

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2025
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NAME OF PROVIDER OR SUPPLIER NEW STANDARD SENIOR LIVING AT MILLVILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 VILLAGE DRIVE MILLVILLE, NJ 08332
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00188562</p> <p>CENSUS: 138</p> <p>SAMPLE SIZE: 5</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

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
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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the Executive Director (ED) failed to ensure the development and enforcement of facility Policies and Procedures (P&Ps). This deficient practice was evidenced by the following:</p> <p>On 9/24/25, the surveyor reviewed the facility's P&P manual provided by the ED and was not able to locate P&Ps regarding staffing, timely medication administration, Registered Nurse (RN) assessments, Certified Medication Aide (CMA) oversight, or pharmaceutical services. In addition, the surveyor was not able to locate a policy that indicated how often General Service Plans (GSPs) were to be updated.</p> <p>On 10/7/25 at 5:52 p.m., the surveyor interviewed the ED to inquire if there were any additional P&Ps that were not in the provided manual, and the ED stated that all the P&Ps were inside the manual.</p>	A 310		
A 401	<p>8:36-4.1(a)(22) Resident Rights</p> <p>(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:</p> <p>22. The right to live in safe and clean</p>	A 401		

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A 401	<p>Continued From page 2</p> <p>conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188562</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident's right to live in safe conditions was enforced for 5 of 5 residents reviewed, Resident #'s 1, 2, 3, 4, and 5. This deficient practice was evidenced by the following:</p> <p>1. On 9/24/25 at 2:13 p.m., the surveyor interviewed the Assistant Director of Nursing (ADON) to inquire if the facility had a Director of Nursing (DON), and the ADON stated that she was acting as the DON and the ADON. The surveyor inquired if the ADON was a Registered Nurse (RN), and the ADON stated that she was a Licensed Practical Nurse (LPN).</p> <p>At 2:41 p.m., the surveyor interviewed the Executive Director (ED) to inquire who oversaw the Certified Medication Aides (CMAs) at the facility, and the ED stated that the CMAs were overseen by herself and the ADON, neither of whom was a RN. The ED stated that there was no RN/DON from 5/1/25-8/10/25 or from 9/19/25 to the date of survey. The surveyor inquired who completed resident assessments, and the ED stated that the ADON did.</p> <p>The surveyor reviewed the Medical Record (MR) of Resident #2, who was diagnosed with </p>	A 401		

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A 401	<p>Continued From page 3</p> <p>NJ Exec Order 26.4b1 .</p> <p>The surveyor reviewed LPN #1's Medication Administration Record (MAR) documentation on NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1), which revealed that Resident #2's NJ Exec Order 26.4b1 was held at 7:30 a.m., for a NJ Exec Order 26.4b1 and again at 11:30 a.m. for a NJ Exec Order 26.4b1.</p> <p>The surveyor then reviewed a PN written by Licensed Practical Nurse (LPN) #1 dated NJ Exec Order 26.4b1, which indicated, "Resident had a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 this afternoon. Resident NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 Resident currently does not have an order for NJ Exec Order 26.4b1 ... Resident has recently started NJ Exec Order 26.4b1 and has NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 Resident was given a NJ Exec Order 26.4b1 and an NJ Exec Order 26.4b1. Resident was sent out NJ Exec Order 26.4b1 per request of [his/her] NJ Exec Order 26.4b1 ... ADON [a Licensed Practical Nurse] and resident's PCP [Primary Care Provider] were also notified." The PN also indicated that the resident left the facility with emergency personnel by NJ Exec Order 26.4b1 at 1:45 p.m., eight hours and 15 minutes after LPN #1 documented a NJ Exec Order 26.4b1.</p> <p>In addition, the surveyor reviewed PNs written by LPN #3 dated NJ Exec Order 26.4b1 which revealed that Resident #2's NJ Exec Order 26.4b1 requested that the resident be sent to the hospital because the resident's NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. The PNs also revealed that Resident #2 was admitted to the hospital with a diagnosis of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 which according to the National Library of Medicine (NLM) is the of the NJ Exec Order 26.4b1 to maintain an NJ Exec Order 26.4b1</p>	A 401		

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A 401	<p>Continued From page 4</p> <p>Further, the surveyor observed three expired bottles of NJ Exec Order 26.4b1 tablets, used as needed for NJ Exec Order 26.4b1, in Resident #2's apartment inside of an unlocked cabinet. Resident #2's service plan initiated on NJ Exec Order 26.4b1, indicated that the resident, "Needs NJ Exec Order 26.4b1 with medications due to NJ Exec Order 26.4b1</p> <p>On 10/7/24, the surveyor returned to the facility and there was still no RN/DON.</p> <p>2. On 9/24/25 at 10:27 a.m., the surveyor interviewed Resident #1 to inquire if the resident received his/her medications on time. Resident #1 stated that his/her medications were not being administered on time and that his/her medication for NJ Exec Order 26.4b1 was not delivered by the pharmacy. Resident #1 also stated that he/she missed two doses of medication, and that the medication was to keep him/her out of the hospital.</p> <p>The surveyor reviewed Resident #1's MR, which revealed that the resident had diagnoses of NJ Exec Order 26.4b1. The surveyor reviewed a pending order for NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was ordered on NJ Exec Order 26.4b1 for the resident to receive a dose on the night of NJ Exec Order 26.4b1 and another dose on NJ Exec Order 26.4b1. The surveyor did not observe documentation on Resident #1's Medication Administration Record (MAR) that indicated that the medication was administered as per the doctor's order. Additionally, the surveyor did not observe a PN that indicated that Resident #1's doctor was notified that the resident did not receive his/her prescribed medication.</p>	A 401		

