STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315518	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	**275 JOHN T O'LEARY BOULEVARD , SOUTH AMBOY, New Jersey, 08879**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). Survey Dates: 09/08/25 to 09/11/25 Survey Census: 136 Sample Size: 35 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION VISIT.	F0000		10/10/2025
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to	F0880	1. The facility has current surveillance, tracking and trending for incidents of [NJ Exec Order 26.4b] and cannot retroactively create this date prior to [NJ Ex Order 26.4(b)(1)]. Resident #7 had [NJ Exec Order 26.4b1] as a result of LPN7 not following appropriate contact precautions. LPN7 was immediately educated by the Director of Nursing on the facility policy and procedure for contact precautions. 2. All residents have the potential to be affected by this deficient practice. 3. The Infection Preventionist educated nurses on the facility policy and procedures for contact precautions. The Director of Nursing educated the U.S. FOIA (b)(6) on the Infection Prevention and Control Program focusing on recording incidents of infections, surveillance, tracking, and trending and any corrective actions taken by the facility. 4. Director of Nursing or designee will observe 5 staff per week for 4 weeks, then 5 staff monthly for	10/10/2025

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

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

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F0880 SS = F	Continued from page 1 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F0880	Continued from page 1 2 months to ensure that staff are properly using PPE for residents who have contact precautions. The Director of Nursing will audit the Infection Prevention and Control Program data monthly for the next 3 months. Results of the audits will be discussed by the Director of Nursing at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team.	10/10/2025

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F0880 SS = F	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, review of facility policies, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to establish and maintain an infection prevention and control program (IPCP) for recording incidents of [NJ Exec Order 26-4a] identified under the facility's IPCP, surveillance, tracking and trending, and the corrective actions taken by the facility. The facility further failed to ensure staff wore the proper personal protective equipment (PPE) when providing care to one (Resident (R)3) out of one reviewed for proper PPE being donned (put on) out of a total sample of 35 residents. This had the potential for an increase in [NJ Exec Order 26-4a] for all the residents of the facility. Findings include: Review of a document titled, "Centers for Disease Control (CDC) . . . National Healthcare Safety Network (NHSN) . . . Long Term Care Facility Component Tracking Infections in Long-Term Care Facilities . . .," dated 01/25, indicated ". . . Surveillance is defined as the ongoing systematic collection, analysis, interpretation, and dissemination of data. A facility infection prevention and control (IPC) program should use surveillance to identify infections and monitor performance of practices to reduce infection risks among residents, staff, and visitors. Information collected during surveillance activities can be used to develop and track prevention priorities for the facility. . . When conducting surveillance, facilities should use clearly defined surveillance definitions that are collected in a consistent way. This method ensures accurate and comparable data regardless of who is performing surveillance. The NHSN LTCF modules provide standard surveillance definitions, allowing participating facilities to consistently apply well defined data elements to ensure accurate, reproducible, and comparable data. . ." Review of a facility policy titled " Infection Prevention and Control Policy and Procedure Manual" dated 04/25 indicated ". . . The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and/or QAPI committee may be involved in interpretation of the data. . . Surveillance includes a review of any or all of the following information to help identify possible indicators of infections. .	F0880		10/10/2025

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F0880 SS = F	Continued from page 3 .Laboratory records. . .Skin care sheets. . .Infection control rounds or interviews. . .Verbal reports from staff. . .Infection documentation records. . .Temperature logs. . .Pharmacy records. . .Antibiotic review. . .and Transfer log/summaries. . ." 1.During an interview on 09/11/25 at 9:01 AM, the Infection Preventionist (IP) 1 and IP2 (who was an [redacted] from [redacted] provided tracking from [redacted] through [redacted]. A request was made for a full year of surveillance data during this interview. During an interview on 09/11/2025 at 9:18 AM the [redacted] stated they did not have access to any other surveillance data since the previous company took the tracking and trending data. 2. Review of R7's "Admission Record," located under the "Profile" tab of the EMR, revealed [redacted] was admitted to the facility on [redacted] and had a diagnosis of [redacted] given on [redacted]. Review of R7's EMR under the "Orders" tab revealed a physician's order, dated [redacted], for contact [redacted] related to [redacted] of [redacted]. Review of R7's "Care Plan," dated [redacted] revealed, "I am on [redacted] therapy [an [redacted]] for [redacted] until [redacted]. [redacted] I medication] for [redacted] until [redacted]." An addition to the "Care Plan," dated [redacted] revealed, "I have [redacted] resistant [redacted] r/t [related to] [redacted] in [redacted]." The approaches included, "[redacted] precautions per policy." During an observation on 09/10/25 at 9:39 AM outside of R7's room, a sign that documented, "[redacted] was in place at the doorway and directed staff to sanitize hands, don (put on) a gown and gloves prior to entering the room, remove the gown and gloves prior to room exit, and to sanitize hands at room exit. There was a bin with available personal protective equipment (PPE) at the door. R7's room door and privacy curtain were open, and LPN7 was observed inside the room	F0880		10/10/2025

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F0880 SS = F	Continued from page 4 administering medications, taking the resident's [NJ Exec O] including [NJ Exec Order 26.4b1], and touching the resident's overbed table. LPN7 was not wearing a gown or gloves. Upon exiting the room, LPN7 did not sanitize her hands. At this time, LPN7 stated R7 had an [NJ Exec Order 26.4b1], so she required a gown and gloves for high-contact care only. She stated she did not have to don any PPE when administering medications or providing care that was not considered a high contact activity. When asked about the [NJ Exec Order 26. NJ Ex Order 26.4(b)(1)] sign on the door, LPN7 stated she was not sure why that was there, as she thought PPE was only required during [NJ Ex Order 26.4(b)(1)] activities and added she would need to check with the [U.S. FOIA (b)(6)] LPN7 confirmed she did not wear a gown or gloves while in R7's room administering medications and monitoring [NJ Exec Or]. During an interview on 09/10/25 at 9:51 AM, the [U.S. FOIA (b)(6)] stated R7 was on [NJ Exec Order] [NJ Ex Order 26.4(b)(1)] due to [NJ Exec Order 26.4b1] and a [NJ Exec Order 26.4b1] in [NJ Exec Order 26.4b1]. He stated staff were to wear [NJ Ex Order 26] and gloves any time they entered the room. Review of the policy titled, "Isolation – Categories of Transmission-Based Precautions," dated September 2022, revealed, "Contact Precautions . . . Staff and visitors wear gloves. . . when entering the room . . . Gloves are removed and hand hygiene performed before leaving the room . . . Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room." NJAC 8:39-19.4	F0880		10/10/2025
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification.	F0641	1.The MDS for Resident #116, Resident # 21, Resident #114, Resident #121 and Resident #26 were modified for accuracy and submitted to CMS. Individual education was done by the Regional Director of Case Management for the MDS coordinators to review the RAI manual for the proper coding of [NJ Ex Order 26.4(b)(1)] and preventative [NJ Exec Order 26] [NJ Ex Order 26.4(b)(1)]. 2. All residents have the potential to be affected by this deficient practice. An audit was conducted for the last 6 months of MDS for accuracy in coding of immunizations and pressure relieving devices, with no concerns identified.	10/10/2025

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F0641 SS = E	Continued from page 5 §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure five of five residents (Resident (R) 116, R21, R114, R121, and R26) out of 35 sampled residents had an accurate "Minimum Data Set (MDS)" assessment. Failure to code the "MDS" correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the residents. Findings include: Review of the RAI manual, dated 10/2024 and located at Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual | CMS, revealed ". . .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. . ."	F0641	Continued from page 5 3. The Regional Director of Case Management educated the U.S. FOIA (b)(6) on accuracy of MDS coding per the RAI manual. 4. The Regional Director of Case Management or designee will review 10 resident's MDS for accuracy of section M and O weekly for 4 weeks and then monthly for 2 months. Results of the audits will be discussed by the Director of Nursing at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team.	10/10/2025

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F0641 SS = E	Continued from page 6 1.Review of R116 electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated that the resident was admitted to the facility on [redacted]. Review of R116's EMR titled quarterly "MDS" located under the "MDS" tab with an Assessment Reference Date (ARD) of [redacted] indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 which revealed the resident was NJ Exec Order 26.4b1. The assessment indicated the resident was at risk for the [redacted] of [redacted], had no current [redacted], and identified that the resident had a [redacted] for [redacted] wheelchair. During an observation conducted on 09/09/25 11:09 AM R116 was sitting in a [redacted] wheelchair, and the wheelchair seat was [redacted] There was no preventative [redacted] on the resident's wheelchair. During an observation conducted on 09/09/25 at 2:40 PM the [redacted] verified R116 sat on a towel, and this was not appropriate for a resident who was at risk for the development of [redacted]. During an interview with the [redacted] and [redacted] on [redacted] at 2:26 PM confirmed R116 did not have [redacted] prevention measures on the resident's wheelchair. Both stated the MDS was incorrect. 2.Review of R21's EMR titled "Admission Record" located under the "Profile" tab indicated that the resident was admitted to the facility on [redacted]. Review of R21's EMR titled annual "MDS" located under the "MDS" tab with an ARD of [redacted] indicated the resident had a "BIMS" score of [redacted] out of 15 which revealed the resident was [redacted] The assessment indicated that the resident was offered a [redacted] but [redacted] declined. Review of R21's EMR titled NJ Ex Order 26.4(b)(1)"	F0641		10/10/2025

