

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>11A017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/16/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VOLANTE OF HAMILTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2560 KUSER ROAD</b> <b>HAMILTON, NJ 08691</b>
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A 000	<p>Initial Comments</p> <p>Initial Comments: Survey Type: Complaint</p> <p>Complaint #: NJ00 176312, 176750, 177045, 185852, 188944, 188989</p> <p>Survey Date: 10/16/2025</p> <p>Sample Size: 6</p> <p>Census: 104</p> <p>The facility was not in substantial compliance with N.J.A.C. Title 8 Chapter 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		
A1051	<p>8:36-15.2 Record Availability</p> <p>The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	A1051		

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

TITLE

(X6) DATE

11/21/25



New Jersey Department of Health

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A1051	<p>Continued From page 2</p> <p>Interventions Tool," dated <sup>NJ Exec Order 26.4b1</sup> [REDACTED], revealed that Resident #4 had a <sup>NJ Exec Order 26.4b1</sup> [REDACTED], and <sup>NJ Exec Order 26.4b1</sup> [REDACTED] to use the <sup>NJ Exec Order 26.4b1</sup> [REDACTED].</p> <p>A review of the New Jersey Universal Transfer Form, dated <sup>NJ Exec Order 26.4b1</sup> [REDACTED], revealed that Resident #4 had a <sup>NJ Exec Order 26.4b1</sup> [REDACTED] on <sup>NJ Exec Order 26.4b1</sup> [REDACTED], and was now <sup>NJ Exec Order 26.4b1</sup> [REDACTED] of <sup>NJ Exec Order 26.4b1</sup> [REDACTED] and <sup>NJ Exec Order 26.4b1</sup> [REDACTED]. Resident #4 now required the use of a wheelchair.</p> <p>On 10/16/2025 at 1:10 PM during an interview with the GM, the surveyor requested the incident report for Resident #4's <sup>NJ Exec Order 26.4b1</sup> [REDACTED] that occurred on <sup>NJ Exec Order 26.4b1</sup> [REDACTED]. The GM replied that he cannot get access the previous electronic medical records and has reached out to Corporate. He said he believed they have the incident report but are unable to locate it since the current Director of Nursing is on vacation and she may have access to it. He concluded that Resident #4's <sup>NJ Exec Order 26.4b1</sup> [REDACTED] happened prior to his employment and he was unfamiliar with what may have occurred.</p> <p>A review of the facility-provided policy titled "Risk Management," and revised January 2024, revealed: "Types of incidents/injuries that would require the completion of an incident report include, but are not limited to: 1. Any potentially dangerous situation for a resident/guest/visitor, such as: A resident/guest/visitor fall - with or without injury." The policy also revealed that, "7. Other unusual occurrences: Any significant change of resident condition, whether or not 911 is called"; and "Injuries or conditions of unknown origin."</p> <p>A review of the facility-provided policy titled</p>	A1051		

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A1051	<p>Continued From page 3</p> <p>"Resident File and Records Policy," and revised August 2025, revealed under "Third Party Requests" that, "Licensing surveyors may have access to the records of residents in licensed apartments upon request."</p> <p>2) On 10/16/2025, the surveyor requested the investigation reports for the [redacted] of Resident #5 that occurred on [redacted]; and for a [redacted] between Resident #5 and Resident #6 that occurred on [redacted].</p> <p>The facility failed to provide the reports.</p> <p>During an interview on 10/16/2025 at 12:35 PM with the surveyor, the EWD said she had searched and could not find the investigation report for the [redacted] incident. The EWD said that the Wellness Director that handled the investigation was out of the country and could not be reached.</p> <p>During surveyor interview on 10/16/2025 at 1:03 PM, the GM said they no longer had access to the previous electronic medical records system and could not find the full investigation for the [redacted] that took place on [redacted]. The GM further stated, "We should have paper copies but we can't find them."</p>	A1051		
A1179	<p>8:36-17.1(a) Provision of Services</p> <p>(a) The facility shall provide and maintain a sanitary and safe environment for residents.</p>	A1179		

