

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>07015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ARBOR TERRACE ROSELAND</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>345 EAGLE ROCK AVENUE ROSELAND, NJ 07068</b>
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A 000	<p>Initial Comments</p> <p>Initial Comments: COMPLAINT #: NJ00181240 and NJ00188735 CENSUS: 82 SAMPLE SIZE: 5</p> <p>TYPE OF SURVEY: Standard Survey of 87 residential units</p> <p>The facility is not in substantial compliance with all 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.</p> <p>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 389	<p>8:36-4.1(a)(16) 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>16. The right to be free from physical and mental abuse and/or neglect;</p> <p>This REQUIREMENT is not met as evidenced</p>	A 389		

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

TITLE

(X6) DATE

12/23/25

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A 389	<p>Continued From page 1</p> <p>by: Based on interview, record review, and facility policy review, the facility failed to ensure residents did not [redacted] from the facility without staff's knowledge for 3 (Resident #1, #2, and #3) of 5 sampled residents. Specifically, on [redacted] at 1:30 PM, Resident #1 [redacted] from the facility and was seen by staff from a third-floor window of the facility [redacted]. On [redacted] at 10:15 AM, Resident #2 [redacted] from the facility and was [redacted] from the facility [redacted] at a [redacted]. On [redacted] at 3:07 PM, Resident #3 [redacted] from the facility by [redacted] that [redacted] the [redacted] to the unit the resident resided on. Resident #3 [redacted] from the [redacted] and [redacted] on the [redacted] where they [redacted] before the resident was seen by a staff member who [redacted] the resident [redacted].</p> <p>It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, harm, impairment, or death to residents.</p> <p>On 10/31/2025, it was determined that the failed practice represented an immediate threat to residents' health and safety. The facility's Executive Director (ED) was verbally informed of the immediacy of the situation involving the residents' [redacted].</p> <p>Findings included:</p> <p>A facility policy titled, "Elopement Precautions," approved by the facility 11/2014, revealed, "Community staff will implement safeguards to minimize the risk of Resident elopement." The</p>	A 389		
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A 389	Continued From page 2  policy revealed a section titled, "Procedure," that specified, "3. Residents identified as at risk for elopement will be provided with an I.D. [identification] bracelet to assist in the Resident's return to the community. 4. Residents who have been assessed as at risk for elopement will be identified for staff monitoring on the RA [Resident Assistant] Task Sheet. 5. The front desk staff will maintain a list of Residents who are NOT safe to go outside alone (sitting on the front porch, walking, etc. [et cetera, and so forth]. Front desk staff will alert the RCD [Resident Care Director] and/or ED if those Residents make an effort to leave the building alone. The list needs to be updated regularly. Care coordination meetings provide a good opportunity for updating the list. 6. The risk of elopement should be fully explained to the family of any Resident at risk for elopement. The family member will need to sign a Shared Responsibility Agreement [SRA]. 7. The following interventions should be considered for Residents who display habitual exit seeking behaviors or who attempt elopement: - Physician reassessment and medical re-evaluation - In-patient assessment by a geriatric psychiatrist - Private duty sitters or a family member or friend to stay with the Resident - Re-evaluation of Resident's activity interests and preferences - Engagement of Resident in a structured exercise program - The Resident Care Director will notify the Resident's family and physician of any exit-seeking behaviors by the Resident. 8. Care staff in the Evergreen program will be trained on the habits and patterns of any exit-seeking Resident as well as on the most successful redirection strategies for those Residents. 9. Care staff on Assisted Living will account for each Resident on their assignment at the start and end of each shift. Any Resident who does not come to the dining room for a meal will be located and	A 389		

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A 389	<p>Continued From page 3</p> <p>checked on. 10. Care staff on Memory Care will account for each Resident on their assignment at the start of the shift, on periodic rounds throughout the shift and before leaving at the end of the shift."</p> <p>1. A resident demographic record revealed the facility admitted Resident #1 on [redacted]. According to the resident's demographic record, the resident had a medical history that included diagnoses of [redacted], a [redacted], and [redacted].</p> <p>An "Initial Assessment," dated [redacted] and signed by the RCD, revealed Resident #1 was at risk for [redacted]. The assessment revealed instructions for staff included that the resident [redacted], with staff, family, or a friend, and that it was unsafe for the resident to [redacted]. The assessment revealed the resident had no history of [redacted].</p> <p>Resident #1's undated "Care Instructions" revealed a section titled, "Safety Instructions," that included, "Resident is at risk for [redacted] on resident frequently on each shift." The Care Instructions directed the RAs to carefully review the "Care Plan." The Care Plan, last updated by the facility on [redacted], revealed no documentation of an [redacted] risk or associated interventions.</p> <p>Resident #1's "[Facility name] Observations," dated [redacted] at 1:50 PM, revealed a "Progress Note" that indicated Resident #1 [redacted] about [redacted]" by a family member.</p> <p>Resident #1's "[Facility name] Observations,"</p>	A 389		

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A 389	<p>Continued From page 4</p> <p>dated <b>NJ Exec Order 26.4b1</b> at 7:34 AM, revealed a "Progress Note" that indicated that during the night, Resident #1 had <b>NJ Exec Order 26.4b1</b> and was <b>NJ Exec Order 26.4b1</b> of their room. The note revealed that the resident stated, <b>NJ Exec Order 26.4b1</b>." The note revealed that <b>NJ Exec Order 26.4b1</b> was <b>NJ Exec Order 26.4b1</b> multiple times, with Resident #1 stating, <b>NJ Exec Order 26.4b1</b>. The note revealed that <b>NJ Exec Order 26.4b1</b> were made on the resident throughout the night.</p> <p>Resident #1's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 7:21 AM, revealed a "Progress Note" that indicated Resident #1 came out of their apartment during the night and sat in the entrance area of the facility stating, <b>NJ Exec Ord</b>. The note revealed <b>NJ Exec Order 26.4b1</b> were made of the resident, and staff ensured the patio door was <b>NJ Exec Order 2</b> in the resident's room.</p> <p>Resident #1's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 6:13 AM, revealed a "Progress Note" that indicated Resident #1 continued to <b>NJ Exec Order 26.4b1</b> of their room, stating they were <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #1's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 7:17 PM, revealed a "Progress Note" that indicated Resident #1 was transferred to an apartment on the <b>NJ Exec Order 26.4b1</b> (the <b>NJ Exec Order 26.4b1</b>).</p> <p>Resident #1's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 10:20 PM, revealed a "Progress Note" that indicated <b>NJ Exec Order 26.4b1</b> remained in place for Resident #1.</p>	A 389		