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F0641 SS = E	Continued from page 7 tab failed to contain evidence that the resident received a [redacted]. During an interview on 09/10/25 at 2:26 PM with the [redacted] and the [redacted], both confirmed the resident did not have evidence of being offered the [redacted]. Both stated the MDS was incorrect. 3.Review of R114's EMR titled "Admission Record" located under the "Profile" tab indicated that the resident was admitted to the facility on [redacted]. Review of R114's EMR titled "[redacted] located under the "[redacted] tab dated [redacted] indicated the resident was administered "[redacted]". Review of R114's EMR titled annual "MDS" located under the "MDS" tab with an ARD of [redacted] indicated the resident had a "BIMS" score of [redacted] out of 15 which revealed the resident was [redacted]. The assessment indicated the resident was up to date with the [redacted]. During an interview on 09/10/25 at 2:26 PM, the [redacted] and the [redacted] confirmed there was no evidence that R114 was offered the [redacted]. Both stated the MDS was incorrect. 4.Review of R121's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on [redacted]. Review of R121's EMR titled annual "MDS" located under the "MDS" tab with an ARD of [redacted] indicated the resident had a "BIMS" score of [redacted] out of 15 which revealed the resident was [redacted]. The assessment indicated the resident was offered and declined the [redacted]. Review of R121's EMR titled "Immunization" located under the "[redacted] tab failed to contain evidence that the resident and/or his representative was provided the opportunity to be [redacted] with the	F0641		10/10/2025

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F0641 SS = E	Continued from page 8 NJ Exec Order 26.4b1 NJ Ex Order 26.4 During an on 09/10/25 at 2:26 PM interview with the U.S. FOIA (b) and U.S. FOIA (b) both confirmed there was no evidence that R121 was offered and declined the NJ Exec Order 26.4b1 NJ Ex Order 26.4 Both stated the MDS was incorrect. 5.Review of R26's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on NJ Exec Order 26. Review of R26's EMR titled annual "MDS" located under the "MDS" tab with an ARD of NJ Exec Order 26. indicated the resident had a "BIMS" score of NJ Ex out of 15 which revealed the resident was NJ Exec Order 26.4b1 NJ Exec Ord The assessment indicated the resident was offered and declined the NJ Exec Order 26.4b1 NJ Ex Order 26.4 Review of R121's titled 'NJ Ex Order 26.4(b)(1) located under the 'NJ Ex Order 26. tab indicated the facility did not offer the resident a NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) During an interview 09/10/25 at 2:26 PM, with the U.S. FOIA (b) and U.S. FOIA (b)(6 confirmed that R121 did not have evidence of being offered the NJ Exec Order 26.4b1 NJ Ex Order 26.4 Both stated the MDS was incorrect. NJAC 8:39- 33.2(d)	F0641		10/10/2025
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during	F0883	1. Resident #21, #26, #114 and #121 and/or responsible parties NJ Ex Ord educated on and offered the NJ Exec Order 26.4b1 NJ Ex Order 26.4 Documentation was entered into the medical record. 2. All residents have the potential to be affected by this deficient practice. An audit was completed on pneumococcal vaccine immunization status of all in house residents, any identified issues were corrected. 3. The Infection Preventionist inserviced nurses on the Pneumococcal Vaccine policy focusing on education, administration and documentation requirements.	10/10/2025

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F0883 SS = E	Continued from page 9 this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer four of five residents (Resident (R) 21,	F0883	Continued from page 9 4. The Infection Preventionist or designee will audit 10 residents per month for 3 months to assure proper documentation and administration of the pneumococcal vaccination. Results of the audits will be discussed by the Infection Preventionist at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team.	10/10/2025

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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) COMPLETION DATE
F0883 SS = E	Continued from page 10 R26, R114, and R121) reviewed for NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) out of 35 sample residents and/or their representatives the opportunity for the residents to be NJ Ex Order 26.4(b)(1 in accordance with nationally recognized standards. This practice had the potential to increase the risk for this resident to contract NJ Exec Order 26.4b1 Findings include: Review from the CDC website titled "PCV20 or PCV21 Vaccination for Adults 65 Years or Older" dated 09/11/24 indicated ". . .Adults 65 years of age or older have the option to receive supplemental PCV20 or PCV21 (not both) if they previously completed the pneumococcal vaccine series with both PCV13 and PPSV23 and meet the following criteria. . .Previously received one dose of PCV13 (but not PCV15, PCV20, or PCV21) at any age, and . . .Previously received all recommended doses of PPSV23 (including 1 dose of PPSV23 at or after 65 years of age). The determination to administer PCV20 or PCV21 is based on a shared clinical decision-making (SCDM) process between a patient and their health care provider. SCDM recommendations are optional and informed by the characteristics, values, and preferences of the patient, and the clinical discretion of the health care provider. . ." Review of the facility policy titled "Pneumococcal Vaccine" dated 10/23 indicated "All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. . .Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series within 30-days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. . ." 1. Review of R21's electronic medical records (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on NJ Exec Order 26. . The resident was over the age of NJ Ex at the time of NJ Ex admission. Review of R21's EMR titled NJ Ex Order 26.4(b)(1)" tab failed to contain evidence that the resident received a NJ Exec Order 26.4b1 NJ Ex Order 26.4	F0883		10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315518	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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F0883 SS = E	Continued from page 11 During an interview on 09/10/2025 at 2:26 PM the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6)) both confirmed that R21 did not have evidence of being offered a NJ Exec Order 26.4b1 NJ Ex Order 26. per CDC recommendations. 2. Review of R26's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on NJ Exec Order 26.4 The resident was over the age of NJ Ex at the time of NJ Ex admission. Review of R26's EMR titled 'NJ Ex Order 26.4(b)(1) located under the 'NJ Ex Order 26 tab failed to indicate the resident was offered a NJ Exec Order 26.4b1 NJ Ex Order 26.4 Review of a document for R26 provided by the facility titled "Patient NJ Ex Order 26.4(b)(1) Administered Report" dated NJ Exec Order 26.4b1 indicated the resident received NJ Exec Order 26.4b1]". During an interview conducted on 09/10/2025 at 2:26 PM the U.S. FOIA (b) and the U.S. FOIA (b) both confirmed the resident should have been offered a second NJ Exec Order 26.4b1 NJ Ex Order 26 per CDC recommendations a year later and this was not done. 3. Review of R114's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on NJ Exec Order 26.4 The resident was over the age of NJ Ex at the time of NJ Ex admission. Review of R114's EMR titled 'NJ Ex Order 26.4(b)(1) located under the 'NJ Ex Order 26 tab dated indicated the resident was administered 'NJ Exec Order 26.4b1 NJ Exec Order 26]". During an interview conducted on 09/10/25 at 2:26 PM the U.S. FOIA (b)(6 and the U.S. FOIA (b) both confirmed R114 did not have evidence of being offered a second NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1 per CDC recommendations. 4. Review of R121's EMR titled "Admission Record" located under the "Profile" tab indicated	F0883		10/10/2025

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F0883 SS = E	Continued from page 12 the resident was admitted to the facility on [redacted]. The resident was over the age of [redacted] at the time of [redacted] admission. Review of R121's titled "[redacted] located under the "[redacted] tab indicated the facility did not offer the resident a [redacted] Review of a document for R121 provided by the facility titled "Patient [redacted] Administered Report" failed to address if the resident was offered a [redacted] During an interview conducted on 09/10/25 at 2:26 PM the [redacted] and [redacted] both confirmed R121 did not receive a [redacted] per CDC recommendations. During an interview on 09/10/25 at 8:27 AM, Infection Preventionist (IP) 2, who was the [redacted] for a sister facility stated if a resident had the [redacted] and the [redacted] the resident would be technically up to date and then five years later to be offered the [redacted] or [redacted] IP2 stated the physician can order whatever their preference was, and the facility would then supply the [redacted] to the resident. IP2 stated the goal was to provide the resident with the opportunity to be [redacted] NJAC 8:39-19.4	F0883		10/10/2025
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure one resident (R 116) out of one reviewed for accommodations of needs, out of a survey sample of 35, was provided and assessed for an appropriate wheelchair. This had the potential for R116 not to be able to [redacted] and have to wait for staff assistance.	F0558	Resident #116 was assessed by [redacted] and received an appropriate wheelchair on [redacted] All residents requiring the use of a wheelchair have the potential to be affected. Residents requiring the use of a wheelchair were assessed for appropriateness of their wheelchair and no other residents identified. Residents will be evaluated by Occupational Therapy at least quarterly to determine if wheelchair is appropriate for each resident. The Director of Nursing and/or designee educated Rehab and Nursing Staff on ensuring residents are in the appropriate wheelchair for each resident.	10/10/2025

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F0558 SS = D	Continued from page 13 Findings include: Review of a facility policy titled "Resident Mobility and Range of Motion" dated 04/20 indicated ". . .Interventions may include therapies, the provision of necessary equipment. . .based on professional standards of practice consistent with state laws and practice acts. . ." Review of R116's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on [redacted] with a diagnosis of [redacted]. Review of R116's EMR titled quarterly "Minimum Data Set (MDS)" located under the "MDS" tab with an Assessment Reference Date (ARD) of [redacted] indicated the resident had a "Brief Interview of Mental Status (BIMS)" score of [redacted] out of 15 which revealed the resident was [redacted]. The assessment indicated the resident had no [redacted] of [redacted] or [redacted]. The assessment indicated the resident required [redacted] to [redacted] assistance with activities of daily living. Review of R116's EMR titled "Care Plan" located under the "Care Plan" tab dated [redacted] revealed the resident had decreased [redacted], [redacted], and [redacted]. One of the interventions included [redacted]) to evaluate and treat. The [redacted] treatment included [redacted] activities and wheelchair management. Review of a document for R116 provided by the facility titled '[redacted] Evaluation & Plan of Treatment" dated [redacted] indicated the [redacted] goal included that the resident would complete all functiona[redacted] from the wheelchair, [redacted] and [redacted]. There was no further assessment which addressed the use of a [redacted] wheelchair [redacted] or for a [redacted] wheelchair (an individual can [redacted]. During an observation on 09/09/25 at 11:09 AM, R116 was sitting in a [redacted] wheelchair. The	F0558	Continued from page 13 The Administrator or designee will audit 5 residents to ensure they are in the appropriate wheelchair weekly for 4 weeks and then monthly for 2 months. Results of the audits will be discussed by the Administrator at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team and adjustments made to the plan of care.	10/10/2025