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A 401	<p>Continued From page 5</p> <p>At 2:13 p.m., the surveyor interviewed the ADON to inquire if the facility received Resident #1's [redacted] and the ADON stated that she received an E-Mail from the pharmacy that indicated that the medication would be available on [redacted]. The surveyor then inquired if Resident #1's doctor was notified that Resident #1 did not receive his/her medication as ordered, and the ADON stated that she did not know.</p> <p>3. On 9/24/25 at 10:14 a.m., the surveyor interviewed the Certified Nursing Assistant (CNA) assigned to the second floor regarding staffing. The CNA stated that the facility was short-staffed and that there was one CNA, and one nurse assigned to units [redacted] and [redacted] which contained approximately 50 residents. The CNA stated that the facility had been short-staffed for three weeks. The CNA also stated that on the day of the survey, Resident #3 and Resident #4 both obtained [redacted], and were sent to the hospital.</p> <p>The surveyor reviewed the MRs of Residents #3 and #4, which confirmed that the residents did have [redacted] with [redacted] that resulted in the residents being sent to the hospital for evaluation. Resident #3 obtained a [redacted] to the [redacted] of his/her [redacted] and Resident #4 obtained an [redacted] to the [redacted] of his/her [redacted].</p> <p>Further, at 10:20 a.m., the surveyor interviewed LPN #1 assigned to the second floor to inquire if she administered resident medications on time. LPN #1 stated that she had not yet administered 9:00 a.m. medications to unit [redacted].</p> <p>On 10/7/25 at 1:42 p.m., the surveyor interviewed a CMA assigned to the [redacted] floor to inquire if</p>	A 401		

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A 401	<p>Continued From page 6</p> <p>she administered resident medications on time. The CMA stated that she had to administer medications to 48 residents and that medications were administered late.</p> <p>4. On 9/24/25 at 9:55 a.m., the surveyor interviewed Resident #5 and observed broken flooring in the resident's apartment that had cardboard taped to it. At this time, Resident #5 stated that the floor had been that way for approximately [redacted] and that he/she recently [redacted] on the flooring and [redacted].</p> <p>The surveyor reviewed a PN in Resident #5's MR, dated [redacted], which confirmed that the resident [redacted] on the hole in the flooring and [redacted].</p> <p>On 1/29/25, during a prior survey at the facility, the surveyor observed broken flooring in Resident #1's apartment. The surveyor informed the facility about the floor during that visit.</p> <p>On 9/24/25 at 10:27 a.m., the surveyor observed that the flooring in Resident #1's apartment was still broken.</p> <p>At 11:08 a.m. and 11:16 a.m., the surveyor interviewed the Director of Maintenance (DOM) to inquire about the broken flooring in Resident #1 and Resident #5's apartments. The DOM stated that he started at the facility approximately [redacted] and that he was trying to fix things. The DOM then stated that he patched the flooring in Resident #5's apartment and that Resident #1's apartment was on a list to receive flooring. The surveyor inquired if the DOM ordered new flooring, and the DOM stated that he did not.</p> <p>The surveyor reviewed the facility's undated policy titled, "Resident Rights," which indicated, "... Procedure: Adhere to the state "Resident's</p>	A 401		

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A 401	Continued From page 7 Rights" at all times ..."	A 401		
A 531	<p>8:36-5.6(c) General Requirements</p> <p>(c) The staffing level in this chapter is minimum only and the assisted living residence, comprehensive personal care, or assisted living program shall employ staff in sufficient number and with sufficient ability and training to provide the basic resident care, assistance, and supervision required, based on an assessment of the acuity of residents' needs.</p> <p>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 staffing was determined based on an assessment of the acuity of residents' needs for an unsampled resident and 4 of 6 residents reviewed, Resident #'s 1, 3, 4, and 6. This deficient practice was evidenced by the following:</p> <p>1. On 9/24/25 at 10:14 a.m., the surveyor interviewed the Certified Nursing Assistant (CNA) assigned to the second floor regarding staffing. The CNA stated that the facility was short-staffed and that there was one CNA, and one Nurse assigned to units [redacted] and [redacted] which contained approximately 50 residents. The CNA stated that the facility had been short-staffed for three weeks. The CNA also stated that on the day of the survey, Resident #3 and Resident #4 both obtained [redacted] NJ Exec Order 26.4b1, and were sent to the hospital.</p> <p>In addition, the CNA stated that she had to provide care to all residents, administer showers,</p>	A 531		