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A1179	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # 177045 and 188989</p> <p>Based on record review, observation and interview, it was determined that the facility failed to provide a safe environment for two [redacted] and [redacted] residents (Resident #5 and Resident #1) from NJ Exec Order 26.4b1. This put the residents in imminent danger for their safety. This deficient practice was identified for 2 of 3 residents reviewed for [redacted].</p> <p>The imminent danger was removed after Resident #5 was placed on every [redacted] and staff were re-educated on [redacted] for signs of [redacted] and changes in resident [redacted] on [redacted].</p> <p>The imminent danger was removed after Resident #1 was placed on [redacted]. The family provided a private aide for [redacted] from 8 PM to 8 AM.</p> <p>This deficient practice was evidenced by the following:</p> <p>A review of the facility provided policy titled, "Missing Resident Elopement Policy" revised on July 2025 revealed that, "An 'elopement' is considered an occurrence in which a resident residing in a licensed apartment leaves the community without following the community's policies and procedures or the terms mutually agreed upon in the service agreement." The policy continued, "In the event it has been determined that the resident has or may have eloped from the community, it is considered an emergency situation and warrants immediate</p>	A1179		

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A1179	<p>Continued From page 5</p> <p>interventions including the notification of the resident's designated emergency contacts and EMS."</p> <p>1) On 10/16/2025, the surveyor reviewed a Facility Reportable Event (FRE), dated [redacted] regarding Resident #5 [redacted] from the facility's [redacted] NJ Exec Order 26.4b1, a unit specific for residents with [redacted] NJ Exec Order 26.4b1. The FRE described the following: On [redacted] NJ Exec Order 26.4b1 at approximately 8:30 PM, a [redacted] NJ Exec Order 26.4b1 Unit Certified Medication Aide ([redacted] #1) went to Resident #5 [redacted] NJ Exec Order 26.4b1 to give the resident their evening medications. Upon entering their [redacted] NJ Ex Order 26.4(b)(1) [redacted] #1 observed the resident [redacted] NJ Exec Order 26.4b1. [redacted] #1 asked other aides on duty if they knew [redacted] the resident [redacted] #1 was informed that Resident #5 was [redacted] in the dining room shortly after dinner. [redacted] #1 went to the dining room and [redacted] NJ Exec Order 26.4b1 the resident. The staff began [redacted] NJ Exec Order 26.4b1 for the resident and were [redacted] NJ Exec Order 26.4b1. The staff called the Director of Wellness (DW) who instructed staff to call [redacted] NJ Exec and she would drive to the facility and [redacted] NJ Exec Order 26.4b1 the surrounding community. While