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F0558 SS = D	Continued from page 14 resident's NJ Exec Order 26.4b1 were placed on NJ Ex Order 26.4(b) attached to the NJ Exec Order 26.4b1 wheelchair. The resident was participating in activities. During an interview on 09/09/25 at 11:52 AM, Certified Nurse Aide (CNA) 1 stated that the NJ Exec Order 26.4b1 wheelchair must have been brought in by R116's family. During an interview on 09/09/25 at 12:17 PM the U.S. FOIA (b)(6)) stated that residents were assessed for the use of a NJ Ex Order 26.4(wheelchair. The U.S. FOIA stated normally residents were assessed for the use of a standard wheelchair and then measurements would be taken for the height, depth, width, and leg rests. The U.S. FOIA (b stated he was unsure if R116 was able to NJ Exec Order 26.4b1 due to NJ Exec Order 26 NJ Exec Order 26.4 . The U.S. FOIA stated he would have tested R116 in a NJ Ex Order 26.4(b) wheelchair prior to the use of a NJ Exec Order 26.4b1 wheelchair. A request was made for any wheelchair assessments for R116. During an interview on 09/09/25 at 2:07 PM, the U.S. FOIA confirmed that the NJ Exe completed an evaluation for R116 but there was no evaluation for the use of which type of wheelchair the resident required. During an observation on 09/09/25 at 2:11 PM, R116 was observed sitting in NJ Exec Order 26.4b1 wheelchair playing activities with the other residents. During an interview on 09/09/25 at 2:40 PM, the U.S. FO stated the NJ Ex Order 26 department typically did not place a resident into a NJ Exec Order 26.4b1 wheelchair since the resident could not be NJ Exec Order 26.4b properly in them. The U.S. FO and surveyor went to observe R116. The U.S. FO stated she was not aware of the resident being in a NJ Exec Order 26.4b1 wheelchair and confirmed that the resident would be NJ Exec Order 26.4b1 on staff for NJ Exec Order 26 During an interview on 09/10/25 at 8:25 AM, CNA2 stated R116 always had a NJ Exec Order 26.4b1 wheelchair. During an interview on 09/11/25 at 11:34 AM, the U.S. FOIA (b)(6) stated that she believed that the family brought the NJ Exec Order 26.4b1 wheelchair for R116 and stated she believed that staff provided the family with risks verses benefits on the use of the	F0558		10/10/2025

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F0558 SS = D	Continued from page 15 [redacted] wheelchair. The [redacted] stated she would verify if this information was in the medical records for the resident. No additional information was provided at the conclusion of this survey. NJAC 8:39-4.1(a)	F0558		10/10/2025
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must	F0584	A screen was immediately installed on Resident #73's window and room was cleaned. All residents have the potential to be affected by the deficient practice. An audit was conducted throughout the facility to ensure that all other windows in resident rooms had screens in the window, with no concerns identified. [redacted] was in-serviced by the Administrator on the importance of ensuring that all window screens are in place in resident rooms. Maintenance Director or designee will check resident windows monthly to ensure screen is in place and in good repair. Maintenance Director or designee will audit 10 rooms weekly x 4 weeks, then 10 rooms monthly x 2 months to ensure that all windows have the screens properly installed. Results of the audits will be discussed by the Maintenance Director at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team.	10/10/2025

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F0584 SS = D	Continued from page 16 maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interviews, and facility policy review, the facility failed to ensure an open window was covered with a screen for one of 33 Initial Pool residents (Resident (R) 73) whose rooms were observed. This failure had potential to increase [NJ Exec O] activity and risk of [NJ Exec Order 26] for R73. Findings include: Review of R73's "Admission Record," located under the "Profile" tab of the electronic medical record revealed [NJ Ex] was admitted to the facility on [NJ Exec Order 26] with diagnoses including NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. Review of R73's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [NJ Exec Order 26] and located under the "MDS" tab of the EMR, revealed [NJ Ex] scored an [NJ Exec O] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating NJ Exec Order 26.4b1. During an observation in R73's room on 09/08/25 at 10:07 AM, R73 was [NJ Exec Orde] to answer most questions and was speaking [NJ Exec Order 26.4b1]. [NJ Ex] room had a [NJ Ex Order] [NJ Exec Order 26.4b] [NJ Exec Order 26.4b1] on the wall, the floor, and the mattress [NJ Ex Order 26.4(b)(1)] and [NJ Ex Orde] in bags on the floor of the room, and [NJ Ex Order 26.4(b)(1)] on the floor. The window was open, and the screen of the window was resting against the wall of the resident's room. There were several flies and other flying insects in the room. During an observation from the hallway outside of R73's room on 09/10/25 at 2:17 PM and on 09/11/25 at 9:00 AM, the window was again observed open with the screen missing, resting against the wall in the room. There were several flying insects in the room. During an interview on 09/11/25 at 9:30 AM, the [U.S. FOIA (b)(6)]) stated the missing window screen had not been reported to him to	F0584		10/10/2025

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F0584 SS = D	Continued from page 17 address. The U.S. FG stated there was a system in place for the staff to create work orders for items that needed fixing, and the staff were expected to report any concerns. The U.S. FG stated if he was aware of the missing screen in R73's window, he would have addressed it right away. The U.S. FG stated R73 had habit of keeping NJ Ex room NJ Ex Or and a window screen was important for keeping flies out of NJ Ex room. Review of the policy titled, "Work Orders, Maintenance," dated August 2025, revealed, "Maintenance work orders shall be completed in order to establish a priority of maintenance service." NJAC 8:39-4.1(a) NJAC 8:39-5.1(a)	F0584		10/10/2025
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F0605	NJ Exec Order 26 NJ Ex Order 26.4(b)(1 was initiated Resident #8. Resident # 10 had an AIMS assessment completed on NJ Exec Order 2 and NJ Exec Order 26.4b1 identified. Residents receiving Psychotropic Medications have the potential to be affected. An Audit was conducted on residents receiving Psychotropic medications for type of behavior being monitored and effectiveness of interventions. No other residents were identified. An audit was conducted on residents receiving Psychotropic medications for the completion of AIMS evaluation. No other residents were identified. Director of Nursing and/or designee educated Licensed Nurses on Behavior Monitoring and Side Effect monitoring for any resident on a psychotropic medication and on completion of AIMs assessment quarterly and as needed. Director of Nursing or designee will review new Psychotropic medication orders daily to ensure orders for side effects and behavior monitoring are in place. Pharmacy Consultant will review residents receiving Psychotropic Medications Monthly for side effect and behavior monitoring orders. The Director of Nursing or designee will audit 10 residents receiving psychotropic medication weekly for 4 weeks and then monthly for 2 months to ensure side effect monitoring, behavior monitoring and AIMS evaluation are in place. Results of the audits will be discussed by the Director of Nursing at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team	10/10/2025

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F0605 SS = D	Continued from page 18 §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the	F0605	Continued from page 18 and adjustments made to the plan of care.	10/10/2025

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F0605 SS = D	Continued from page 19 clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure adequate monitoring for the use of [redacted] medications for two of five residents (Resident (R) 8 and R10) reviewed for unnecessary medications out of a total sample of 35 residents. For R8, [redacted] were not identified for monitoring of medication effectiveness and failed to ensure ongoing assessment for [redacted] of medication for R10. These failures had the potential to contribute to unnecessary [redacted] medication use and risk for [redacted] of the medications. Findings include: 1.Review of R8's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR) revealed [redacted] was admitted to the facility on [redacted] with diagnoses including [redacted], and [redacted]	F0605		10/10/2025

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F0605 SS = D	Continued from page 20 Review of R8's EMR under the "Orders" tab revealed a physician's order, dated [redacted], for NJ Exec Order 26.4b1 medication] [redacted] at bedtime for [redacted]. Review of R8's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted] and located under the "MDS" tab of the EMR, revealed [redacted] scored [redacted] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating NJ Exec Order 26.4b1. R8 did not exhibit [redacted] or [redacted] symptoms [redacted] received routine [redacted] medication and gradual dose reduction (GDR) had not been attempted. Review of R8's "Care Plan," dated [redacted] and located under the "Care Plan" tab of the EMR, revealed, "The resident uses [redacted] medications NJ Exec Order 26.4b1 medication] r/t [related to] [redacted] management" and the goal was, "[R8] will reduce the use of [redacted] medication through the review date. The approaches included, "Administer medications as ordered. Monitor/document for [redacted] and [redacted]. R8's "Care Plan" did not describe [redacted] to monitor to determine [redacted] of the medication. Review of R8's "MAR," dated [redacted] and located under the "Orders" tab of the EMR, revealed [redacted] received [redacted] medication daily. The "MAR" documented [redacted] were exhibited on NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 [redacted], and [redacted]. Review of R8's EMR under the "Progress Notes" tab revealed no corresponding notes to indicate the [redacted] of the [redacted], the [redacted] the non-pharmacological intervention, and the intervention's [redacted]. Review of R8's "Medication Administration Record (MAR)," dated [redacted] and located under the "Orders" tab of the EMR, revealed [redacted] received [redacted] medication daily. The "MAR" documented [redacted] were exhibited on [redacted], and [redacted].	F0605		10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315518	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD , SOUTH AMBOY, New Jersey, 08879

