursing, Social Worker, Director of Operations, Receptionist, and the Drivers on the change of address form/directions and contact information procedures on 10/14/25.
4. The Administrator and Director of Nursing (DON) will review Medical Record (MR) upon admission and quarterly starting on 11/1/25.

Completion Date: 10/14/25 and Ongoing Quarterly

M805 8:43F-16.5(a)(b)(c) Infection Control, Sanitation, Housekeeping

1. The Director of Operations (DOO) replaced all stained and/or missing tiles on 9/3/25. The Director of Operations (DOO) purchased missing framing on 10/8/25 and was replaced on 10/8/25. The Director of Operations (DOO) removed First Aid cabinets and discarded them on 9/3/25. The Director of Nursing (DON) replaced the pads on the additional Automatic Electronic Defibrillator (AED) on 10/13/2025.
2. All participants in the facility may have the potential of being affected.
3. The Administrator conducted Quality Assurance (QA) training with all staff on 10/1/25. The training included **Infection Control, Sanitation, Housekeeping, and Safety**. On 10/1/25, the Administrator developed and implemented a calendar alert system through Microsoft Outlook, which will re-occur monthly and ongoing. On 10/1/25, the Administrator added the Director of Nursing (DON), Social Worker (SW), and Director of Operations (DO) to the alert system. All staff are to report any potential hazard to the Administrator immediately.
4. The Administrator started the monthly review on 10/1/25 and completed it on 10/31/25. The Administrator's monitoring alert system is set to re-occur monthly, starting in November 2025. Any areas of concern will be addressed immediately. This practice is ongoing.

Completion Date: 10/31/25 and Ongoing Monthly

M813 8:43F-16.7(a) (1-23) Infection Control, Sanitation, Housekeeping

1. The Director of Operations (DOO) removed rugs and discarded them on 9/3/25. The Director of Operations removed Flammable materials and placed them in a locked storage closet to ensure the safety of participants on 9/3/25.
2. All Participants have the potential of being affected by these unsafe practices.

3. The Administrator provided Quality Assurance Training on 10/1/25 on Infection Control, Sanitation, Housekeeping and Safety procedures to all staff. The Administrator will conduct a quarterly meeting in January 2026 with the Director of Nursing (DON), Social Worker (SW), and Director of Operations (DO). Mandatory training will start in January 2026 for all staff upon hiring, and yearly thereafter. On 10/1/25, the Administrator developed and implemented a quarterly Quality Assurance Meeting calendar alert system through Microsoft Outlook calendar, to ensure that meetings occur. The Director of Nursing, Social Worker, and Director of Operations were all added to the re-occurring email alert system. On 10/1/25.
4. The Administrator has been conducting Quarterly Safety meetings since July 6, 2016. The Administrator conducted a Quarterly Quality Assurance safety meeting on 10/1/25 with all staff. The Administrator will monitor the recurring Microsoft Outlook Calendar alert system and conduct a Quality Assurance Meeting quarterly to remain in compliance. Mandatory Quality Assurance training for all staff will be conducted yearly.

Completion Date: 10/01/2025 Ongoing Quarterly

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 04016	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/5/2025
NAME OF FACILITY STARS ADULT MEDICAL DAY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1470 HADDON AVENUE CAMDEN, NJ 08103

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0377	Correction	ID Prefix M0425	Correction	ID Prefix M0481	Correction
Reg. # 8:43F-5.4(b)	Completed	Reg. # 8:43F-7.1(a)	Completed	Reg. # 8:43F-8.2	Completed
LSC	10/31/2025	LSC	11/17/2025	LSC	09/28/2025
ID Prefix M0689	Correction	ID Prefix M0701	Correction	ID Prefix M0805	Correction
Reg. # 8:43F-14.17(f)(g)	Completed	Reg. # 8:43F-15.3(a)(1)	Completed	Reg. # 8:43F-16.5(a)(b)(c)	Completed
LSC	09/23/2025	LSC	10/14/2025	LSC	10/31/2025
ID Prefix M0813	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-16.7(a)(1-23)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/01/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON
 9/2/2025

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

☐ YES ☐ NO