driving to the facility, the DW saw the resident [redacted] NJ Exec Order 26.4b1 about a [redacted] NJ Exec Order 26.4b1. Resident #5 appeared [redacted] NJ Exec Order 26.4b1 but did [redacted] NJ Exec Order 26.4b1 of [redacted] NJ Exec Order 26.4b1 to the [redacted] NJ Exec Order 26.4b1. The DW and Resident # 5 [redacted] NJ Exec Order 26.4b1 to the facility at approximately 9:10 PM. The facility viewed the security cameras that showed Resident #5 [redacted] NJ Exec Order 26.4b1 at 7:37 PM. The facility documented that because the cameras did not face the [redacted] NJ Exec Order 26.4b1 they could not determine how the resident [redacted] NJ Exec Order 26.4b1. The FRE included that the doors locked within 3 to 5 seconds of being closed.</p> <p>On 10/16/2025, the surveyor reviewed the Emergency Data Summary (an admission</p>	A1179		
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A1179	<p>Continued From page 6</p> <p>summary) which revealed that Resident #5 was admitted to the facility with diagnoses which included, but were not limited to, NJ Exec Order 26.4b1 [REDACTED]</p> <p>A review of the facility Health Service Plan Evaluation (written guide that focuses on medical, nursing, and specialized care needs), with an evaluation date of NJ Exec Order 26.4b1 [REDACTED] revealed NJ Exec Order 26.4b1 [REDACTED] #5 was NJ Exec Order 26.4b1 [REDACTED], required supervision and NJ Exec Order 26.4b1 [REDACTED] due to making NJ Exec Order 26.4b1 [REDACTED] and NJ Exec Order 26.4b1 [REDACTED] and had a history of NJ Exec Order 26.4b1 [REDACTED] within the facility and may NJ Exec Order 26.4b1 [REDACTED].</p> <p>Upon request from the surveyor on 10/16/2025, the facility could not provide a full investigation report. The General Manager (GM) said they could not gain access from the previous electronic medical record system. The GM further stated, "We should have paper copies, but we can't find them."</p> <p>During a tour of the unit on 10/16/2025 at 11:25 AM the surveyor observed the NJ Exec Order 26.4b1 [REDACTED] Unit was located by the Assisted Living exit of the building. There were two cameras noted in the lobby but neither one faced the two NJ Exec Order 26.4b1 [REDACTED] doors. The surveyor observed that both doors needed a key fob to exit or enter. All staff observed at the time had a key fob.</p> <p>During an interview, on 10/16/2025 at 11:29 AM, with the surveyor, the NJ Exec Order 26.4b1 [REDACTED] said that Resident #5 had always NJ Exec Order 26.4b1 [REDACTED] in and out of other residents' NJ Exec Order 26.4b1 [REDACTED] and would be observed NJ Exec Order 26.4b1 [REDACTED] by the doors at times. NJ Exec Order 26.4b1 [REDACTED] #1 said staff would NJ Exec Order 26.4b1 [REDACTED] Resident #5 to activities. NJ Exec Order 26.4b1 [REDACTED] #1 further said that the doors to the NJ Exec Order 26.4b1 [REDACTED] unit are always</p>	A1179		