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A 531	<p>Continued From page 8</p> <p>do laundry, take out trash and more. The surveyor inquired if the Executive Director (ED) was made aware of the staffing concern. The CNA stated that the ED was aware, and that the facility had a meeting, and the new owners stated that the whole facility would have three CNAs in the morning, three in the evening, and one overnight.</p> <p>The surveyor reviewed the Medical Record (MR) of Resident #3 and Resident #4, which confirmed that both residents had a [redacted] with [redacted] on [redacted].</p> <p>Further review of Resident #3's MR revealed that the resident was admitted to the facility in [redacted] of [redacted] with a diagnosis of repeated [redacted].</p> <p>On 10/7/25 at 1:29 p.m., the surveyor interviewed Resident #4's [redacted] who was also a resident at the facility, to inquire about Resident #4's [redacted] on [redacted]. Resident #4's [redacted] stated that he/she [redacted] Resident #4 after Resident #4 [redacted]. During this interview, Resident #4's [redacted] stated that he/she [redacted] Resident #4 and [redacted] Resident #4 [redacted] each morning. The surveyor inquired if facility staff assisted Resident #4 with care, and Resident #4's [redacted] stated that staff assisted with medications and nothing more.</p> <p>Further review of Resident #4's MR revealed that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses of [redacted] with [redacted]. Resident #4 did not have a documented service plan.</p> <p>The surveyor reviewed the facility's resident council minutes dated [redacted],</p>	A 531		
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A 531	<p>Continued From page 9</p> <p>which revealed concerns regarding CNAs "constantly" using their phones, residents needing help with ADLs (Activities of Daily Living), and the facility's need for more CNAs.</p> <p>2. On 9/24/25 at 10:20 a.m., the surveyor interviewed Licensed Practical Nurse (LPN) #1 assigned to the second floor to inquire if she administered resident medications on time. LPN #1 stated that she had not yet administered 9:00 a.m. medications to unit [REDACTED]</p> <p>At 10:26 a.m., the surveyor interviewed Resident #1, whose apartment was located on unit [REDACTED]. During the interview, the resident stated that nursing staff did not administer his/her medication on time.</p> <p>At 10:32 a.m., the surveyor interviewed Resident #6, who was also located on unit [REDACTED]. Resident #6 stated that nursing staff administered his/her medications late five to six times a week. Resident #6 explained that the facility cut staff and that due to the staff cut, he/she had not received his/her 9:00 a.m. medications.</p> <p>At 10:46 a.m., the surveyor exited Resident #6's apartment and observed that LPN #1 was 16 apartments away preparing medications for another resident.</p> <p>On 10/7/25 at 1:42 p.m., the surveyor interviewed a Certified Medication Aide (CMA) on the second floor to inquire if she administered resident medications on time. The CMA stated that she had 48 residents to administer medication to and that medications were administered late to some residents.</p> <p>On 9/24/25 and 10/7/25, the facility staffed one</p>	A 531		

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A 531	<p>Continued From page 10</p> <p>Nurse and one CNA on the second floor. On [redacted], two residents [redacted] sustained [redacted], and were sent to the hospital, and several residents received their medications late. In addition, Resident #4's [redacted] who was also a resident, provided care to Resident #4 instead of facility staff.</p> <p>The surveyor was not able to locate a policy and procedure regarding acuity based staffing or timely medication administration.</p>	A 531		
A 745	<p>8:36-7.2(f) Resident Assessments and Care Plans</p> <p>(f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188562</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that health care assessments were documented by a Registered Nurse (RN) as required in accordance with the rules of this chapter for 5 of 5 residents reviewed, Resident #'s 1, 2, 3, 4, and 5. This deficient practice was evidenced by the following:</p> <p>On 9/24/25 at 2:41 p.m., the surveyor interviewed the Executive Director (ED), who stated that there was no RN/Director of Nursing (DON) at the</p>	A 745		

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A 745	<p>Continued From page 11</p> <p>facility from 5/1/25-8/10/25 or from 9/19/25 to the date of survey. The surveyor inquired who completed resident assessments, and the ED stated that the Assistant Director of Nursing (ADON), who was a Licensed Practical Nurse (LPN), completed assessments. The surveyor inquired if the ED was aware that assessments had to be completed by a RN, and the ED stated that she was aware and that she was doing what she was told to do.</p> <p>The surveyor reviewed the Medical Records (MRs) of Resident #'s 1, 2, 3, 4, and 5, which revealed the following:</p> <ol style="list-style-type: none"> 1. Resident #1 was last assessed on [redacted] by an LPN. 2. Resident #2 was last assessed on [redacted] by an LPN. Review of Progress Notes (PNs) in Resident #2's MR revealed that on [redacted], the resident returned from the hospital after being admitted for NJ Exec Order 26.4b1 [redacted] and that on [redacted], the resident returned from the hospital after being admitted for [redacted] due to NJ Exec Order 26.4b1. The surveyor did not observe any assessments that were completed by a RN before or after Resident #2's hospitalizations. 3. Resident #3 was assessed on [redacted] by an LPN and on [redacted] however, the assessment on [redacted] was in progress and not signed. The surveyor also reviewed PNs written by an LPN dated [redacted], which indicated that the resident had a [redacted] a [redacted] to the [redacted] of his/her [redacted] and was sent to the hospital. Further, the surveyor reviewed additional PNs, which revealed that Resident #3 also had [redacted] on NJ Exec Order 26.4b1. The 	A 745		
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NAME OF PROVIDER OR SUPPLIER NEW STANDARD SENIOR LIVING AT MILLVILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 VILLAGE DRIVE MILLVILLE, NJ 08332
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 745	<p>Continued From page 12</p> <p>surveyor did not observe any assessments that were completed by a RN following Resident #3's [redacted] or return to the facility after the previously mentioned hospital visit.</p> <p>4. Resident #4 did not have any completed assessments.</p> <p>5. Resident #5 was last assessed on [redacted] by an LPN. Review of a PN written by an LPN dated [redacted] revealed that Resident #5 [redacted]. The surveyor did not observe that an assessment was completed by a RN following Resident #5's [redacted].</p> <p>The surveyor reviewed the facility's policy titled, "Post Fall Evaluation," which indicated, "Procedure: 1. The post fall assessment (form CS104) is completed after a resident falls by DON or designee ..."</p> <p>The surveyor reviewed the facility's Policy and Procedure Manual and was not able to locate any additional policies on RN assessments.</p>	A 745		
A 749	<p>8:36-7.3(a) Resident Assessments and Care Plans</p> <p>(a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p> <p>This REQUIREMENT is not met as evidenced</p>	A 749		