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F0605 SS = D	Continued from page 21 Review of R8's EMR under the "Progress Notes" tab revealed no corresponding notes to indicate the [redacted] of the [redacted], the [redacted], the non-pharmacological intervention, and the intervention's [redacted]. During an interview on 09/10/25 at 2:57 PM, Licensed Practical Nurse (LPN) 7 stated R8 did not exhibit any [redacted] symptoms and was [redacted]." During an interview on 09/10/25 at 3:12 PM, Recreation Aide (RecA) 1 stated R8 did not exhibit [redacted] symptoms and was [redacted] and [redacted]. During an interview on 09/11/25 at 9:50 AM, the [redacted]) stated R8's most recent [redacted] report documented a dose reduction of the [redacted] was not indicated as the resident was experiencing [redacted]. The [redacted] stated it was important to monitor not only if a [redacted] occurred, but the [redacted] exhibited and any contributing factors to ensure adequate monitoring for [redacted] of the medication. The [redacted] also stated the [redacted], and individualized interventions should be included in the "Care Plan." During an interview on 09/11/25 at 11:37 AM, the [redacted]) stated a behavior tracking sheet should be completed to quantify the specific behaviors exhibited and interventions used; however, these sheets were not yet in place. The [redacted] stated at minimum, a corresponding "Progress Note" describing the behavior should be entered. The [redacted] stated it was important to track specific behaviors to determine if the medication could be trialed for a dose reduction. The [redacted] also stated these specific behaviors should be outlined in the "Care Plan." Review of the facility's policy titled, "Psychotropic Medication Use," dated February 2025, revealed, "Residents receiving psychotropic medication are monitored and the response to treatment is documented." 2.Review of the "Admission Record" located in the "Profile" tab of the EMR revealed R10 was admitted to the facility on [redacted] with diagnoses of [redacted]	F0605		10/10/2025

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F0605 SS = D	Continued from page 22 NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 Review of the "Evaluations" tab in the EMR revealed an "AIMS" (abnormal involuntary movement scale assessment used to determine if there are any adverse side effects that develop when someone is taking an NJ Exec Order 26.4b1 medication) was completed on NJ Exec Ord... with a score of NJ Exec O. There was no evidence of any other "AIMS" being completed. There was no other evidence in the medical record that any monitoring for NJ Exec Order 26.4b1 was being completed. Review of the significant change "MDS" located in the "MDS" tab of the EMR with an ARD of NJ Exec Order 26.4 revealed R10 had a "BIMS" score of NJ Exec O out of 15 which indicated R10 was NJ Exec Order 26.4b1 in NJ Exec Order 26.4 and was administered an NJ Exec Order 26.4b1 medication during the NJ Exec Order 26.4b observation period. Review of the "Order Summary" dated NJ Exec Order 26 revealed R10 had an "Order" for NJ Exec Order 26.4b1 medication NJ E NJ Ex Order 26.4(b)(1) every 12 hours for NJ Exec Order 26.4b1] During an interview on 09/11/25 at 10:11 AM, the U.S. FOIA confirmed there was no other documentation to show there was any monitoring for any NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b for R10 and there had been a lack of monitoring overall for the use of an NJ Exec Order 26.4b1 NJAC 8:39-4.1(a)6 NJAC 8:39-27.1(a)	F0605		10/10/2025
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the	F0628	Resident #7 was readmitted to the facility on NJ Exec Order 2. All residents have the potential to be affected by this deficient practice. The Administrator in serviced the Social Workers on the requirement to issue a written transfer notice to any resident who has a hospital transfer.	10/10/2025

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F0628 SS = D	Continued from page 23 receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F0628	Continued from page 23 The Administrator or designee will audit 5 residents per month who had a hospital transfer to assure resident and/or responsible party was provided with a written transfer notice. Results of the audits will be discussed by the Administrator at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team.	10/10/2025

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F0628 SS = D	Continued from page 24 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency	F0628		10/10/2025

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F0628 SS = D	Continued from page 25 responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written	F0628		10/10/2025

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F0628 SS = D	Continued from page 26 notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure one resident (Resident (R)7) reviewed for a hospital [redacted] out of a total sample of 35 was provided with a written [redacted] notice. This failure has the potential to affect all residents by not having knowledge of where and why a resident was [redacted] and/or how to appeal the [redacted], if desired. Findings include: Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed, R7 was admitted to the facility [redacted] Review of the "Progress Notes" located in the "Progress Notes" tab of the EMR revealed on [redacted], "...Seen by U.S. FOIA (b)(6)]. Order rec'd [received] and carried out to send to [hospital name] for NJ Exec Order 26.4b1 eval and treat..." Review of the "Progress Notes" located in the "Progress Notes" tab of the EMR, revealed on [redacted], "...Called NJ Exec Order 26.4b1] Department for a status update. Patient was admitted. Admitting	F0628		10/10/2025

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F0628 SS = D	Continued from page 27 diagnosis [NJ Exec Order 26.4b1] ..." Review of the EMR did not show documentation that R7 and/or [NJ Exec Order 26.4b1] was provided with a written [NJ Exec Order] notice regarding [NJ Exec Order 26.4b1] to the hospital, as required. During an interview on 09/10/25 at 11:36 AM, the [U.S. FOIA (b)(6)] was asked if the [NJ Exec Order] notice had been provided to R7, as it was not documented in the EMR. The [U.S. FOIA (b)(6)] stated, "We stopped doing them in May. I was not aware that we needed to keep doing them." NJAC 8:39-4.1(a)	F0628		10/10/2025
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure the [NJ Ex Order 26.4(b)(1)] and Resident Review [NJ Ex Order 26.4(b)(1)] Determination recommendations were developed and implemented for one of four residents (Resident (R) 73) reviewed for PASARR out of a total sample of 35 residents. This failure had the potential to lead to continued or worsening [NJ Exec Order 26.4b] symptoms without intervention. Findings include:	F0644	The [NJ Ex Order 26.4(b)(1)] for Resident #73 was reviewed by the long-term care social worker for any special needs and/or [NJ Exec Order 26] [NJ Ex Order 26.4(b)(1)] An individualized Crisis Management plan was developed by the Interdisciplinary Team as well as an individualized [NJ Exec Order 26] [NJ Ex Order 26.4(b)(1)] program and the Care plan was updated to address all [NJ Ex Order 26.4(b)(1)] All residents with Level II PASAAR have the potential to be affected by this deficient practice. An audit was conducted for all Level II PASAAR residents, and none were found deficient. The Regional Director of Social Services educated facility social workers and Interdisciplinary team on ensuring PASRR Level II Determination recommendations are reviewed and a plan is developed and implemented for the resident. The Administrator or designee will review 5 resident charts (if applicable) with PASSAR Level II's weekly for 4 weeks and then monthly for 2 months to ensure determination recommendations were developed and implemented. Results of the audits will be discussed by the Administrator at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team and adjustments made to the plan of care.	10/10/2025

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F0644 SS = D	Continued from page 28 Review of R73's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR) revealed [redacted] was admitted to the facility on [redacted] with diagnoses including [redacted], and [redacted]. Review of R73's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted] and located under the "MDS" tab of the EMR, revealed [redacted] scored [redacted] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating [redacted]. R73 experienced [redacted] and exhibited [redacted] of [redacted] of care daily. Review of R73's [redacted] Determination Notification," dated [redacted] and located in the "Miscellaneous" tab of the EMR, revealed the following recommendations were included: "Formulate and implement a [redacted] modification plan to address any [redacted] and "Develop a Crisis Intervention/Safety Plan with the client." Review of R73's "Care Plan," located under the "Care Plan" tab of the EMR and dated [redacted] revealed, "I meet the [redacted] of determination secondary to diagnosis of [redacted] . . . Recommendations as follows: Med [medication] monitoring, routine f/u [follow up] visits with [redacted] and [redacted] routine lab testing, develop [redacted] intervention plan for client." The approaches included: "Case consultation . . . [and] Structured [redacted], medication monitoring." Further review of R73's "Care Plan" revealed the focus, dated [redacted] "[R73] has a diagnosis of [redacted]. [R73] has a history of [redacted] and [redacted] . . . [R73] becomes [redacted] during care, [redacted] and [redacted] and will [redacted] at staff." The approaches included: Medications as ordered . . . Track [redacted] . . . Validate resident's [redacted] . . . Approach in [redacted] manner . . . [and] Inform [R73] of care provided. Review of R73's EMR revealed there was no evidence of a [redacted] modification plan or [redacted] intervention/safety plan.	F0644		10/10/2025

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F0644 SS = D	Continued from page 29 During an interview on 09/11/25 at 9:57 AM, the U.S. FOIA (b)(6)) stated she was in the process of making referrals to health facilities for R73, as care could not be managed in the facility. She stated R73's included all care including labs, and medications as well as washing in the washing walls with , leaving and on the floor, on the floor, and refusing staff to enter room. The stated a modification program and crisis intervention/safety plan were not created for R73 because refused care. The stated the NJ Ex Order 26.4(b)(1) recommendations were typically sent to the U.S. FOIA (b)(6) for follow up and she was unsure why these recommendations were not followed through. During an interview on 09/11/25 at 11:29 AM, the U.S. FOIA (b)(6)) stated R73 had related to , and the best way to manage was to leave and re-approach at a later time when can be with. The stated there was a certain way for staff to approach R73 to not off . The stated these approaches should be included in the "Care Plan" or in a modification plan. The stated R73's were not for the nursing home and referrals were being made for health care. The was unaware the NJ Ex Order 26.4(b)(1) recommendations were not implemented. Review of the policy titled, "Admission Criteria," dated March 2019, revealed, " Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate . . . The state PASARR representative provides a copy of the report to the facility . . . The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation." NJAC 8:39-40.3(d)	F0644		10/10/2025