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A 389	<p>Continued From page 5</p> <p>Resident #1's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 6:58 AM, revealed a "Progress Note" that indicated Resident #1 was noted <b>NJ Exec Order 26.4b1</b> and stated <b>NJ Exec Order 26.4b1</b>. " The note revealed the resident had to be <b>NJ Exec Order 26.4b1</b> multiple times <b>NJ Ex Order 26.4(b)(1)</b> new apartment.</p> <p>Resident #1's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 7:08 PM, revealed a "Other" note that indicated the resident was <b>NJ Exec Order 26.4b1</b> on <b>NJ Exec Order 26.4b1</b> at 1:30 PM. The note revealed the RCD was notified that Resident #1 was observed by a RA <b>NJ Exec Order 26.4b1</b>. The note revealed the RA immediately notified other staff of her observations, and several staff responded to the <b>NJ Exec Order 26.4b1</b> and were able to <b>NJ Exec Order</b> Resident #1 to the facility. The note revealed the resident was <b>NJ Exec Order 26.4b1</b> and had no <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #1's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 5:32 PM, revealed a <b>"NJ Exec Order 26.4b1"</b> note written by the RCD that indicated Resident #1 had <b>NJ Exec Order 26.4b1</b> and had <b>NJ Exec Order 26.4b1</b>. The note revealed Resident #1 stated they had taken a <b>NJ Exec Order 26.4b1</b>. " The note revealed the resident appeared <b>NJ Exec Order 26.4b1</b>, but <b>NJ Exec Order 26.4b1</b> with <b>NJ Exec Order 26.4b1</b> to the facility. The note revealed the RCD spoke to Resident #1 and determined the resident was <b>"NJ Exec Order 26.4b1</b> they had put themself in. The note revealed that based on the resident's actions, the resident was transferred to the <b>NJ Exec Order 26.4b1</b> to ensure they were in a "safe environment."</p>	A 389		

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A 389	<p>Continued From page 6</p> <p>Resident #1's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 7:26 AM, revealed a "Progress Note" that indicated Resident #1 <b>NJ Exec Order 26.4b1</b> and started to <b>NJ Exec Order 26.4b1</b> and stated, <b>NJ Exec Order 26.4b1</b></p> <p>A "Reportable Event Record/Report," dated <b>NJ Exec Order 26.4b1</b> at 5:00 PM and completed by the ED, revealed that on <b>NJ Exec Order 26.4b1</b> at 1:30 PM, a significant event occurred at the <b>NJ Ex Order 26.4(b)(1)</b> the facility. The report indicated that at approximately 1:15 PM, Resident #1 was observed by the Receptionist <b>NJ Exec Order 26.4b1</b>. The report revealed that at approximately 1:30 PM, the resident had <b>NJ Exec Order 26.4b1</b> to the facility as they customarily did, and at that time, an RA from a third-floor window of the facility saw Resident #1 <b>NJ Exec Order 26.4b1</b>. The report revealed the RA immediately announced her observation over the walkie-talkie and multiple staff to include the ED, Business Office Director, and care givers went to <b>NJ Exec Order 26.4b1</b>. Per the report, Resident #1 told staff they wanted to <b>NJ Exec Order 26.4b1</b>. The report revealed the resident was <b>NJ Exec Order 26.4b1</b> at about 1:35 PM and was assessed by a nurse and deemed to be in <b>NJ Exec Order 26.4b1</b>. The report revealed that a plan of care was developed that addressed this issue, and planned interventions were in place when the event occurred. The report revealed that the facility considered the event to be an <b>NJ Ex Order 26.4(b)(1)</b> because, upon Resident #1's (initial) assessment, the resident <b>NJ Exec Order 26.4b1</b> with staff, family, or friends as per the family's preference."</p> <p>Resident #1's demographic record revealed a section titled "Evaluation and Service Plans" that indicated Resident #1's "Initial Assessment" was</p>	A 389		
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A 389	<p>Continued From page 7</p> <p>completed on [redacted], one week prior to the resident's admission to the facility. The record revealed that a "NJ Exec Order 26.4b1" assessment was completed on [redacted], one day after the [redacted]. Further review revealed that the facility completed no additional assessments after Resident #1's [redacted].</p> <p>During an interview on 10/28/2025 at 2:07 PM, the Receptionist, who was identified in the "Reportable Event Record/Report," stated she was there on the day of Resident #1's [redacted]. She stated the resident had a history of [redacted] and she saw Resident #1 go [redacted] did. The Receptionist stated she heard someone say Resident #1 "NJ Exec Order 26.4b1." She stated the resident had [redacted] before.</p> <p>During an interview on 10/28/2025 at 2:32 PM, RA #6 stated she was assigned to Resident #1 on the day of the [redacted]. She stated that she remembered a staff member paged (said over the walkie-talkie) that it [redacted]. RA #6 stated she helped [redacted] Resident #1 and [redacted] to the facility. When asked about Resident #1 having a history of [redacted], RA #6 stated the resident "NJ Exec Order 26.4b1," and was [redacted]. She stated Resident #1 was allowed to be [redacted] the facility, but she was not sure the resident was [redacted]. RA #6 then stated she thought Resident #1 was [redacted], " as Resident #1 needed to be [redacted] while [redacted]. RA #6 stated she was unsure who would [redacted] the resident when [redacted].</p>	A 389		