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A 749	<p>Continued From page 13</p> <p>by: Complaint #: NJ00188562</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop and implement General Service Plans (GSPs) for 5 of 5 residents reviewed, Resident #'s 1, 2, 3, 4, and 5. This deficient practice was evidenced by the following:</p> <p>On 9/24/25 and 10/7/25, the surveyor reviewed the Medical Records (MRs) of Resident #'s 1, 2, 3, 4, and 5, which revealed the following:</p> <ol style="list-style-type: none"> 1. Resident #1, who was admitted to the facility in [redacted] of [redacted] with diagnoses of [redacted], did not have a GSP. The Assistant Director of Nursing (ADON) later provided the surveyor with a GSP for Resident #1 that was initiated on [redacted], however, the GSP did not address the resident's [redacted]. 2. Resident #2, who was admitted to the facility in [redacted] with diagnoses of [redacted] was hospitalized from [redacted] for a [redacted] which was [redacted]. The surveyor reviewed a GSP provided by the ADON, which revealed that a GSP was not initiated for Resident #2 until [redacted]. In addition, Resident #2's GSP was not updated following a hospitalization from [redacted] for a [redacted]. 3. Resident #3, who was admitted to the facility in [redacted] of [redacted] with diagnoses of [redacted] and [redacted], had [redacted] on [redacted]. The surveyor reviewed Resident 	A 749		

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A 749	<p>Continued From page 14</p> <p>#3's GSP initiated on [redacted] NJ Exec Order 26.4b1, which revealed that the GSP did not address [redacted] NJ Exec Ord.</p> <p>4. Resident #4, who was admitted to the facility in [redacted] NJ Exec Ord. of [redacted] NJ Exec Ord. with a diagnosis of [redacted] NJ Exec Order 26.4b1 did not have a GSP.</p> <p>5. Resident #5, who was admitted to the facility in [redacted] NJ Exec Order of [redacted] NJ Exec Ord. with diagnoses of [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1, had a [redacted] NJ Exec. on [redacted] NJ Exec Order 26.4b1. The surveyor reviewed Resident #5's GSP initiated [redacted] NJ Exec Order 26.4b1, which revealed that the GSP did not address [redacted] NJ Exec Ord.</p> <p>At 11:59 a.m., the surveyor interviewed the Assistant Director of Nursing (ADON) to inquire the reason Resident #4 did not have a GSP, and the ADON stated that she started in [redacted] NJ Exec C of [redacted] NJ Exec Ord. and that she was trying to catch up on GSPs.</p> <p>The surveyor reviewed the facility's undated policy titled, "Coordination/Individualization of Services," which indicated, "... Policy Statement: All services will be tailored to each individual's specific needs ..."</p> <p>The surveyor reviewed the facility's Policy and Procedure Manual and was not able to locate a policy that indicated how often GSPs were to be updated.</p>	A 749		
A 779	<p>8:36-7.5(c) Resident Assessments and Care Plans</p> <p>(c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care</p>	A 779		