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656	1. Resident #116 care plan was developed for [NJ Exec Order 26.4b1] care. Resident # 56 care plan was developed for individual [NJ Exec Order 2] plan. The Director of Nurses in-serviced the IDCP team on the RAI compliance regarding the development of care planning activity of daily living. 2. All residents have the potential to be affected by this deficient practice when activity of daily living has not been accurately care planned. An audit of care plans was conducted to review ADL care planning with CAA review. 3. All members of the IDCP team were in-serviced by the corporate MDS person on the policy and procedure for care planning and reviewing the CAA of each individual resident. 4. The Assistant Director of Nurses and Unit Managers will audit 10 charts weekly x 30 days, then 5 charts weekly x 30 days, ongoing for activity of daily living and care plan compliance. All findings will be reported at the Quality Assurance meeting x 2 quarters.	10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315518	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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F0656 SS = D	Continued from page 31 Based on observation, record review, review of facility policy, and interview, the facility failed to develop a person-centered comprehensive plan of care with measurable goals and plans for two of 35 sampled residents (Resident (R)116 and R56) reviewed for care plans. The failure had the potential for the residents to have unmet care needs. Findings include: Review of a facility policy titled "Care Plans, Comprehensive Person-Centered" dated 03/22 indicated ". . .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. . .Care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. . ." 1.Review of R116's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on [redacted]. Review of R116's EMR titled admission "Minimum Data Set (MDS)" located under the "MDS" tab with an Assessment Reference Date (ARD) of [redacted] indicated the staff could not [redacted] the resident's "Brief Interview for Mental Status (BIMS). The assessment indicated the resident had [redacted], and was assessed and considered to be at risk for the development of [redacted] Under the "[redacted]) revealed the resident triggered for the development of [redacted] and directed the staff to develop a care plan. Review of R116's EMR titled "Care Plan" located under the "Care Plan" tab failed to contain evidence that the clinical staff developed a [redacted] care plan. During an interview on 09/10/25 at 2:26 PM, the [redacted] and the [redacted]) stated if a resident triggers under the "[redacted] the care plan should reflect this.	F0656		10/10/2025

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F0656 SS = D	Continued from page 32 During an interview on 09/10/25 at 3:25 PM the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) confirmed that a NJ Exec Order 26.4b1 care plan should have been developed for R116, and it was not. During an interview on 09/11/25 at 10:28 AM the U.S. FOIA (b)(6)) confirmed if R116 triggered under the NJ Ex Orde the care plan should have been developed. 2. Review of R56's "Admission Record," located under the "Profile" tab of the EMR, revealed NJ Exec was admitted to the facility NJ Exec Order 26 and had diagnoses including NJ Exec Order 26.4b1 , and NJ Exec Order 26.4b1 . Review of R56's quarterly "MDS," with an ARD of NJ Exec Order 26 and located under the "MDS" tab of the EMR, revealed NJ Exec was NJ Exec Order 26.4b1 able to make NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . R56 was always NJ Exec Order 26.4b1 of NJ Exec Order 2 and frequently NJ Exec Order 26.4b1 of NJ Exec Orde NJ Exec required NJ Exec Order 26.4b1 assistance with NJ Exec Order 2 hygiene and did not use the NJ Exec O . Review of R56's "Care Plan," dated NJ Ex Order 26.4b and located under the "Care Plan" tab of the EMR, revealed NJ Exec was NJ Exec Order 26.4b1 on staff for NJ Ex Order 26.4(b)(1 with activities of daily living. The "Care Plan" did not address R56's NJ Exec Order 26.4b1 or NJ Exec Order 2 NJ Ex Order 26.4 needs. During an interview on 09/11/25 at 11:37 AM, the U.S. FOIA (b)(6)) stated a toileting/changing schedule was based on each individual; the facility did not have a protocol to apply to every resident. The U.S. FOIA stated the information on how often to check and change R56 should be included in NJ Exe "Care Plan." During an interview on 09/11/25 at 12:27 PM, the U.S. FOIA (b)(6)) stated R56's NJ Exec Order 26.4b1 and NJ Exec Order 2 hygiene needs should have been addressed in the "Care Plan." NJAC 8:39-11.2(e) thru(i)	F0656		10/10/2025

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F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure one of five residents reviewed for unnecessary medications (Resident (R) 12) received NJ Ex Order 26.4(NJ Exec medication as ordered and failed to notify the physician of missed doses of the medication out of a total sample of 35 residents. This failure had the potential to NJ Ex Order 26.4(b)(1) or contribute to worsening NJ Exec Order 2 and . Findings include: Review of R12's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed NJ Exec was admitted to the facility on NJ Exec Order 26 and had diagnoses including NJ Exec Order 26.4b1, and NJ Exec Order 26.4 . Review of R12's annual "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26 and located in the "MDS" tab of the EMR, revealed NJ Exec was NJ Exec Order 26.4b1 r able to make NJ Exec Orde NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1. Review of R12's "Electronic Medication Administration Record (eMAR)," dated NJ Exec Order 26.4b1 NJ Exec O and located under the "Orders" tab of the EMR, revealed a physician's order, dated NJ Exec Order 26.4 for NJ Exec Order 26.4b1 NJ Ex Order 26.4(NJ Exec O , one NJ Ex Order 26.4(b)(1 in the NJ Exec Order three times a day for for NJ Exec Ord days. The "eMAR" documented the NJ Exec NJ Ex Order 26.4(was NJ Ex Order 26 twice on NJ Exec Order 26 and three times on Exec Order , then was not administered at all on NJ Exec Order 26.4b1, then was administered three times daily on NJ Exec Order 26.4 . On NJ Exec Order 26 and NJ Exec Order 26 , Licensed Practical Nurse (LPN) 7 documented three times daily,	F0684	1. The Director of Nurses provided individual education to LPN 7 regarding the policy and procedure for "Unavailable Medication" Resident #12's physician was notified immediately with no change in order. The pharmacy was contacted and the medication was delivered. 2. All residents have the potential to be affected by this deficient practice when medications are not available. An audit of all medication carts was conducted to ensure that all medications were available. None were found to be deficient. 3. The Assistant Director of Nurses provided in-service to all nurses on the policy and procedure for "Unavailable Medications." 4. The 11-7 shift nurses will audit the unit medication carts and immediately report any unavailable medications to the Nursing Supervisor. Audits will be conducted daily for 30 days and then three times weekly for 2 months. The Unit Managers will report findings of these audits to the Director of Nursing. Results of the audits will be discussed by the Director of Nursing at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team and adjustments made to the plan of care.	10/10/2025

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F0684 SS = D	Continued from page 34 "drug/treatment not administered." Review of R12's EMR under the "Progress Notes" tab revealed the following corresponding notes: -An "eMar Medication Administration Note" dated [redacted] at 2:56 PM documented, "Awaiting delivery." -An "eMar Medication Administration Note" dated [redacted] at 2:57 PM documented, "Awaiting delivery." -An "eMar Medication Administration Note" dated [redacted] at 4:33 PM documented, "Awaiting delivery." -An "eMar Medication Administration Note" dated [redacted] at 10:57 AM documented, "Not available." -An "eMar Medication Administration Note" dated [redacted] at 3:30 PM documented, "Not available." An "eMar Medication Administration Note" dated [redacted] at 6:15 PM documented, "Not available." During an interview on 09/09/25 at 12:34 PM, LPN7 stated that over the weekend on [redacted] and [redacted], she was unable to find the [redacted] ointment for R12. She stated she looked for the medication but did not see it anywhere. LPN7 stated she did not alert the physician to the missed doses of medication nor contact the pharmacy to determine whether the medication had been delivered. She stated she should have called the physician as the medication was only ordered for seven days but she had already missed two days of application. During an interview on 09/11/25 at 11:35 AM, the [redacted]) stated LPN7 should have contacted the pharmacy to check on the status of the medication and notified the physician of the missed doses. Review of the policy titled, "Unavailable Medication," dated June 2021, revealed, "In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall: a. Contact the pharmacy regarding the unavailable medication.	F0684		10/10/2025

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F0684 SS = D	Continued from page 35 b. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. c. Notify the physician of the unavailable medication, explain the circumstances, report the date of expected availability, and provide the alternative medication(s) recommended by pharmacy. i. Obtain a new order and discontinue prior order, or ii. Obtain a hold order for the unavailable medication." NJAC 8:39-27.1(a)	F0684		10/10/2025
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, facility document review, facility policy review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure [redacted] prevention measures were in place for two residents out of four reviewed (Resident (R) 116 and R3) for [redacted] out of a total sample of 35 residents. This had the potential for the residents to develop [redacted] and/or worsen current [redacted] Findings include:	F0686	1. For Resident #116, the [redacted] was removed from resident's wheelchair and a [redacted] was placed in the wheelchair. Family was educated on risk and benefits of maintaining [redacted] to wheelchair. Resident #116 care plan was updated. The Director of Nursing provided individual education to [redacted] regarding the need for applying the [redacted] to Resident # 3. Resident # 3 [redacted] were immediately applied. Resident # 3 care plan was reviewed and updated. 2. All residents have the potential to be affected by this deficient practice. An audit of all residents who have need for protective equipment was conducted to ensure proper equipment was in place, with no concerns identified. 3. The Assistant Director of Nurse in-serviced the Unit Managers, Nurses and CNAs on the policy and procedure titled "Prevention of Pressure Injuries", emphasizing assuring resident's pressure relieving devices are in place as needed. 4. The Assistant Director of Nursing or designee will audit 10 residents weekly for 30 days, then 5 residents weekly for 60 days to ensure proper preventive equipment is in use and care plan is up to date care for the proper preventive equipment. Results of the audits will be discussed by the Assistant Director of Nursing at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team and adjustments made to the plan of care.	10/10/2025