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A 389	<p>Continued From page 8</p> <p>During an interview on 10/29/2025 at 10:23 AM, the RCD stated Resident #1 was assessed at the time of move in and was not deemed at risk for [redacted]. She said the resident had some [redacted] after having lived with family members and [redacted]. The RCD stated that to her knowledge, Resident #1 had never had any [redacted] prior to [redacted]. She stated Resident #1 was [redacted] when talking about [redacted] to be with family, and she did not think the resident was at risk for [redacted] and that the resident's service plan did not need to be updated. The RCD then stated that in hindsight, she should have moved the resident to the [redacted] unit prior to the resident [redacted], based on the resident's [redacted].</p> <p>2. A resident demographic record revealed the facility admitted Resident #2 on [redacted]. According to the demographic record, the resident had a medical history that included diagnoses of [redacted].</p> <p>An "Initial Assessment" dated [redacted] and signed by the RCD revealed Resident #2 was at risk for [redacted]. The assessment revealed instructions for staff that the resident [redacted] with staff, family, or a friend and that it was unsafe for the resident to [redacted]. The assessment revealed the resident had no history of [redacted]. The assessment revealed Resident #2 had a recent hospital stay and attempted to leave while admitted there, and [redacted]. Resident #2. The assessment revealed Resident #2 was to have a</p>	A 389		
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A 389	<p>Continued From page 9</p> <p><b>NJ Exec Order 26.4b1</b> from 6:00 PM to 6:00 AM, and at 6:00 AM, a family member would be the resident's companion until 6:00 PM for the first two weeks while adjusting to the facility. The assessment revealed that after two weeks' time, the use of the <b>NJ Exec Order 26.4b1</b> would be re-evaluated for continuation or reduction of the <b>NJ Exec Order 26.4b1</b> hours.</p> <p>Resident #2's "Care Plan," last updated by the facility on <b>NJ Exec Order 26.4b1</b> revealed the resident required '<b>NJ Exec Order 26.4b1</b>.' The Care Plan revealed Resident #2 had their <b>NJ Exec Order 26.4b1</b> and would <b>NJ Exec Order 26.4b1</b>. Per the Care Plan, the resident had a recent hospital stay and <b>NJ Exec Order 26.4b1</b> while they were admitted there. The Care Plan revealed that staff were instructed, "If this should happen <b>NJ Exec Order 26.4b1</b>."</p> <p>Resident #2's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 9:20 PM, revealed a "Admission/Readmission" note that indicated Resident #2 was admitted from the hospital and was treated for <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #2's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 11:34 AM, revealed a "Progress Note" that indicated Resident #2 was at risk for <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #2's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 11:36 AM, revealed an "Other" note that indicated the RCD was notified that Resident #2's <b>NJ Exec Order 26.4b1</b> aide would no longer be coming, and staff would continue to be <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #2's "[Facility name] Observations," dated <b>NJ Exec Order 26.4b1</b> at 11:26 AM, revealed a</p>	A 389		