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A 779	<p>Continued From page 15 intervention or medical care.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188562</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to notify a Registered Nurse (RN) of a resident's [redacted] and/or [redacted] for 3 of 5 residents reviewed, Resident #'s 2, 3, and 4. This deficient practice was evidenced by the following:</p> <p>1. On 9/24/25 at 2:41 p.m., the surveyor interviewed the Executive Director (ED), who stated that there was no RN/Director of Nursing (DON) at the facility from 5/1/25-8/10/25 or from 9/19/25 to the date of survey.</p> <p>The surveyor reviewed the Medical Record (MR) of Resident #2, which reviewed a PN written by Licensed Practical Nurse (LPN) #1 dated [redacted], which indicated, "Resident had a [redacted] this afternoon. Resident [redacted] ... Resident has recently started [redacted] and has [redacted] due to [redacted] from [redacted]. Resident was given a [redacted] to help [redacted] and an [redacted]. Resident was sent out [redacted] per request of [his/her] [redacted] ... ADON [a Licensed Practical Nurse] and resident's PCP [Primary Care Provider] were also notified."</p> <p>In addition, the surveyor reviewed a PN written by</p>	A 779		
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A 779	<p>Continued From page 16</p> <p>LPN #3 dated [redacted] which indicated, "Per cover nurse resident was made aware by [redacted] that [redacted] was ranging between [redacted] ... Residents' [redacted] requested for [redacted] to be sent to [hospital] for further evaluation. [redacted] was called resident was [redacted] ... ADON and [redacted] made aware ..."</p> <p>On 10/7/24 at 12:34 p.m., the surveyor interviewed Resident #2's [redacted] via telephone to inquire about the previously mentioned incidents. Resident #2's [redacted] stated that on [redacted] she called the resident who stated that he/she [redacted]. Resident #2's [redacted] stated that the resident told her that his/her [redacted] Resident #2's [redacted] stated that she then called LPN #1 and told the LPN to send the resident to the hospital.</p> <p>In addition, Resident #2's [redacted] stated that on [redacted] she visited the resident and observed that the resident had "NJ Exec Order 26.4b1". Resident #2's [redacted] stated that she checked the resident's [redacted], which revealed that the resident's [redacted] was in the [redacted] Resident #2's [redacted] stated that she sat the resident up and administered a [redacted] treatment. In the same interview, Resident #2's [redacted] stated that she was a nurse and that when she listened to the resident's [redacted], she heard [redacted] on the resident's [redacted] Resident #2's [redacted] stated that she then requested that LPN #3 send the resident to the hospital.</p> <p>The surveyor reviewed a follow-up PN written by LPN #3 dated [redacted], which indicated that Resident #2 was admitted to the hospital with a [redacted] and [redacted].</p>	A 779		
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A 779	<p>Continued From page 17</p> <p>2. At 10:14 a.m., the surveyor interviewed the CNA on the second floor regarding staffing. The CNA stated that the facility was short-staffed and that Resident #3 and Resident #4 both obtained a [redacted], and were sent to the hospital.</p> <p>The surveyor reviewed the MR of Resident #3, which revealed a PN written by LPN #4 dated [redacted], which indicated, "630am heard resident [redacted]. Responded promptly to note resident [redacted] ... [redacted] noted to [redacted]. Resident reports [redacted] ... [redacted] called for eval [evaluation] r/t [related to] [redacted] .. Emergency contact, ADON, ADM [Administrator] and NP [Nurse Practitioner] made aware of [redacted] with [redacted] Further, the surveyor reviewed additional PNs, which revealed that Resident #3 also had [redacted] on [redacted] Resident #3 [redacted] and/or [redacted] with the previously mentioned [redacted] however, the PNs did not indicate that a RN was notified.</p> <p>The surveyor then reviewed the MR of Resident #4, which revealed a PN written by LPN #1 dated [redacted] which indicated, "Nurse was alerted by CNA [Certified Nursing Assistant] and residents' [redacted] that resident was on the [redacted] ... Resident had [an] [redacted] on the [redacted] [his/her] [redacted] ... Resident sent to [hospital] ... Resident's [redacted] ADON, and PCP were all notified ..."</p> <p>On 10/7/24, the surveyor returned to the facility, and there was still no RN/DON.</p> <p>The surveyor reviewed the facility's policy and procedure titled, "Emergency Care," which</p>	A 779		
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A 779	<p>Continued From page 18</p> <p>indicated that all staff were trained and qualified to notify the nurse and/or 911. However, the policy did not specify if the nurse was an LPN or RN.</p> <p>In addition, the surveyor reviewed the facility's undated policy and procedure titled, "Post Fall Evaluation," which indicated, "Procedure: 1. The post fall assessment (form CS104) is completed after a resident falls by DON or designee ..."</p> <p>The facility had no RN oversight to assess resident nursing and/or medical needs. Further, Resident #2's NJ Exec Order 26.4b1 had to request for nursing staff to send the resident to the hospital on two separate occasions where the resident was in NJ Exec Order 26.4b1.</p>	A 779		
A 793	<p>8:36-8.2 Nursing Services</p> <p>A facility shall have at least one registered professional nurse available at all times.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188562</p> <p>Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that a Registered Nurse (RN) was available at all times. This deficient practice was evidenced by the following:</p> <p>On 9/24/25 at 2:13 p.m., the surveyor interviewed the Assistant Director of Nursing (ADON) to inquire if the facility had a Director of Nursing (DON). The ADON stated that she was acting as the DON and the ADON. The surveyor inquired if</p>	A 793		

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A 793	<p>Continued From page 19</p> <p>the ADON was a Registered Nurse (RN), and the ADON stated that she was a Licensed Practical Nurse (LPN). The ADON stated that there was no RN/DON at the facility from March to September of 2025 or from the former RN/DON's last day NJ Exec Order 26.451 to the day of survey. The ADON stated that corporate staff would visit the facility. The surveyor inquired how often corporate staff were at the facility, and the ADON stated that the Regional Director of Operations and the Regional Director of Clinical Services were at the facility "a couple days last week" and that they did not come the week of the survey.</p> <p>At 2:41 p.m., the surveyor interviewed the Executive Director (ED) to inquire if there was a RN at the facility. The ED stated that there was no RN/DON from 5/1/25-8/10/25 or from 9/19/25 to the date of survey. The surveyor informed the ED that regulations required that the facility have a RN, and the ED verbalized understanding.</p> <p>On 10/7/24, the surveyor returned to the facility, and there was still no RN/DON.</p> <p>The surveyor was not able to locate a policy and procedure regarding nurse staffing requirements.</p>	A 793		
A 925	<p>8:36-11.2 Pharmaceutical Services</p> <p>The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations.</p>	A 925		