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A1179	<p>Continued From page 7</p> <p>locked, and that the doors are checked to make sure they are working properly several times a day including after the incident.</p> <p>During an interview, on 10/16/2025 at 1:25 PM, with the surveyor, the [redacted] said that Resident #5 was a [redacted] prior to the [redacted]. The [redacted] said the resident was known to wait in the dining room and go to the main unit doors and jiggle the handles to get the [redacted]. The [redacted] also said that they would [redacted] the resident anytime they observed he/she in the dining room by the main doors.</p> <p>During an interview, on 10/16/2025 at 2:39 PM, the surveyor asked the GM about how the facility prevented elopements from the [redacted]. The GM said, "We have the unit locked and staff rounds there. There's not much more we can do."</p> <p>2) On 10/16/2025, the surveyor reviewed an FRE, dated [redacted], regarding Resident #1 [redacted] from the facility. The FRE described the following: On [redacted] between 2:35 AM and 3:00 AM, Resident #1 was seen at 2:30 AM by nursing staff and was [redacted] to his/her apartment. The staff member stayed near Resident #1's [redacted] until being called away by another resident. When the staff member returned, Resident #1 was [redacted]. Staff then [redacted] for the resident and was [redacted]. The Assistant Director of Nursing and Executive Director were notified. The [redacted] arrived at the facility after being called by a [redacted] returned the resident to the facility and stated that they observed Resident #1 [redacted] at approximately 3:45 AM. The</p>	A1179		
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A1179	<p>Continued From page 8</p> <p>resident was assessed and <b>NJ Exec Order 26.4b1</b>.</p> <p>On 10/16/2025, the surveyor reviewed Resident #1's Medical Record which revealed that he/she had diagnoses of, but not limited to, <b>NJ Exec Order 26.4b1</b></p> <p>The surveyor reviewed of Resident #1's Health Service Plan, updated on <b>NJ Exec Order 26.4b1</b> which revealed that he/she was <b>NJ Exec Order 26.4b1</b>. The Plan further revealed under <b>NJ Exec Order 26.4b1</b> that he/she had no <b>NJ Exec Order 26.4b1</b> and that the resident does not have a current or a history of <b>NJ Exec Order 26.4b1</b></p> <p>A review of the Resident Note by Caregiver #1, dated <b>NJ Exec Order 26.4b1</b> at 2:31 AM, revealed that she was called by a Care Partner because Resident #1 seemed <b>NJ Exec Order 26.4b1</b> and was asking about their <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b>. When Caregiver #1 arrived, Resident #1 asked for a <b>NJ Exec</b> to see their <b>NJ Exec Order 26.4b1</b>. Caregiver #1 talked to the resident and <b>NJ Exec Order 26.4b1</b> the resident back to their room. Caregiver #1 sat by the elevator for 40 minutes and observed Resident #1 remain in their room. After 40 minutes, Caregiver #1 told the Care Partner that she was leaving and to call her if there were any more issues. After 15 minutes, the Care Partner contacted Caregiver #1 that <b>NJ Exec Order 26.4b1</b>. A <b>NJ Exec Order 26.4b1</b> was started. Caregiver #1 went back to Resident #1's room and observed the resident <b>NJ Exec Order 26.4b1</b>. Caregiver #1 and the Care Partner went <b>NJ Exec Order 26.4b1</b> to <b>NJ Exec Order 26.4b1</b> for the resident when a <b>NJ Exec Order 26.4b1</b> care arrived and the <b>NJ Exec Order 26.4b1</b> asked if they were <b>NJ Exec Order 26.4b1</b> for someone. The <b>NJ Exec Order 26.4b1</b> stated that someone called <b>NJ Exec Order 26.4b1</b> regarding a <b>NJ Exec Order 26.4b1</b></p>	A1179		
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A1179	<p>Continued From page 9</p> <p>NJ Exec Order 26.4b1. A NJ Exec Order 26.4b1 then pulled up, with Resident #1 in the NJ Exec asking if the facility was NJ Exec Order 26.4b1. The NJ Exec Order stated that they NJ Exec Order Resident #1 NJ Exec Order 26.4b1. Resident #1 was NJ Exec Order 26.4b1 at 3:43 AM.</p> <p>On 10/16/2025 at 11:53 AM during an interview with the surveyor, the staff member at the Concierge desk said that at night, the front doors of the facility lock to prevent anyone entering the facility but automatically open for anyone NJ Exec Order the facility.</p> <p>On 10/16/2025 at 12:15 PM during an interview with the surveyor, the General Manager (GM) of the facility said that overnight rounding by staff is completed about every two hours. He said that there is no reporting or documenting required on rounding. The surveyor asked if the facility had a system to alert staff when someone NJ Exec Order the facility. The GM said there is no alert system to notify staff if someone NJ Exec Order</p> <p>On the same date at 2:30 PM during an interview with the surveyor, the GM said that residents are supposed to sign out of the facility, but Resident #1 did not. The GM further explained that the Concierge staff member was not there at the time of the incident. He said they are usually there until 10 PM.</p> <p>During the same interview with the surveyor, the GM was asked if a resident showed signs of NJ Exec Order 26.4b1 and NJ Exec Order the apartment, what should staff have done. The GM replied that staff had the resident go to their apartment and Caregiver #1 sat near the apartment for 40 minutes with no issues until she was called away. The GM concluded by stating, "In hindsight, she should've</p>	A1179		
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A1179	Continued From page 10 called someone to take over."	A1179		