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A 389	<p>Continued From page 10</p> <p>"Progress Note" that indicated Resident #2 was observed by the Receptionist to be [redacted] and the resident handed her their [redacted] and [redacted]. The note revealed the resident [redacted] and said [redacted]. Per the note, staff were called to intervene, and Resident #2 stated they [redacted]."</p> <p>Resident #2's "[Facility name] Observations," dated [redacted] at 3:28 PM, revealed a "Progress Note" that indicated Resident #2 was observed by staff [redacted]. The note revealed that the resident was asked if family was [redacted], and the resident replied, "[redacted]." The note revealed Resident #2 again proceeded to hand in their [redacted], so the resident was [redacted] and was [redacted] with [redacted] and [redacted].</p> <p>Resident #2's "[Facility name] Observations," dated [redacted] at 4:59 PM, revealed an "Other" note that indicated that at 10:00 AM, Resident #2 was noted going out of the facility for a [redacted]. The note revealed that at approximately 10:15 AM, the resident had not [redacted] as the resident was accustomed to doing. Per the note, staff were alerted and immediately [redacted] the facility [redacted]. The note revealed staff members got into their [redacted] for Resident #2. Per the note, Resident #2 was [redacted] by a staff member, [redacted] from the [redacted] [redacted]. The note revealed the [redacted] had been notified that Resident #2 was [redacted] and once the resident was [redacted] a [redacted] instructed a staff member to [redacted] with the resident at the [redacted] and the [redacted] were on their way to meet them there. The note revealed the [redacted] advised</p>	A 389		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>07015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ARBOR TERRACE ROSELAND</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>345 EAGLE ROCK AVENUE ROSELAND, NJ 07068</b>
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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
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A 389	<p>Continued From page 11</p> <p>staff that Resident #2 needed to be assessed by an emergency medical technician (EMT) upon <b>NJ Exec Order 26.4b1</b>. The note revealed that at 10:57 AM, Resident #2 <b>NJ Exec Order 26.4b1</b> accompanied by <b>NJ Exec Order 26.4b1</b> and was assessed by EMTs. Per the note the resident was deemed to be in "<b>NJ Exec Order 26.4b1</b>" and that there was no need for any further medical treatment.</p> <p>A "Reportable Event Record/Report" dated <b>NJ Exec Order 26.4b1</b> and completed by the ED revealed a significant event occurred when Resident #2 <b>NJ Exec Order 26.4b1</b> from the facility. The report indicated that at about 10:00 AM, Resident #2 was observed by the Receptionist <b>NJ Ex Order 26.4(b)(1)</b> for their <b>NJ Ex Order 26.4(b)(1)</b> and at approximately 10:15 AM, Resident #2 had not <b>NJ Exec Order 26.4b1</b> as they were accustomed to doing. The report indicated the receptionist brought this concern to the attention of a staff member who immediately <b>NJ Exec Order 26.4b1</b> the <b>NJ Exec Order 26.4b1</b>. The report revealed the facility staff <b>NJ Exec Order 26.4b1</b>. The report revealed staff members got in their automobiles and <b>NJ Exec Order 26.4b1</b> for the resident <b>NJ Exec Order 26.4b1</b>. Per the report, Resident #2 was then <b>NJ Exec Order 26.4b1</b> approximately <b>NJ Exec Order 26.4b1</b>. The report revealed the <b>NJ Exec Order 26.4b1</b> was informed that Resident #2 was <b>NJ Exec Order 26.4b1</b>. The report revealed that the <b>NJ Exec Order 26.4b1</b> who were with the ED informed the staff member who <b>NJ Exec Order 26.4b1</b> the resident to stay with Resident #2 until the <b>NJ Exec Order 26.4b1</b> and ED arrived. The report revealed that upon arrival of the <b>NJ Exec Order 26.4b1</b> at the <b>NJ Exec Order 26.4b1</b>, the officer advised the ED that Resident #2 needed to be evaluated by EMT upon return to the facility. Per the report, at 10:57 AM, Resident #2 returned to the facility accompanied by <b>NJ Exec Order 26.4b1</b>. The report revealed EMT responders assessed the resident and Resident</p>	A 389		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>07015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2025</b>
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A 389	<p>Continued From page 12</p> <p>#2 was deemed to be in "NJ Exec Order 26.4b1" and there was no need for further medical treatment. The report indicated that upon return to the facility, Resident #2 was transferred to a room in the NJ Exec Order 26.4b1.</p> <p>Resident #2's "[Facility name] Observations," dated NJ Exec Order 26.4b1 at 5:04 PM, revealed an "Other" note that indicated Resident #2 was visited by their primary physician and transferred to the NJ Exec Order 26.4b1 unit.</p> <p>During an interview on 10/28/2025 at 2:20 PM, RA #6 stated she remembered Resident #2 and that the resident had NJ Exec Order 26.4b1 at the beginning of their stay, so family would come and stay with the resident. She stated the NJ Exec Order 26.4b1 started up again, and since Resident #2 was NJ Exec Order 26.4b1 the resident was NJ Exec Order 26.4b1 and one day just kept NJ Exec Order 26.4b1</p> <p>During an interview on 10/29/2025 at 2:48 PM, RA #7 stated she remembered Resident #2 and that the resident was always NJ Exec Order 26.4b1. She stated the family had a NJ Exec Order 26.4b1 for the resident to keep the resident at the facility, but then the NJ Exec Order 26.4b1 stopped coming.</p> <p>During an interview on 10/29/2025 at 3:10 PM, the Receptionist, who was present on NJ Exec Order 26.4b1 when Resident #2 NJ Exec Order 26.4b1 from the facility, stated she remembered Resident #2 and that the resident NJ Exec Order 26.4b1 and would always tell NJ Exec Order 26.4b1. She stated that on the day of the NJ Exec Order 26.4b1 Resident #2 said NJ Exec Order 26.4b1, and when the resident NJ Exec Order 26.4b1 in, she NJ Exec Order 26.4b1 the resident was. She stated she had another staff member go and NJ Exec Order 26.4b1 around the</p>	A 389		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>07015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2025</b>
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A 389	<p>Continued From page 13</p> <p><b>NJ Exec Order 26.4b1</b> to see if Resident #2 was <b>NJ Exec Or</b> there. The Receptionist stated she called over the walkie talkie system and announced Resident #2 was <b>NJ Exec Order 26.4b1</b>. She stated that staff went from room to room in the building, while others <b>NJ Exec Order 26.4b1</b> for the resident <b>NJ Exec Order 26.4b1</b>. She stated Resident #2 was found at a <b>NJ Exec Order 26.4b1</b>. When asked about any prior <b>NJ Exec Order 26.4b1</b> Resident #2 may have had prior to the actual <b>NJ Exec Order 26.4b1</b> the Receptionist stated Resident #2 had given her their <b>NJ Exec Or</b> and <b>NJ Exec Order 26.4b1</b> at the very beginning of their stay, and had stated they were <b>NJ Exec Order 26.4b1</b> however, she would have only considered that an <b>NJ Exec Order 26.4b1</b> attempt if the resident had <b>NJ Exec Order 26.4b1</b> or <b>NJ Exec Order 26.4b1</b> with her when she tried to <b>NJ Exec Order 26.4b1</b> them.</p> <p>During an interview on 10/29/2025 at 9:42 AM, the RCD stated she was the one responsible for updating residents' assessments, and assessments were completed upon moving in and after 30 - 40 days. The RCD stated that for the <b>NJ Exec Order 26.4b1</b> after admission, Resident #2 had a <b>NJ Exec Order 26.4b1</b> with the resident daily during the day and a caregiver that would come and relieve the family member because Resident #2 was having <b>NJ Exec Order 26.4b1</b> when they first came to the facility. She stated that after the <b>NJ Exec Order 26.4b1</b>, through her own observations and talking with staff, they felt Resident #2 was <b>NJ Exec Order 26.4b1</b>, and it was safe to <b>NJ Ex</b> <b>NJ Exec Order 26.4b1</b>. The RCD stated she did not have that documented anywhere (in the medical record) and denied knowledge or being aware that Resident #2 had attempted <b>NJ Exec Order 26.4b1</b> at the hospital just prior to coming there. During the interview, the RCD reviewed the resident's medical record and acknowledge that it was documented the resident was at risk of <b>NJ Exec Order 26.4b1</b> prior to admission but admitted that</p>	A 389		
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A 389	<p>Continued From page 14</p> <p>she did not remember that Resident #2 had NJ Exec Order 26.4b1 and was unsafe to NJ Exec Order 26.4b1. The RCD stated that after Resident #2 had NJ Exec Order 26.4b1 she read the (progress) notes where it was documented that the resident had NJ Exec Order 26.4b1 prior to the NJ Exec Order 26.4b1. She stated she spoke to the nurse who documented the NJ Exec Order 26.4b1 and told her she should have made her aware of them, and the RCD would have put interventions in place to prevent NJ Exec Order 26.4b1. The RCD stated that up until Resident #2 was NJ Exec Order 26.4b1, she was unaware of the resident's many attempts to leave the facility prior to NJ Exec Order 26.4b1.</p> <p>3. A demographic record revealed the facility admitted Resident #3 on NJ Exec Order 26.4b1. According to the demographic record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1.</p> <p>An "Assessment and Service Plan Services Library" form dated NJ Exec Order 26.4b1 revealed an "Initial Assessment" that indicated for "Resident Security" the resident could only NJ Exec Order 26.4b1 with staff, family, or a friend, and was NJ Exec Order 26.4b1. The assessment revealed the resident had no history of NJ Exec Order 26.4b1.</p> <p>During an interview on 10/28/2025 at 12:00 PM, the ED stated that prior to NJ Exec Order 26.4b1, the facility used a different electronic system, and they no longer had access to the whole system so she could not retrieve Resident #3's entire medical record from the time of the NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1. The ED stated that no initial "Care Plan" was available to review for initial documentation of an NJ Exec Order 26.4b1 risk, nor a Care Plan dated after the</p>	A 389		
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A 389	<p>Continued From page 15</p> <p><b>NJ Exec Order 26.4b1</b> to review interventions put into place following the event.</p> <p>Resident #3's "Charting Notes," dated <b>NJ Exec Order 26.4b1</b> at 4:23 PM, revealed a late entry for <b>NJ Exec Order 26.4b1</b> at approximately 6:30 PM, in which Resident #3 had <b>NJ Exec Order 26.4b1</b>. The note revealed the resident was assessed with <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b> to activities.</p> <p>Resident #3's "Charting Notes," dated <b>NJ Exec Order 26.4b1</b> at 10:48 AM, revealed that on <b>NJ Ex Order 26.4(b)(1)</b>, at approximately 6:00 PM, Resident #3 <b>NJ Exec Order</b> and expressed to staff that they <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order</b> by the <b>NJ Exec Order 26.4b1</b>. The notes revealed staff had <b>NJ Exec Order 26.4b1</b> the resident away from the <b>NJ Exec Order 26.4b1</b> and after a few minutes, Resident #3 stated they were <b>NJ Exec Order 26.4b1</b>; however, the resident <b>NJ Exec Order 26.4b1</b> and went to the <b>NJ Exec Order 26.4b1</b>. The notes revealed the <b>NJ Exec Order 26.4b1</b>, and the staff responded immediately. The notes revealed that in <b>NJ Exec Order 26.4b1</b> Resident #3 away from the <b>NJ Exec Order 26.4b1</b> the resident <b>NJ Exec Order 26.4b1</b> to the other end of the <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b>. The notes revealed the resident's power of attorney (POA) was notified about needing a possible <b>NJ Ex Order 26.4(b)(1)</b> <b>NJ Exec Order 26.4b1</b> or a <b>NJ Exec Order 26.4b1</b> evaluation outside of the facility.</p> <p>Resident #3's "Charting Notes," dated <b>NJ Exec Order 26.4b1</b> at 10:15 AM, revealed that a <b>NJ Exec Order 26.4b1</b> employee <b>NJ Exec Order 26.4b1</b> and did not stay at the <b>NJ Exec Order 26.4b1</b> to ensure the <b>NJ Exec Order 26.4b1</b>. The notes revealed Resident #3 entered the <b>NJ Exec Order 26.4b1</b> and was seen by staff getting off the <b>NJ Exec Order 26.4b1</b> and staff <b>NJ Exec Order 26.4b1</b> the resident <b>NJ Exec Order 26.4b1</b> to the <b>NJ Exec Order 26.4b1</b>.</p>	A 389		
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A 389	<p>Continued From page 16</p> <p>Resident #3's "Charting Notes," dated [redacted] at 3:47 PM, revealed that at 1:38 PM, Resident #3 entered the [redacted] and [redacted] on the [redacted]. The notes revealed the resident was [redacted] to the [redacted] unit. The notes revealed that new interventions were put into place to [redacted] and [redacted] on other floors to help [redacted]. Resident #3's [redacted] to [redacted] the [redacted].</p> <p>Resident #3's "Assessment and Service Plan Services Library" form dated [redacted] revealed a "[redacted]" assessment that indicated Resident #3 had [redacted] with or without purpose such as a [redacted] to the [redacted] or [redacted] or [redacted] on the [redacted]; however it was not safe for the resident to [redacted].</p> <p>Resident #3's "Charting Notes," dated [redacted] at 7:15 AM, revealed Resident #3 had made multiple attempts to [redacted] and was [redacted] many times. The notes revealed the resident stated [redacted]; they did not [redacted], and their [redacted]. The notes revealed the resident [redacted] for [redacted] to get [redacted] residents' [redacted].</p> <p>Resident #3's "Charting Notes," dated [redacted] at 2:27 PM, revealed Resident #3 [redacted] the [redacted] at 6:11 AM when an outside vendor [redacted] from the [redacted] to the [redacted]. Per the notes, when the door of the [redacted], the resident [redacted] and [redacted]. The notes revealed Resident #3 was seen by a staff member and [redacted] unit, and the [redacted] was going to be changed.</p>	A 389		