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A 925	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that pharmaceutical services were provided to a resident in accordance with the prescriber's order for 1 of 5 residents reviewed, Resident #1. This deficient practice was evidenced by the following:</p> <p>On 9/24/25 at 10:20 a.m., the surveyor interviewed the Licensed Practical Nurse (LPN) #1 on the second floor to inquire if she administered resident medications on time. LPN #1 stated that she had not yet administered 9:00 a.m. medications to unit [REDACTED]</p> <p>At 10:26 a.m., the surveyor interviewed Resident #1, whose apartment was located on unit [REDACTED]. During the interview, the resident stated that nursing staff did not administer his/her medication on time and that his/her medication for [REDACTED] was not delivered by the pharmacy. Resident #1 stated that he/she missed two doses of the medication, and that the medication [REDACTED]</p> <p>The surveyor reviewed Resident #1's MR, which revealed a pending confirmation order for [REDACTED]</p> <p>The [REDACTED] was ordered on [REDACTED] for the resident to receive a dose on the night of [REDACTED] and another dose on [REDACTED]. The surveyor did not observe documentation on Resident #1's Medication Administration Record (MAR) that indicated that the medication was administered as ordered. Additionally, the</p>	A 925		
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A 925	<p>Continued From page 21</p> <p>surveyor did not observe a PN that indicated that Resident #1's doctor was notified that the resident did not receive his/her medication as prescribed.</p> <p>At 2:13 p.m., the surveyor interviewed the ADON to inquire if the facility received Resident #1's [redacted] and the ADON stated that she received an E-Mail from the pharmacy that indicated that the medication would be available on [redacted]. The surveyor then inquired if Resident #1's doctor was notified that Resident #1 did not receive his/her medication as ordered, and the ADON stated that she did not know.</p> <p>The surveyor was not able to locate a policy and procedure on providing pharmaceutical services to residents in accordance with the prescribed orders.</p> <p>Further, the surveyor reviewed the MR of Resident #1, which indicated that the resident had diagnoses of [redacted], [redacted], [redacted]. Review of Resident #1's MAR for [redacted] revealed the following:</p> <ul style="list-style-type: none"> - On [redacted], Resident #1's [redacted] was not available at 8:00 a.m., 1:00 p.m., or 6:00 p.m. - On [redacted], Resident #1's [redacted] was not available. - On [redacted], Resident #1's [redacted] were not available. - On [redacted], Resident #1's [redacted] was not available. <p>On [redacted], the facility failed to ensure that</p>	A 925		

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A 925	Continued From page 22 Resident #1 received medications as prescribed. On 1/12/26, with a Directed Plan of Correction (DPOC) in place, the facility failed to ensure that Resident #1 and Resident #2 received medications as prescribed. This is a repeat deficiency.	A 925		
A 937	8:36-11.5(a) Pharmaceutical Services (a) The administration of medications is within the scope of practice and remains the responsibility of the registered professional nurse. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188562 Based on interview and record review, it was determined that the facility failed to ensure that a Registered Nurse (RN) supervised tasks delegated to Licensed Practical Nurses (LPNs) and Certified Medication Aides (CMAs), in accordance with the New Jersey Board of Nursing N.J.A.C. 13:37-6.2, for 1 of 5 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 9/24/25 at 2:41 p.m., the surveyor interviewed the Executive Director (ED) to inquire who oversaw the CMAs at the facility, and the ED stated that the CMAs were overseen by herself	A 937		

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NAME OF PROVIDER OR SUPPLIER NEW STANDARD SENIOR LIVING AT MILLVILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 VILLAGE DRIVE MILLVILLE, NJ 08332
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 937	<p>Continued From page 23</p> <p>and the Assistant Director of Nursing (ADON), neither of whom was a RN. The ED stated that there was no RN/DON from 5/1/25-8/10/25 or from 9/19/25 to the date of survey.</p> <p>At 12:34 p.m., the surveyor interviewed Resident #2's [redacted] by telephone, who stated that on [redacted] the resident's NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1). Resident #2's [redacted] stated that she requested for LPN #1 to send the resident to the hospital and that the LPN was going to allow the resident to try to [redacted] the resident's NJ Exec Order 26.4b1.</p> <p>In addition, Resident #2's daughter stated that nurses at the facility did not administer the resident's [redacted] and that she found multiple boxes of [redacted] in the resident's apartment. Resident #2's [redacted] stated that when she asked LPN #1 why the nurses did not administer the resident's [redacted] the LPN stated that the resident could administer the [redacted] NJ Exec Order 26.4b1. Further, Resident #2's [redacted] stated that she observed LPN #2 administer night-time medications to the resident and that the LPN did not administer the resident's [redacted] Resident #2's [redacted] stated that she "said something" to LPN #2 and that the LPN then went to retrieve the [redacted]</p> <p>The surveyor reviewed Resident #2's Medication Administration Record (MAR) for [redacted] of [redacted] which confirmed that the resident had an order for [redacted] NJ Exec Order 26.4b1 by mouth twice a day for [redacted] The MAR revealed that [redacted] was documented for the [redacted] for the entire month of [redacted] NJ Exec Order 26.4b1. In addition, the surveyor reviewed LPN #1's MAR documentation on [redacted] NJ Exec Order 26.4b1, for [redacted] NJ Exec Order 26.4b1), which</p>	A 937		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2025
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NAME OF PROVIDER OR SUPPLIER NEW STANDARD SENIOR LIVING AT MILLVILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 VILLAGE DRIVE MILLVILLE, NJ 08332
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A 937	<p>Continued From page 24</p> <p>revealed that Resident #2's ^{NJ Exec Order 26.4b1} was held at 7:30 a.m., for a ^{NJ Exec Order 26.4b1}, and at 11:30 a.m. for a ^{NJ Exec Order 26.4b1}.</p> <p>The surveyor reviewed a Progress Note (PN) in Resident #2's Medical Record (MR) dated ^{NJ Exec Order 26.4b1}, written by LPN #1, which indicated that the resident left the facility with emergency personnel by ^{NJ Exec Order 26.4b1} at 1:45 p.m., eight hours and 15 minutes after LPN #1 documented a ^{NJ Exec Order 26.4b1}.</p> <p>At 10:11 a.m., the surveyor interviewed the ADON to inquire what the documented chart code ^{NJ Exec Order 26.4b1} on the MAR meant, and the ADON stated, "I don't know what that means."</p> <p>The surveyor reviewed the facility's Policy and Procedure manual and was not able to locate a policy regarding RN review of resident MARs or RN oversight.</p>	A 937		
A1181	<p>8:36-17.1(b) Housekeeping-Sanitation-Safety-Maintenance</p> <p>(b) The facility shall provide housekeeping, laundry, pest control, and maintenance services, and shall provide assistance to residents who require assistance with these services in their residential units</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188562</p> <p>Based on observation, interview, and review of pertinent facility documents, it was determined</p>	A1181		