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F0686 SS = D	Continued from page 36 Review of the RAI manual, dated 10/2024 and located at Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual | CMS, revealed ". . .The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound. . ." Review of a facility policy titled "Prevention of Pressure Injuries" dated 04/20 indicated ". . .The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors...Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. . .Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. . .For prevention measures associated with specific devices, consult current clinical practice guidelines. . ." 1.Review of R116's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on [redacted]. Review of R116's EMR titled quarterly "MDS" located under the "MDS" tab with an assessment Reference Date (ARD) of [redacted] indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 which revealed the resident was [redacted]. The assessment indicated the resident used a wheelchair for [redacted], required [redacted] from staff for activities of daily living, and was considered to be at risk for the [redacted] of [redacted] and the facility had applied [redacted] to [redacted] wheelchair. During an observation on 09/09/25 at 11:09 AM,	F0686		10/10/2025

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F0686 SS = D	Continued from page 37 R116 sat in a NJ Exec Order 26.4b1 wheelchair and under was a NJ Ex Order 26.4(b)(1). At 2:11 AM, R116 sat in a NJ Exec Order 26.4b1 wheelchair and under was a NJ Ex Ord During an interview on 09/10/25 at 8:03 AM, the U.S. FOIA (b)(6)) stated if a resident was at risk for the development of NJ Exec Order 26. the physician would order baseline NJ Exec Order 26.4b, and U.S. FOIA (b)(6)) would assess the resident to ensure the resident adequately. The U.S. FOIA (b)(6) stated R116's goal was to continue to assist with NJ Ex Order 26 and involved in activities. U.S. FOIA (b) stated all the Exec Order 26.4b1 wheelchairs should have NJ Ex Order 26.4(b)(1). During an interview on 09/09/2025 at 2:40 PM, the U.S. FOIA (b)(6)) stated that NJ Ex Order 26 did not like the use of a NJ Exec Order 26.4b1 wheelchairs since the wheelchair was difficult to NJ Exec Order 26.4b a resident in. During this interview, the observed the resident and confirmed the resident was not on a cushion and would recommend a NJ Exec O NJ Ex Order 26 due to the resident being at risk for the NJ Ex Order 26.4(b)(1) of NJ Exec Order 26.4b1. The also confirmed that the resident sat on NJ Ex Order 26.4(b)(1) during this interview. During an interview on 09/10/2025 at 8:25 AM, Certified Nurse Aide (CNA) 2 stated that R116 never had a NJ Exec Ord NJ Ex Order 26. to be placed on the resident's wheelchair. CNA2 stated she was unsure who placed the resident NJ Ex Order 26.4(b)(. During an interview on 09/11/25 at 10:09 AM, the U.S. FOIA (b) stated R116's the resident had a NJ Exec O cushion but R116's family member would place the NJ Ex Order 26.4(b)(1) the resident's NJ Ex Ord instead of NJ Ex Order 26.4(b)(1) . 2. Review of R3's "Admission Record," located under the "Profile" tab of the EMR, revealed NJ Exec was admitted to the facility on NJ Exec Order 26. and had diagnoses including NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 2, and NJ Exec Order 26.4b Review of R3's significant NJ Exec Order 2 of NJ Exec Order 26.4 "MDS," with an ARD of NJ Exec Order 26. and located under the "MDS" tab of the EMR, revealed NJ Exec was NJ Exec Order 26.4b1 able to make NJ Exec Order 26.4b1 and	F0686		10/10/2025

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F0686 SS = D	Continued from page 38 had NJ Exec Order 26.4b1. R3 was at risk for development of NJ Exec Order 26.4b1, and had one NJ Exec Order 26.4b1. Review of R3's "Care Plan," located under the "Care Plan" tab of the EMR and dated NJ Ex Order 26.4(b), revealed, "The resident has NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 r/t [related to] history of NJ Exec Order 26.4b1. The approaches included: "Follow facility policies/ protocols for the prevention and treatment of NJ Exec Order 26.4b1." The "Care Plan" did not include the specific interventions to use for prevention. Review of R3's "Progress Note" by the U.S. FOIA (b)(6), U.S. FOIA (b)(6), dated NJ Ex Order 26.4(b) and located under the "Miscellaneous" tab of the EMR, revealed, "Patient has a new NJ Exec Order 26.4b1. Possibly from NJ Exec Order 26.4b1. has hx [history] of NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 all which increases [sic] NJ Exec Order 26.4b1 NJ Ex Order 26.4(b) and further NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) Reviewed with staff the importance of NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and strict NJ Exec Order 26.4b1 control . . . NJ Ex Order 26.4(b)(1) per Facility Protocol – NJ Exec Order 26.4b1 Review of R3's EMR under the "Orders" tab revealed no order for use of NJ Exec Order 26.4b1 to NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1. During observations on 09/10/25 at 8:45 AM, 10:07 AM, 11:38 AM, 1:16 PM, 2:11 PM, and 2:24 PM, and 2:42 R3 was seated in NJ Exec Order 26.4b1 wheelchair in the day room. NJ Exec Order 26.4b1 had NJ Exec Order 26.4b1 directly on NJ Ex Order 26.4(b)(1) and was not wearing NJ Exec Order 26.4b1. During an interview on 09/10/25 at 2:11 PM, CNA5 confirmed R3 was not wearing NJ Exec Order 26.4b1. She stated NJ Exec Order 26.4b1 thought NJ Exec Order 26.4b1 only wore NJ Exec Order 26.4b1 while in bed. During an interview on 09/10/25 at 2:42 PM, LPN7 stated R3 should be wearing NJ Exec Order 26.4b1 every day, in and out of bed as NJ Exec Order 26.4b1 spent NJ Exec Order 26.4b1 time out of bed in a NJ Exec Order 26.4b1 wheelchair. LPN7 stated NJ Exec Order 26.4b1 had a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1, and the NJ Exec Order 26.4b1 were important to NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) and prevention of NJ Ex Order 26.4(b)(1). LPN7 confirmed R3 did not have NJ Exec Order 26.4b1 on. LPN7 stated she was unable to find a physician's order for use of the NJ Exec Order 26.4b1	F0686		10/10/2025

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F0686 SS = D	Continued from page 39 During an interview on 09/11/25 at 11:44 AM, the [redacted] stated R3 should have the [redacted] on at all times while in bed and while out of bed in [redacted] wheelchair. The [redacted] stated the [redacted] should be included in the physician orders and "Care Plan." Review of the policy titled, "Pressure Ulcers/Skin Breakdown – Clinical Protocol," dated March 2014, revealed, "The physician will help identify medical interventions related to wound management." Review of the policy titled, "Prevention of Pressure Injuries," dated April 2020, revealed, "Review the resident's "Care Plan" and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable." NJAC 8:39-27.1(a)	F0686		10/10/2025
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure interventions were in place for one of one resident (Resident (R) 56) out of two residents reviewed for	F0688	1. A [redacted] was immediately placed in the [redacted] of resident #56. The Director of Nurses provided individual education to LPN #7 on the policy titled "Resident Mobility and Range of Motion" The care plan for resident # 56 was reviewed and updated. 2. All residents have the potential to be affected by this deficient practice. An audit was conducted for all residents who have a limit in range of motion to ensure the proper equipment is applied, with no concerns identified. 3. The Assistant Director of Nurses in-serviced Nurses and CNA's on the policy and procedure titled "Resident Mobility and Range of Motion". 4. The Therapy Director or designee will evaluate 10 residents monthly for appropriate treatment and services for range of motion and mobility, then 5 residents monthly for 2 months. The resident care plans will be reviewed and updated as necessary. Results of the audits will be discussed by the Therapy Director at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team and adjustments made to the plan of care.	10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315518	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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F0688 SS = D	Continued from page 40 NJ Exec Order 26.4b1) out of a total sample of 35 residents. This had the potential for the residents NJ Exec Order 26.4b1 to NJ Ex Order 26. Findings include: Review of R56's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed NJ Exec was admitted to the facility NJ Exec Order 26 and had diagnoses including NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. Review of R56's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26 and located under the "MDS" tab of the EMR, revealed NJ Exec was NJ Exec Order 26.4b1 able to make NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. R56 did not have limited NJ Exec Order. Review of R56's "Care Plan," dated NJ Ex Order 26.4(b) and located under the "Care Plan" tab of the EMR, revealed NJ Exec was NJ Exec Order 26.4b1 on staff for assistance with activities of daily living. The "Care Plan" did not address R56's NJ Exec O NJ Exec Order 26.4b1 or interventions to manage it. Review of R56's EMR under the "Orders" tab revealed a physician's order, dated NJ Exec Order 26, for NJ Exec Orde NJ Ex to be applied to NJ Exec Order 26.4 daily. NJ Exec O checks and hand hygiene at AM/PM." Review of R56's "Care Plan," located under the "Care Plan" tab of the EMR and dated NJ Ex Order 26.4(b) revealed, "Continue to do NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(and "Keep NJ Exec NJ Ex Order 26.4(b)(1) ." The "Care Plan" did not address the use of a NJ Exec Orde NJ Ex in the NJ Exec Order 26.4. Review of R56's "Treatment Administration Record (TAR)," dated NJ Exec Order 26.4b1 and located under the "Orders" tab of the EMR, revealed the order to apply a NJ Exec Orde roll to the NJ Exec Order 26 was signed as completed daily. During an observation on 09/08/25 at 10:31 AM, R56 was seated in NJ Exec Order 26.4b1 wheelchair in the NJ Exec Order 2 group without a NJ Exec Orde NJ Ex in NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 was in NJ Exec NJ Ex and was NJ Ex Order 26.4(b)(1) R56 was not seen to use NJ Exec Order 26.4b1.	F0688		10/10/2025