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A 389	<p>Continued From page 17</p> <p>Resident #3's "Charting Notes," dated [redacted] NJ Exec Order 26.4b1 revealed, Resident #3 had a medication changed to be given at bedtime to assist the resident to [redacted] NJ Exec Order because the resident was [redacted] NJ Exec Order 26.4b1 attempting to [redacted] NJ Exec Order 26.4b1 but was [redacted] NJ Exec Order 26.4b1 resident [redacted] NJ Exec Order instead.</p> <p>Resident #3's "Charting Notes," dated [redacted] NJ Exec Order 26.4b1 at 6:30 PM, revealed Resident #3 continued to [redacted] NJ Exec Order 26.4b1 in the afternoon. The notes revealed the resident would [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order [redacted]. Per the notes, Resident #3 could be [redacted] NJ Exec Order 26.4b1; however, their [redacted] NJ Exec Order 26.4b1, and the resident [redacted] NJ Exec Order 26.4b1 what was said to [redacted] NJ Exec Order 26.4b1 them a few minutes prior, so the resident would [redacted] NJ Exec Order 26.4b1 [redacted].</p> <p>Resident #3's "Charting Notes," dated [redacted] NJ Exec Order 26.4b1 at 5:56 PM, revealed that per camera footage Resident #3 was [redacted] NJ Exec Order 26.4b1 at 3:07 PM. The notes revealed that at times, the resident [redacted] NJ Exec Order 26.4b1 other times the resident would start [redacted] NJ Exec Order 26.4b1 the [redacted] NJ Exec Order 26.4b1. Per the notes, Resident #3 [redacted] NJ Exec Order 26.4b1 and the [redacted] NJ Exec Order 26.4b1 opened; the resident [redacted] NJ Exec Order 26.4b1 and rode it down to the [redacted] NJ Exec Order 26.4b1. The notes revealed Resident #3 [redacted] NJ Exec Order 26.4b1 out the [redacted] NJ Exec Order 26.4b1 of the facility and was seen by a staff member, who [redacted] NJ Exec Order 26.4b1 from [redacted] NJ Exec Order 26.4b1 and called for help.</p> <p>A "Reportable Event Record/Report" dated [redacted] NJ Exec Order 26.4b1 indicated a significant event occurred on [redacted] NJ Exec Order 26.4b1 at 3:07 PM when Resident #3 [redacted] NJ Exec Order 26.4b1 from the facility. The report indicated that at approximately 3:07 PM, Resident #3 was [redacted] NJ Exec Order 26.4b1 on the [redacted] NJ Exec Order 26.4b1 that opens the</p>	A 389		