New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER NEW STANDARD SENIOR LIVING AT MILLVILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 VILLAGE DRIVE MILLVILLE, NJ 08332
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A1181	<p>Continued From page 25</p> <p>that the facility failed to provide housekeeping, laundry, pest control, and maintenance services for 3 of 5 residents reviewed, Resident #'s 1, 2, and 5. This deficient practice was evidenced by the following:</p> <p>1. On 9/24/25 at 9:40 a.m., the surveyor toured Resident #2's apartment in the presence of a Certified Nursing Assistant (CNA). Upon entering the room, the surveyor observed three boxes of NJ Ex Order 26.4(b)(1) stacked in front of the entrance and NJ Ex Order 26.4(b)(1) sitting on the resident's bedside table. At this time, the CNA removed the NJ Ex Order 26.4(b)(1) from Resident #2's apartment, who was hospitalized since NJ Ex Order 26.4(b)(1). A Licensed Practical Nurse (LPN) then entered the apartment and moved the three boxes of NJ Ex Order 26.4(b)(1) that were stacked in front of the entrance. At this time, the surveyor inquired if the resident was moving after boxes, bins, and bags were observed stacked throughout the apartment. The LPN stated that the resident NJ Ex Order 26.4b1 and that the room was NJ Ex Order 26.4b1 before Resident #2's NJ Ex Order 26.4b1. The LPN also stated that Resident #2 had a NJ Ex Order 26.4b1 that would NJ Ex Order 26.4b1 in the resident's apartment.</p> <p>On 10/7/24 at 12:34 p.m., the surveyor interviewed Resident #2's NJ Ex Order 26.4b1 by telephone. Resident #2's NJ Ex Order 26.4b1 stated, "I can't ever sit with [Resident #2] and spend time with [him/her], there is always NJ Ex Order 26.4b1 or something to do". Resident #2's NJ Ex Order 26.4b1 stated that she had to clean the resident's apartment every time she came to visit and that in NJ Ex Order 26.4b1, she found NJ Ex Order 26.4(b)(1) in the resident's room.</p> <p>The surveyor reviewed Resident #2's service plan initiated on NJ Ex Order 26.4b1, which indicated that the facility would assist the resident with NJ Ex Order 26.4b1 and</p>	A1181		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2025
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NAME OF PROVIDER OR SUPPLIER NEW STANDARD SENIOR LIVING AT MILLVILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 VILLAGE DRIVE MILLVILLE, NJ 08332
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A1181	<p>Continued From page 26</p> <p>housekeeping.</p> <p>At 1:52 p.m., the surveyor interviewed the Housekeeping Aide (HA) assigned to Resident #2's apartment to inquire how often he cleaned resident apartments, and the HA stated that apartments were cleaned once a week. The surveyor then inquire how often the HA cleaned Resident #2's apartment, and the HA stated that Resident #2's [redacted] cleaned the resident's apartment. The HA stated that Resident #2's [redacted] spent approximately [redacted] the resident's apartment after the resident was hospitalized. The surveyor inquired if the HA ever cleaned Resident #2's apartment, and the HA stated that housekeeping staff did not touch resident personal belongings, so he only cleaned the open areas of Resident #2's apartment that he could get to.</p> <p>2. At 9:55 a.m., the surveyor interviewed Resident #5 and observed that the flooring in the resident's apartment was broken with cardboard taped on it. The surveyor asked Resident #5 how long the floor had been broken, and the resident stated that the floor had been broken for approximately [redacted]. Resident #5 then stated that approximately a week and a half prior to survey, he/she [redacted] on the flooring and [redacted]. At this time, the surveyor observed [redacted] in the resident's room.</p> <p>The surveyor reviewed a PN in Resident #5's MR, dated [redacted], which confirmed that the resident [redacted] on the hole in the flooring and [redacted].</p> <p>The surveyor reviewed the facility's maintenance request binder, which revealed an entry dated [redacted], that indicated that Resident #5's</p>	A1181		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2025
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NAME OF PROVIDER OR SUPPLIER NEW STANDARD SENIOR LIVING AT MILLVILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 VILLAGE DRIVE MILLVILLE, NJ 08332