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F0688 SS = D	Continued from page 41 During an observation on 09/09/25 at 8:51 AM, R56 was seated in [NJ Exec Order 26.4b1] wheelchair at the breakfast table. [NJ Exec Order 26.4b1] was in [NJ Ex] and there was no [NJ Exec Orde] [NJ Ex] in the [NJ Ex Orde] [NJ Exec Order 26.4b1] remained [NJ Ex Order 26]. During observations on 09/10/25 at 10:56 AM and 2:48 PM, R56 was seated in [NJ Exec Order 26.4b1] wheelchair in the [NJ Exec Order 2] group [NJ Exec O] did not have a [NJ Exec Orde] [NJ Ex] in [NJ Exec Order 26.4b1], which was [NJ Ex Order 2] on [NJ Ex] [NJ Ex O] w/c to [NJ Exec Order 2] group after changing in room. During an observation and concurrent interview on 09/10/25 at 3:08 PM, Licensed Practical Nurse (LPN) 7 confirmed R56 did not have a [NJ Exec Orde] [NJ Ex] in [NJ Exec Order] [NJ Exec Orde] and [NJ Exec] needed to have it to protect [NJ Exec Order 2] due to [NJ Exec Order 26.4b1]. LPN7 did not know why the [NJ Exec Orde] [NJ Ex] was not applied but was documented on the "TAR" as completed. LPN7 placed a [NJ Exec Orde] roll in R56's [NJ Exec Order 26.4] and stated it was a [NJ Exec Order 26.4b] to get it in [NJ Ex Order 26.4(b)]. During an interview on 09/11/25 at 11:37 AM, the [U.S. FOIA (b)(6)]) stated he had no explanation for the [NJ Exec Orde] roll not being applied as ordered and signed as completed on the "TAR." The [U.S. FOIA] stated the [NJ Exec Orde] [NJ Ex] should be applied to R56's [NJ Exec Order 26] daily. Review of the policy titled, "Resident Mobility and Range of Motion," dated July 2017, revealed "Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility . . . As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to ROM and mobility, including . . . skin integrity issues . . . The care plan will be developed by the interdisciplinary team based on comprehensive assessment." NJAC 8:39-27.1(a)	F0688		10/10/2025
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F0695	1. An [NJ Exec Order 26.4b] was immediately placed in the room of resident # 142 by the Director of Nursing. 2. All residents with a tracheostomy have the potential to be affected by this deficient practice. An	10/10/2025

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F0695 SS = D	Continued from page 42 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, interview, and facility policy review, the facility failed to provide [redacted] care per standards of practice for one of two sampled residents (Resident (R)142) reviewed for [redacted] care out of a total sample of 35 residents. Specifically, the facility failed to ensure [redacted] equipment [redacted] was accessible. The failure had the potential for the resident to have [redacted] and unmet care needs. Findings include: Review of a facility policy titled "Tracheostomy Care" dated 06/25/25 failed to address the importance of an [redacted] to be stored by a resident, who has [redacted] at bedside. Review of R142's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on [redacted]. Review of R142's EMR titled "Care Plan" located under the "Care Plan" tab dated [redacted] indicated the resident had a [redacted] related to [redacted] and that the resident required [redacted] equipment at the bedside which included an [redacted]. Review of R142's EMR titled admission "Minimum Data Set (MDS)" located under the "MDS" tab dated [redacted] was in progress and data could not be collected. During an observation and interview on 09/09/25 at 6:05 AM, [redacted] entered R142's room and proceeded to show the [redacted] medical equipment which was at the bedside of the resident. [redacted] confirmed there was no [redacted] at the resident's bedside. [redacted] stated it was important	F0695	Continued from page 42 audit of all facility residents with a tracheostomy was conducted to ensure an Ambu-bag was placed near the resident. None were found to be deficient. 3. The Assistant Director of Nurses in-serviced nurses on the policy and procedure titled "Tracheostomy Care", including the requirement to have an Ambu-bag at bedside. The Assistant Director of Nurses as well as the Unit Managers reviewed care plans for all tracheostomy residents to ensure interventions were in place. 4. The Assistant Director of Nurses and/or Unit Managers will observe weekly each resident's room where a resident resides with a tracheostomy to ensure an Ambu-bag is present at bedside x 30 days, then 4 times per month for 2 months. Results of the audits will be discussed by the Assistant Director of Nursing at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team and adjustments made to the plan of care.	10/10/2025

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F0695 SS = D	Continued from page 43 for an [NJ Exec Order 26.4b] to be at the bedside if the resident was [NJ Exec Order 26.4b] to [NJ Exec Order 26.4b] on [NJ Exec Order 26.4b] own and required [NJ Exec Order 26.4b] assistance with the [NJ Exec Order 26.4b]. During an interview on 09/11/25 at 10:09 AM, the [U.S. FOIA (b)(6)]) stated he was unsure why the [NJ Exec Order 26.4b1] was not at the bedside of R142 but it was [NJ Exec Order 26.4b] for the clinical staff to have access to the [NJ Exec Order 26.4b] if the resident was [NJ Exec Order 26.4b] to [NJ Exec Order 26.4b] on [NJ Exec Order 26.4b] own. NJAC 8:39-5.1(a) NJAC 8:39-27.1(a)	F0695		10/10/2025
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F0756	Resident #7's physician was contacted and the order for the [NJ Exec Order 26.4b] was adjusted. All residents have the potential to be affected by the deficient practice. The Medical Director educated Attending Physician's on the importance of reviewing and responding to Pharmacy Consultant Recommendations for their individual residents. Unit Managers will place all Pharmacy Consultant recommendations in binders and are responsible for ensuring that the Attending Physician reviews and responds to Pharmacy Consultant Recommendations. The Assistant Director of Nursing or designee will audit 10 residents per month for the next 3 months to ensure that Pharmacy Consultant recommendations are being reviewed and responded to by the Attending Physician. Results of the audits will be discussed by the Assistant Director of Nursing at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team.	10/10/2025

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F0756 SS = D	Continued from page 44 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the physician responded to the U.S. FOIA (b)(6) medication reviews for one resident (Resident (R7) out of five reviewed for unnecessary medications in a total sample of 35 residents. This failure placed the resident at risk of receiving unnecessary medications. Findings include: Review of the facility policy titled, "Medication Regimen Reviews (MRR)," dated July 2025, revealed, "…A licensed pharmacist reviews the medication regiment of each resident at least monthly…The purpose of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication…Upon receiving the MRR, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them…If the physician does not provide a timely or adequate response, or the consultant pharmacist identified that no action has been taken, he/she contacts the medical director or the administrator…" Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R7 was originally admitted to the facility on NJ Exec Order 26 and was readmitted after a hospital NJ Exec on NJ Exec Order 26 with diagnoses that included NJ Exec Order 26.4b1), and a NJ Exec Order 26.4b1 of the NJ Exec Order 26 and NJ Exec O Review of an NJ Exec Order 26 "Pharmacist Consultant Report" provided by the U.S. FOIA (b)(6) r revealed, "This resident has an order for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1	F0756		10/10/2025

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F0756 SS = D	Continued from page 45 NJ Exec Order 26.4b1 q [every] 8 hours. NJ Exec Order 26.4b should not be dosed after PM in order to minimize the potential for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1]. Please update U.S. FOIA (b)(6)] orders and MAR [Medication Administration Record] to indicate doses separated by at least 3 hours and the last dose of the day no later than PM." There was no provided documentation or indication on the "Pharmacy Consultant Report" that R7's physician had responded to the request by the U.S. FOIA (b)(6) Review of the NJ Exec O and NJ Exec Order 26.4b "MARs" located in the "Orders" tab of the EMR revealed R7 was restarted on NJ Exec Order 26.4b1] on NJ Exec Order 26. The medication was ordered at NJ Exec NJ Ex O every eight hours. Hold for NJ Exec Order NJ Exec Order 26.4b1] greater than NJ Exec ." The dosing times of the NJ Exec Order 26.4b " were listed as 6:00 AM, 2:00 PM, and 10:00 PM. Review of the NJ Exec Order 26.4b1 "MAR" revealed R7 had an order for "NJ Exec Order 26.4b1 NJ Ex Order 2 8 hours. Hold for NJ Exec Order 2 greater than NJ Exec ." Dated Exec Order 26 . Review of the NJ Ex Order 26.4b "U.S. FOIA (b)(6) Report" provided by the U.S. FOIA (b)(6) revealed, "This resident has an order for " NJ Exec Order 26.4b q 8 hours. NJ Exec Order 26.4b should not be dosed after NJ E PM in order to minimize the potential for NJ Exec Orde NJ Exec Order 26.4b1 . Please update U.S. FO orders and MAR to indicate doses separated by at least 3 hours and the last dose of the day no later than NJ E PM." There was no documentation on the "U.S. FOIA (b)(6) Report" indicating that the physician was notified of the U.S. FOIA (b)(6) recommendation or that the order had been changed on the "MAR." Review of the NJ Exec Order 26.4b1 "MAR" revealed R7 was being administered NJ Exec Order 26.4b1 q 8 hours. The dosing times were listed as 6:00 AM, 2:00 PM, and 10:00 PM. During an interview on 09/11/25 at 10:14 AM, the U.S. FOIA (b)(6)) stated, "The physician came in and ordered the NJ Exec Order 26.4b for two times	F0756		10/10/2025