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A 389	<p>Continued From page 18</p> <p><b>NJ Exec Order 26.4</b> to the unit the resident resided on. The notes revealed Resident #3 <b>NJ Ex Order 26.4(b)(1)</b> and the <b>NJ Exec Order 26.4b1</b>, allowing Resident #3 to <b>NJ Exec Order 26.4b1</b> from the <b>NJ Exec O</b> floor. The notes revealed the resident <b>NJ Exec Order</b> on the <b>NJ Exec Order 26.4b</b> where they <b>NJ Exec Order 26.4b1</b> before the resident was <b>NJ Ex Order 26.4(b)(1)</b> staff member who <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/29/2025 at 2:33 PM, Certified Medication Aide (CMA) #1 stated she knew Resident #3, and when the resident first came to the facility, they were <b>NJ Exec Order 26.4b1</b>. She stated that after a <b>NJ Exec Order 26.4b1</b>, the resident had a <b>NJ Exec Order 26.4b1</b> and tried to <b>NJ Exec Order 26.4b1</b> <b>NJ Ex Order 26.4(b)</b>. CMA #1 stated Resident #3 <b>NJ Exec Order 26.4b1</b> the <b>NJ Exec Order 26.4b1</b> and could still <b>NJ Exec O</b> at the time. CMA #1 stated when the resident saw the signs posted on the <b>NJ Exec Order 26.4b1</b> that said to <b>NJ Exec Order 26.4b1</b> <b>NJ Exec Order 26.4b1</b>," that was exactly what Resident #3 did. CMA #1 stated the <b>NJ Exec Order 26.4b1</b> would <b>NJ Exec Order 2</b> but by the time a staff member could get to the resident, they were on the <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/29/2025 at 2:44 PM, RA #3 stated she knew Resident #3 and was the staff member that saw the resident <b>NJ Exec Order</b> and <b>NJ Exec Order 26.4b1</b>. RA #3 stated the resident had <b>NJ Exec Order 26.4b1</b> of the facility and had <b>NJ Exec Order 26.4b1</b> out of the door before she could <b>NJ Exec Order 26.4b1</b> the resident. RA #3 stated that Resident #3 had gotten off the <b>NJ Exec Order 26.4</b> and <b>NJ Exec Order 26.4b1</b> when she recognized who the resident was and <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/29/2025 at 2:52 PM, RA #4 stated she knew Resident #3 and that the</p>	A 389		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>07015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ARBOR TERRACE ROSELAND</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>345 EAGLE ROCK AVENUE ROSELAND, NJ 07068</b>
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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
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A 389	<p>Continued From page 19</p> <p>resident would <b>NJ Ex Order 26.4(b)(1)</b> every day and would try to <b>NJ Ex Order 26.4(b)(1)</b> <b>NJ Exec Order 26.4b1</b> on the <b>NJ Exec Order 26.4b1</b>. RA #4 said she was the staff member that <b>NJ Exec Order 26.4b1</b> Resident #3 <b>NJ Exec Order 26.4b1</b> to the <b>NJ Exec Order 26.4b1</b> once the resident was <b>NJ Ex Order 26.4(b)(1)</b> <b>NJ Exec Order 26.4b1</b> on <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/29/2025 at 3:00 PM, RA #5 stated she knew Resident #3 had tried to <b>NJ Exec Order 26.4b1</b> at times and <b>NJ Exec Order 26.4b1</b>. RA #5 stated that Resident #3, even though the resident <b>NJ Exec Order 26.4b1</b> now and <b>NJ Exec Order 26.4b1</b>, would still <b>NJ Exec Order 26.4b1</b> the <b>NJ Exec Order 26.4b1</b>, and would tell staff the <b>NJ Exec Order 26.4b1</b> was <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/29/2025 at 10:18 AM, the RCD stated Resident #3 was admitted to the <b>NJ Exec Order 26.4b1</b> unit, which was a <b>NJ Exec Order 26.4b1</b> unit, where residents with <b>NJ Exec Order 26.4b1</b> and those who were at risk of <b>NJ Exec Order 26.4b1</b> were <b>NJ Exec Order 26.4b1</b> closely. She stated Resident #3 had <b>NJ Exec Order 26.4b1</b> from the building since the resident had not <b>NJ Exec Order 26.4b1</b>. The RCD stated that Resident #3's service plan had them at risk of <b>NJ Exec Order 26.4b1</b> and was one of the reasons for admission to the <b>NJ Exec Order 26.4b1</b> unit. The RCD stated she did not feel Resident #3's <b>NJ Exec Order 26.4b1</b> to be updated on the service plan since staff were able to <b>NJ Exec Order 26.4b1</b> the resident during the multiple attempts to <b>NJ Exec Order 26.4b1</b> the unit, and also when the resident did <b>NJ Exec Order 26.4b1</b> the unit either through the <b>NJ Exec Order 26.4b1</b>. The RCD stated she was not aware of Resident #3 <b>NJ Exec Order 26.4b1</b> on the <b>NJ Exec Order 26.4b1</b> prior to the resident successfully doing so. The RCD again stated she did not consider Resident #3's <b>NJ Exec Order 26.4b1</b> the facility an <b>NJ Exec Order 26.4b1</b> because the resident <b>NJ Exec Order 26.4b1</b> the <b>NJ Exec Order 26.4b1</b> before staff <b>NJ Exec Order 26.4b1</b> in.</p>	A 389		
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A 389	<p>Continued From page 20</p> <p>She stated an additional keypad was added for the <sup>NJ Exec Order 26.4</sup> so that Resident #3 would have to <b>NJ Exec Order 26.4b1</b> to open the <sup>NJ Exec Order 26.4b1</sup> and felt the <sup>NJ Ex Order 26.4(b)(1)</sup> would be sufficient in preventing that incident from happening again.</p> <p>During an interview on 10/30/2025 at 1:18 PM, the RCD stated it was her expectation that the residents were kept as safe as possible. She stated the staff needed to be more proactive with <b>NJ Exec Order 26.4b1</b> to prevent potential <sup>NJ Exec Order 26.4b1</sup> and <sup>NJ Exec Ord</sup> to the residents. The RCD further stated the resident's assessments needed to be accurate and updated as needed, and she needed to pay more attention to the information in the assessments to ensure she was aware of the documented potential for <sup>NJ Exec Order 26.4b1</sup>.</p> <p>During an interview on 10/30/2025 at 1:45 PM, the ED stated it was her expectation that the residents of the facility were kept safe. She further stated that the medical record needed to be accurate and updated with any <sup>NJ Exec Order 26.4b1</sup> or <b>NJ Exec Order 26.4b1</b>, with interventions put into place to help keep the residents safe.</p>	A 389		
A1409	<p>8:36-21.1(d) Quality Improvement</p> <p>(d) The administrator shall implement measures to ensure that corrections or improvements are made.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the Executive Director (ED) failed to ensure <sup>NJ Exec Order 26.4b1</sup> for 3 (Resident #1, #2, and</p>	A1409		