POC # 2 Received 12/21/25  
Acceptable

# AZALEA



AT HAMILTON

— A LEISURE CARE COMMUNITY —

Tag# A1051

8:36-15.2 Record Availability

Complaint# 176312, 177045, 188944

Element #1 — Corrective action taken for Resident #4, Resident #5 and Resident #6.

1. Resident #4 and Resident #5 status: Resident #4 no longer resides at the community. Resident's #5 still resides at the community. The community will work with the corporate home office to ensure availability of electronic records for incident report from [NJ Exec Order 26.4b1]. This will be completed by 12/31/2025. The incident report from [NJ Exec Order 26.4b1] was completed by the Health and Wellness Director on 10/20/2025.
2. Resident #6 status: Resident #6 still resides at the community. The Director of Health and Wellness completed the incident report from [NJ Exec Order 26.4b1] for Resident #6 on 10/20/2025.

Element #2 — Identification of other residents and protective actions

1. All residents have the potential to be affected by this. The Director of Health and Wellness will conduct a re-education on completion of all incident reports with all staff by 12/15/2025.
2. Leisure Care legal department is working with the previous operator to have access to all resident files. This started on 10/16/2025. Date of completion will be 12/31/2025.

Element #3 — Systemic measures to prevent recurrence

1. The community began utilization of a new electronic records system (ALIS) on 11/11/2025. All records will be kept electronically via this system now and going forward.
2. The Director of Health and Wellness, General Manager, and/or designee, will review any incident reports in the electronic system to ensure completion within 72 hours of the incident.
3. Health and Wellness staff were trained on incident reports and completing incident reports in the electronic system on 11/20/2025 by the Health and Wellness Director.

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## AT HAMILTON

— A LEISURE CARE COMMUNITY —

### Element #4 — Monitoring; Ongoing Evaluation Monitoring Plan

1. The Health and Wellness Director, General Manager, and/or designee will review all incidents daily in the morning stand-up meeting. This went into effect on 10/20/2025.
2. Ongoing education of the staff to ensure completion of incident reports will continue and completed by 12/15/2025.
3. Leisure Care legal department is working with the previous operator to have access to all resident files. Date of completion will be 12/31/2025.

Tag# A1179

8:36-17.1(a) Provision of Services

Compliant# 177045 and 188989

### Element #1-Corrective action taken for Resident #1 and Resident #5.

1. Resident #1 was immediately placed on **NJ Exec Order 26.4b1** on **NJ Exec Order 26.4b1** as family provided a private aide for **NJ Exec Order 26.4b1** on the overnight. For Resident #5, imminent danger was removed when the resident was immediately placed on **NJ Exec Order 26.4b1** and staff were re-educated on 9/14/2024 on **NJ Exec Order 26.4b1** risks.

### Element #2- How the facility will identify other residents having the potential to be affected by the same deficient practice:

1. All residents have the potential to be affected by this. The Health and Wellness Director, and/or designee assess all residents prior to moving in to determine if the resident needs to be in the secure memory care unit; assessments continue every six months for all residents. Prior to move in, the healthcare provider completes the Global Deterioration Scale to determine resident cognitive status and proper placement within the community.

### Element #3- What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.

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1. Residents are reassessed every six months, or with significant change in condition, to determine appropriate placement within the community. This is completed by the Health and Wellness Director or designee.
2. Daily resident checks are done, and staff notates completion of check on “daily apartment door check” to ensure residents are safe and accounted for. The education was given to staff on daily resident checks by the Health and Wellness Director on 11/3/2025. The Health and Wellness Director will educate the staff on documenting the checks by 12/15/2025.
3. Staff will complete incident report when there is a change in condition and proper interventions will be put in place. This was education was completed by the Health and Wellness Director on 11/17/2025. Health & Wellness Director, General Manager, and/or designee, will review incident reports daily. Effective 11/17/2025.

Element #4-How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

1. All staff was re-educated on identifying elopement risks by the Health and Wellness Director on 9/15/2024 and again on 11/3/2025.
2. The Health and Services Director and/or designee continue assessments every six months or with change of condition to ensure appropriate placement within the community.
3. Staff to report changes in resident conditions daily, and complete incident reports as needed.
4. Incident reports are reviewed by Health and Wellness Director, General Manager, and/or designee daily to ensure completion and appropriate interventions. Effective 9/25/2025.
5. The community will conduct an elopement drill on 12/9/2025, and one will be conducted 1 once per quarter per shift ongoing. The completion date for this practice to be corrected and back in compliance will be 12/15/2025.

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 11A017 <span style="float:right">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/9/2025 <span style="float:right">Y3</span>
NAME OF FACILITY VOLANTE OF HAMILTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2560 KUSER ROAD HAMILTON, NJ 08691	

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 A1051	Correction	ID Prefix A1179	Correction	ID Prefix	Correction
Reg. # 8:36-15.2	Completed	Reg. # 8:36-17.1(a)	Completed	Reg. #	Completed
LSC	12/31/2025	LSC	12/15/2025	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 10/16/2025		<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		