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A1181	<p>Continued From page 27</p> <p>apartment needed a floor repair. Additionally, the surveyor reviewed a second maintenance request entry dated NJ Exec Order, that indicated that Resident #5's apartment floor had a hole in it. These maintenance request entries were not signed and dated as completed.</p> <p>At 10:26 a.m., the surveyor interviewed Resident #1 and observed that the resident's flooring was still broken. This surveyor conducted a prior survey at the facility on 1/29/25 and observed the broken flooring in Resident #1's apartment. The surveyor informed the facility about the floor during that visit.</p> <p>At 11:08 a.m. and 11:16 a.m., the surveyor interviewed the Director of Maintenance (DOM) to inquire about the broken flooring in Resident #1 and Resident #5's apartments. The DOM stated that he started at the facility approximately NJ Exec O and that he was trying to fix things. The DOM then stated that he patched a hole in the flooring in Resident #5's apartment and that Resident #1's apartment was on a list to receive flooring. The surveyor inquired if the DOM ordered new flooring, and the DOM stated that he did not.</p> <p>The surveyor reviewed the facility's resident council minutes dated NJ Exec Order 26.4b1, which indicated concerns regarding NJ Ex Order 26.4(b)(1) and apartments not being cleaned.</p> <p>3. At 12:06 p.m., the surveyor observed that a hallway on the first floor had four consecutive ceiling lights that did not work.</p> <p>On 10/7/25, the surveyor observed that Resident #1 and Resident #5's flooring was still broken, and the ceiling lights on the first floor still did not</p>	A1181		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2025
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A1181	<p>Continued From page 28</p> <p>work.</p> <p>The surveyor reviewed the facility's undated policy titled, "Routine (Weekly) Dwelling Unit Cleaning," which indicated, "...Procedure: ... 2. Clean according to resident's assistance/service plan, adding or deleting tasks according to special instructions from supervisor ..."</p> <p>The surveyor also reviewed the facility's undated policy titled, "Personal Laundry," which indicated, "... Procedure: ...3. The amount of assistance provided will depend on each resident's assistance/service plan ..."</p> <p>Additionally, the surveyor reviewed the facility's undated policy titled, "Insect Infestation/Control," which indicated, "...Policy Statement: ... A contracted professional exterminator is retained for routine treatment on a monthly basis to prevent/control normal pests such as ants, gnats, spiders, etc. ..."</p> <p>Lastly, the surveyor reviewed the facility's undated policy titled, "Maintenance Work Request," which indicated, "... Procedure: ...4. All Maintenance Work Requests will be followed up on within five days of receipt, unless the work needed is of an urgent nature, in which case it will be done immediately ..."</p>	A1181		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 06A003	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/23/2025
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NAME OF FACILITY NEW STANDARD SENIOR LIVING AT MILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 VILLAGE DRIVE MILLVILLE, NJ 08332
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0401	Correction	ID Prefix A0531	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-5.6(c)	Completed
LSC	12/23/2025	LSC	12/23/2025	LSC	12/23/2025
ID Prefix A0745	Correction	ID Prefix A0749	Correction	ID Prefix A0779	Correction
Reg. # 8:36-7.2(f)	Completed	Reg. # 8:36-7.3(a)	Completed	Reg. # 8:36-7.5(c)	Completed
LSC	12/23/2025	LSC	12/23/2025	LSC	12/23/2025
ID Prefix A0793	Correction	ID Prefix A0925	Correction	ID Prefix A0937	Correction
Reg. # 8:36-8.2	Completed	Reg. # 8:36-11.2	Completed	Reg. # 8:36-11.5(a)	Completed
LSC	12/23/2025	LSC	12/23/2025	LSC	12/23/2025
ID Prefix A1181	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.1(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/23/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 10/7/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 06A003	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/23/2025
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NAME OF FACILITY NEW STANDARD SENIOR LIVING AT MILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 VILLAGE DRIVE MILLVILLE, NJ 08332
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 12/23/2025	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 12/23/2025	ID Prefix A0531 Reg. # 8:36-5.6(c) LSC	Correction Completed 12/23/2025
ID Prefix A0745 Reg. # 8:36-7.2(f) LSC	Correction Completed 12/23/2025	ID Prefix A0749 Reg. # 8:36-7.3(a) LSC	Correction Completed 12/23/2025	ID Prefix A0779 Reg. # 8:36-7.5(c) LSC	Correction Completed 12/23/2025
ID Prefix A0793 Reg. # 8:36-8.2 LSC	Correction Completed 12/23/2025	ID Prefix A0925 Reg. # 8:36-11.2 LSC	Correction Completed 12/23/2025	ID Prefix A0937 Reg. # 8:36-11.5(a) LSC	Correction Completed 12/23/2025
ID Prefix A1181 Reg. # 8:36-17.1(b) LSC	Correction Completed 12/23/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 10/7/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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