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A1409	<p>Continued From page 21</p> <p>#3) of 5 sampled residents were reviewed by the facility's Quality Assurance program and failed to effectively develop and implement quality improvement measures to ensure that corrective actions and improvements were implemented in an attempt to prevent further [redacted] and maintain residents' safety. Specifically, on [redacted] at 1:30 PM, Resident #1 [redacted] and was seen by staff from a [redacted] of the facility [redacted]. On [redacted] at 10:15 AM, Resident #2 [redacted] from the facility and was [redacted] from the facility [redacted]. On [redacted] at 3:07 PM, Resident #3 [redacted] from the facility by [redacted] on the [redacted] that opens the [redacted] to the unit the resident resided on. Resident #3 [redacted] the [redacted] from the [redacted] floor and [redacted] on the [redacted] floor where they [redacted] before the resident was seen by a staff member who [redacted] the resident [redacted].</p> <p>It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, harm, impairment, or death to residents.</p> <p>On 10/31/2025, it was determined that the failed practice represented an immediate threat to residents' health and safety. The facility's ED was verbally informed of the immediacy of the situation involving the residents' [redacted].</p> <p>Findings included:</p> <p>A facility policy titled, "Quality Assurance Reporting Responsibilities," approved by the facility 04/2015, specified, "The Community will compile a weekly and monthly report of QA</p>	A1409		
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A1409	<p>Continued From page 22</p> <p>[quality assurance] Data, trends and action items to be submitted to the corporate staff as an internal QA process."</p> <p>A facility policy titled, "Quality Assurance," effective 03/01/2004, revealed, "Policy: Each assisted living (AL) residence shall develop, implement, and maintain a documented, ongoing quality assurance (QA) program." The policy revealed the section titled, "Process:" included, "The purpose of this program shall be to attain and maintain a high-quality assisted living residence through an ongoing process of quality improvement that monitors quality, identifies areas to improve and methods to improve them, and evaluates the progress achieved." The policy revealed, "Quality improvement documentation shall be kept on file for a minimum of five years."</p> <p>A "Reportable Event Record/Report," dated <b>NJ Exec Order 26.4b1</b> at 5:00 PM and completed by the ED, revealed that on <b>NJ Exec Order 26.4b1</b> at 1:30 PM, a significant event occurred at the <b>NJ Ex Order 26.4(b)(1)</b> the facility. The report indicated that at approximately 1:15 PM, Resident #1 was observed by the Receptionist going to sit on a <b>NJ Exec Order 26.4b1</b>. The report revealed that at approximately 1:30 PM, the resident had <b>NJ Exec Order 26.4b1</b> did, and at that time, an RA from <b>NJ Ex Order 26.4(b)(1)</b> of the facility saw Resident #1 <b>NJ Exec Order 26.4b1</b>. The report revealed the RA immediately announced her observation over the walkie-talkie and multiple staff to include the ED, Business Office Director, and care givers went to <b>NJ Ex Order 26.4(b)(1)</b> the resident <b>NJ Ex Order 26.4(b)(1)</b>. Per the report, Resident #1 told staff they <b>NJ Exec Order 26.4b1</b>. The report revealed the resident was <b>NJ Exec Order 26.4b1</b> about 1:35 PM and was assessed by a nurse and deemed to be in</p>	A1409		
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A1409	<p>Continued From page 23</p> <p>"NJ Exec Order 26.4b1." The report revealed that a plan of care was developed that addressed this issue, and planned interventions were in place when the event occurred. The report revealed that the facility considered the event to be an NJ Exec Order 26.4b1 because, upon Resident #1's (initial) assessment, the resident "NJ Exec Order 26.4b1 with staff, family, or friends as per the family's preference."</p> <p>A "Reportable Event Record/Report" dated NJ Exec Order 26.4b1 and completed by the ED revealed a significant event occurred when Resident #2 NJ Exec Order 26.4b1 from the facility. The report indicated that at about 10:00 AM, Resident #2 was observed by the Receptionist NJ Ex Order 26.4(b)(1) and at approximately 10:15 AM, Resident #2 had not NJ Ex Order 26.4(b)(1) as they were accustomed to doing. The report indicated the receptionist brought this concern to the attention of a staff member who immediately NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1. The report revealed the facility staff NJ Exec Order 26.4b1. The report revealed staff members got in their automobiles and NJ Exec Order 26.4b1 for the resident NJ Exec Order 26.4b1. Per the report, Resident #2 was then NJ Exec Order 26.4b1 approximately NJ Exec Order 26.4b1. The report revealed the NJ Exec Order 26.4b1 was informed that Resident #2 was NJ Exec Order 26.4b1. The report revealed that the NJ Exec Order 26.4b1 who were with the ED informed the staff member who located the resident to stay with Resident #2 until the NJ Exec Order 26.4b1 and ED arrived. The report revealed that upon arrival of the NJ Exec Order 26.4b1 at the NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 advised the ED that Resident #2 needed to be evaluated by EMT upon return to the facility. Per the report, at 10:57 AM, Resident #2 NJ Exec Order 26.4b1 accompanied by two NJ Exec Order 26.4b1. The report revealed EMT</p>	A1409		
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A1409	<p>Continued From page 24</p> <p>responders assessed the resident and Resident #2 was deemed to be in "NJ Exec Order 26.4b1" and there was no need for further medical treatment. The report indicated that upon return to the facility, Resident #2 was transferred to a room in the NJ Exec Order 26.4b1.</p> <p>A "Reportable Event Record/Report" dated NJ Exec Order 26.4b1 indicated a significant event occurred on NJ Exec Order 26.4b1 at 3:07 PM when Resident #3 NJ Exec Order 26.4b1 from the facility. The report indicated that at approximately 3:07 PM, Resident #3 was NJ Exec Order 26.4b1 that opens the NJ Exec Order 26.4b1 to the unit the resident resided on. The notes revealed Resident #3 entered the NJ Ex Order 26.4b1, and the NJ Exec Order 26.4b1 opened, allowing Resident #3 to NJ Exec Order 26.4b1 from the NJ Exec Order 26.4b1 floor. The notes revealed the resident NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 floor where NJ Exec Order 26.4b1 before the resident was seen by a staff member who NJ Exec Order 26.4b1.</p> <p>During an interview on 10/30/2025 at 1:10 PM, the ED said they have a QA committee that meets monthly. She indicated that she thought they had discussed these three NJ Exec Order 26.4b1 in the meetings.</p> <p>During a follow-up interview on 10/30/2025 at 1:40 PM, the ED indicated all she had on the NJ Ex Order 26.4(b)(1) were the NJ Exec Order 26.4b1 drills that were conducted with each of the three residents and stated she could not find where they had been addressed in the QA meetings.</p> <p>During a follow-up interview on 10/30/2025 at 1:45 PM, the ED said that she expected incidents, such as NJ Exec Order 26.4b1 to be discussed in the QA meetings to prevent any future NJ Exec Order 26.4b1.</p>	A1409		
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POC #3 received 11/1/26  
Accepted 1/12/24

ARBOR TERRACE ROSELAND

Plan of Correction  
Arbor Terrace Roseland  
Survey Date: 10/27/2025

A 389

Element # 1

Resident # 1 – He/She was affected by this finding. All residents have the right to be free from **NJ Exec Order 26.4b1** Resident #1 is currently residing in our community. Upon return back to the community, he/she was transferred to our **NJ Exec Order 26.4b1** community for **NJ Exec Order 26.4b1** His/Her primary care physician and responsible party were notified, and they agreed with the transfer to our **NJ Exec Order 26.4b1** community. Incident report, **NJ Exec Order 26.4b1** check **NJ Exec Order 26.4b1** assessment, vital signs, service plan update were done upon return back to the community. Executive Director and Resident Care Director (RN), met with POA to discuss new care plan. Resident Service Plan was updated on 9/9/2025 per NJ regulation.

Resident # 2 – He/She was affected by this finding. All residents have the right to be **NJ Exec Order 26.4b1** Resident #2 no longer resides in our community. Upon return back to the community, his/her primary care physician and responsible party were notified, and they agreed with the transfer to our **NJ Exec Order 26.4b1** community. Incident report **NJ Exec Order 26.4b1** **NJ Exec Order 26.4b1** assessment, vital signs, service plan update were done upon return back to the community. Executive Director and Resident Care Director (RN), met with POA to discuss new care plan. He/She was transferred to another secure environment in a different community.

Resident # 3 – He/She was affected by this finding. All residents have the right to be **NJ Exec Order 26.4b1** Resident #3 is currently residing in our community. Upon return back to the community, His/Her primary care physician and responsible party were notified. The **NJ Exec Order 26.4b1** were changed. His/her MD and **NJ Exec Order 26.4b1** were notified to review medications. **NJ Exec Order 26.4b1** in-service was done on 10/30/2024. Incident report, full **NJ Exec Order 26.4b1** **NJ Exec Order 26.4b1** assessment, vital signs, service plan update were done upon elopement. Executive Director and Resident Care Director (RN), met with POA to discuss new care plan.

All staff were educated by the Executive Director, Resident Care Director (RN), Director of Health and IP (RN), Traditional Care Director, Dining Director and/or Mind and Memory Care Director (MMD) on Elopement, missing person policies and standards, Q/A review and Resident Rights. All staff received a copy of the Missing resident's response plan & drills, Elopement risk assessment and interventions, Resident behavioral expressions, resident evaluation and Re-evaluation process, shift reporting process via 24-hour communication and Resident Rights. Description of In-service provided. (Please see attached in-service sign in sheets dated from 12/16/2025 to 12/22/2025)

All staff received a copy of the Missing resident response plan & drills, Elopement risk assessment and interventions, Resident behavioral expressions, resident evaluation and Re-evaluation process, shift reporting process via 24-hour communication, and Residents' Rights from 12/16/2025 to 12/22/2025). All staff completed the education and will continue to be educated on the same for the next two quarters and then annually. All new hires will be educated on the same topics during orientation. Resident summary template and Service Plan have been updated as needed and upon assessments for risk reduction.

#### Element #2

All residents have the potential to be affected by this practice.

#### Element # 3

(A) All staff were educated by the Executive Director, Resident Care Director (RN), Director of Health and IP (RN), Traditional Care Director, Dining Director and/or Mind and Memory Care Director (MMD) on Elopement, missing person policies and standards, and Q/A review. All staff received a copy of the Missing residents' response plan & drills, Elopement risk assessment and interventions, Resident behavioral expressions, resident evaluation and Re-evaluation process, shift reporting process via 24-hour communication and Resident Rights. Description of In-service provided.

The education for all staff was completed on 12/22/2025 and they will continue to be educated on the same topic for the next two quarters and then annually. All new hires will be educated on the same topic during orientation.

(B) All AL / MC residents were assessed by Resident Care Director (RN), from November 6, 2025 to November 11, 2025 to determine if they are appropriate for Assisted Living or Memory Care (Assessments available upon request). Resident summary template and Service Plans have been updated to reflect their current needs and will be updated as needed and upon their next scheduled assessment for risk reduction.

(C) For every new admission coming from the hospital, Resident Care Director (RN), will review all the hospital records. The RN will speak with nurses and aides and review the notes from treating physicians. It is our practice to complete risk assessments for all new residents and those readmitted.

(D) If there is any indication of packing and/or exit seeking, the Resident Care Director (RN), will do an immediate re-assessment for Memory Care appropriateness. The Resident Care Director (RN) will notify their primary care physician, responsible party and update their service plan per NJ regulation.

#### Element #4

(A) Every resident that requires assessment for AL appropriateness will be reviewed weekly at the Care Coordination meeting.

(B) Executive Director or designee will review every new admission clinical document. This practice will continue for the next two months and will be random, thereafter.

The deficient practice was completed on 12/22/2025.

NJ Exec Order 26.4

approved  
1/12/26

A 1409

Element # 1

Resident # 1 – He/She was affected by this finding. Resident #1 currently resides in our facility.

Resident # 2 – He/She was affected by this finding. Resident #2 was an NJ Ex Order 26.4(b)(1) resident and no longer resides in our facility.

Resident # 3 – He/She was affected by this finding. Resident #3 currently resides in our facility.

The Quality Assurance meeting to address the corrective action for residents 1 and 3 was completed on November 11, 2025. Quality Assurance meetings will be held once a month followed by our weekly Care Coordination meeting. In the Q/A meetings, there will be an overall review of any previously identified residents at risk for elopement, effectiveness of interventions implemented during Care Coordination meetings and consultation with residents' primary care physician and regional support team for any further immediate interventions needed to ensure the safety and compliance of the resident and their placement.

Element # 2

All residents have the potential to be affected by this practice.

Element #3

Quality Assurance meeting to address the corrective action for residents 1 and 3 was completed on November 11, 2025. The second Quality Assurance meeting was held on December 23, 2025. Quality Assurance meetings will be held once a month. In this Q/A meeting, we reviewed the outcome of the elopement drill that was done on 12/17/2025, recent changes in condition, and new admissions. In Q/A meetings, there will be communication of any resident change of conditions, including behaviors that may increase risk for elopement. Those identified residents will be reassessed for appropriateness of placement. Primary Care Physician will be

notified, and appropriate interventions will be put in place and reflected on their service plan.

Element #4

(A) Executive Director, or designee will direct the Q/A meetings on a monthly basis, and invite associates from all departments, including front line associates to share identifying factors and contributing behaviors which may assist in elopement prevention.

The deficient practice was completed on 12/23/2025.

NJ Exec Order 264f

*approved  
1/12/26*

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 07015	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/12/2026
NAME OF FACILITY ARBOR TERRACE ROSELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 345 EAGLE ROCK AVENUE ROSELAND, NJ 07068

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 A0389	Correction	ID Prefix A1409	Correction	ID Prefix	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-21.1(d)	Completed	Reg. #	Completed
LSC	12/22/2025	LSC	12/23/2025	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	
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/31/2025		<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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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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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