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F0756 SS = D	Continued from page 46 daily, yesterday. The [U.S. FOIA] was asked how the physician knows about the pharmacy recommendations and when does he answers them. The [U.S. FOIA (b)] stated, "We send them to him electronically. He is not very good at electronics and did not return them to us timely." During an interview on 09/11/25 at 11:06 AM, the [U.S. FOIA (b)(6)] was asked if the physician had responded to her recommendations. The [U.S. FOIA (b)(6)] stated, "No." During a follow-up interview on 09/11/25 at 12:23 PM, the [U.S. FOIA] stated, "We will usually put the pharmacy recommendation reports in the physician folder. Sometimes they don't check them. My expectation is they are reviewed in a timely manner." NJAC 8:39-29.3	F0756		10/10/2025
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all	F0842	The care plan for Resident #7 was corrected to reflect the correct class of medication. The [NJ Exec Order 20.4b] precautions order for Resident #64 was revised. The Director of Nursing provided individual education for Registered Nurse 1 who entered the inaccurate [NJ Exec Order 20.4b1] result in Resident #70's chart. All residents have the potential to be affected. The Assistant Director of Nursing inserviced nurses on the policy and procedure for Charting and Documentation, focusing on importance of accurate entries in the medical record. The Assistant Director of Nursing and/or Unit Managers will audit 10 charts weekly for 30 days and then 5 charts weekly for 60 days to ensure accurate entries in the medical record. Results of the audits will be discussed by the Assistant Director of Nursing at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team and adjustments made to the plan of care.	10/10/2025

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F0842 SS = D	Continued from page 47 information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F0842		10/10/2025

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F0842 SS = D	Continued from page 48 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and review of facility policy, the facility failed to ensure the medical record was complete and accurate for three residents (Residents (R)7, R64, and R70) out of total sample of 35 residents reviewed. This failure had the potential for the resident's health status not be accurate, complete, and possibly create unmet care needs. Findings include: Review of the facility policy titled, "Charting and Documentation," dated July 2017 revealed, "…Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate…" 1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed that R7 was admitted to the facility with a diagnosis that included NJ Exec Order 26.4b1. Review of the [redacted] "Comprehensive Care Plan" located in the "Care Plan" tab of the EMR revealed, "I use [redacted] medication [a class of medications used to treat [redacted] disorders, such as [redacted] and [redacted] r/t [related to] NJ Exec Order 26.4b1 [redacted] Review of the EMR did not show documentation that R7 had a diagnosis of [redacted] or was being administered an [redacted] medication. During an interview on 09/10/25 at 10:28 AM, [redacted] U.S. FOIA (b)(6) asked if R7 was taking an [redacted] medication for [redacted], per the "Care Plan." The [redacted] stated, "No, that was an error and should have been [redacted] instead of [redacted] and [redacted] did not have a diagnosis of [redacted]." 2. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed R64 was admitted to the facility on [redacted] with a diagnosis that	F0842		10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315518	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD , SOUTH AMBOY, New Jersey, 08879

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F0842 SS = D	Continued from page 49 included NJ Exec Order 26.4b1 Review of the "Order Summary" located in the "Orders" tab of the EMR revealed, "[redacted] precautions…No water from the sink or foam cup at bedside. May drink bottled water…" Review of the "Order Summary" located in the "Orders" tab of the EMR revealed, "[redacted]] diet, [redacted] texture, [redacted] consistency." Review of the [redacted] "Nutrition Care Plan" located in the "Care Plan" tab of the EMR revealed, "R64 is at risk of [redacted] …dependence on [redacted]] regimen for [redacted] …" Interventions included, but not limited to: Provide [redacted] as ordered: Currently on [redacted] Daily…Q8H [every eight hours]." Date initiated on [redacted]. During an interview on 09/09/25 at 2:15 PM, the [redacted] was shown the "Order" for bottled water and stated, "This is an error. The [redacted] wrote that order and it is inaccurate as [redacted] is [redacted]." 3. Review of R70's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on [redacted]. Review of R70's EMR titled physician "Orders" located under the "Orders" tab dated [redacted] indicated the resident was to receive [redacted] before meals and at bedtime by sliding scale as follows: [redacted] and to call the physician if the resident's [redacted] was less than [redacted] units; [redacted] and to call the resident's physician if the resident's [redacted] was greater than [redacted] Review of R70's EMR titled admission "Minimum Data Set (MDS)" located under the "MDS" tab with an Assessment Reference Date (ARD) of [redacted] out of 15 which revealed the resident was NJ Exec Order 26.4b1. The assessment indicated the resident took [redacted] Review of R70's EMR titled "Medication Administration Record (MAR)" located under the "Orders" tab for the month of [redacted] revealed the	F0842		10/10/2025

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F0842 SS = D	Continued from page 50 resident had a [NJ Exec Order 26.4b1] result of [NJ Exec Orde] on [NJ Exec Order 26] and on [NJ Exec Order 26,] at 11:00 AM. Review of R70's EMR titled "MAR" located under the "Orders" tab for the month of [NJ Exec Or] revealed the resident had [NJ Exec Order 26.4b1] result of [NJ Exec Or] on [NJ Exec Order 26]. Review of R70's EMR titled nursing "Progress Notes" located under the "Prog Note" tab failed to contain corresponding documentation of the abnormal [NJ Exec Order 26.4b1] results. During an interview on 09/10/25 at 8:16 AM, the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)]) confirmed the [NJ Exec Order 26.4b1] entry for R70 was incorrect. During an interview on 09/10/25 at 8:17 PM Registered Nurse (RN) 1 confirmed the data entry error and stated she was unaware that there was a code for unapplicable since R70 did not require [NJ Exec Orde]. NJAC 8:39-4.1(a) NJAC 8:39-5.1(a)	F0842		10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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VENETIAN CARE & REHABILITATION CENTER, THE	**275 JOHN T O'LEARY BOULEVARD , SOUTH AMBOY, New Jersey, 08879**

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		10/10/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each	S0560	No residents were negatively affected. The staffing coordinator or designee conducts an ongoing staffing analysis by shift to determine the amount of licensed nursing staff required by regulatory requirements to meet the care needs of the residents based on daily census and is used to ensure additional staff are scheduled to cover call outs. All residents have the potential to be affected by the process. The Staffing Coordinator was inserviced by the Director of Nursing regarding the required CNA staffing ratios. The Administrator contacted the facility Recruiter to inform them of the facilities needs. The Administrator and the Recruiter have a weekly call to discuss needs and strategize to fill open positions. The Staffing Coordinator and Director Of Nursing will meet daily to review staffing for the upcoming days to ensure proper staffing ratios based on census. A software platform is utilized by the facility which enables the off shift supervisors and nurse managers who are interested in picking up additional shifts. Referral bonuses are offered for current employees who support filing vacant shifts as well as retaining current staff. Sign on bonuses are offered for all new CNAs. The Administrator will review the minutes from resident council meetings on a monthly basis to determine whether there are concerns with care related to staffing. The Administrator audits staffing ratios on the online platform on a daily	10/10/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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S0560	Continued from page 1 direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -08/24/25 had 6 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/24/25 had 12.5 total staff for 136 residents on the evening shift, required at least 14 total staff. -08/25/25 had 8 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/26/25 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/27/25 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/28/25 had 11 CNAs for 141 residents on the day shift, required at least 18 CNAs. -08/29/25 had 10 CNAs for 138 residents on the day shift, required at least 17 CNAs. -08/30/25 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/31/25 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -09/01/25 had 14 CNAs for 135 residents on the day shift, required at least 17 CNAs. -09/02/25 had 11 CNAs for 134 residents on the day shift, required at least 17 CNAs. -09/03/25 had 10 CNAs for 133 residents on the day shift, required at least 17 CNAs. -09/04/25 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -09/05/25 had 9 CNAs for 133 residents on the day shift, required at least 17 CNAs.	S0560	Continued from page 1 basis. Results of these audits will be reviewed by the Administrator at the QAPI meeting monthly for a period of three months and any variances will be reviewed by the committee and revisions to the plan will be completed.	10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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S0560	Continued from page 2 -09/06/25 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs.	S0560		10/10/2025
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 08/24/2025 to 09/06/2025, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 14 days. The	S1680	No residents were negatively affected. The staffing coordinator or designee conducts an ongoing staffing analysis by shift to determine the amount of licensed nursing staff required by regulatory requirements to meet the care needs of the residents based on daily census and acuities is used to ensure additional staff are scheduled to cover call outs. All residents have the potential to be affected by the process. The Staffing Coordinator was inserviced by the Director of Nursing regarding the required CNA staffing ratios and to factor in acuities for nursing. The Administrator contacted the facility Recruiter to inform them of the facilities needs. The Administrator and the Recruiter have a weekly call to discuss needs and strategize to fill open positions. The Staffing Coordinator and Director Of Nursing will meet daily to review staffing for the upcoming days to ensure proper staffing ratios based on census and acuities. A software platform is utilized by the facility which enables the off shift supervisors and nurse managers who are interested in picking up additional shifts. Referral bonuses are offered for current employees who support filing vacant shifts as well as retaining current staff. Sign on bonuses are offered for all new CNAs. The Administrator will review the minutes from resident council meetings on a monthly basis to determine whether there are concerns with care related to staffing. The Administrator audits staffing ratios on the online platform on a daily basis. Results of these audits will be reviewed by the Administrator at the QAPI meeting monthly for a period of three months and any variances will be reviewed by the committee and revisions to the plan will be completed.	10/10/2025

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S1680	Continued from page 3 required staffing hours and actual staffing hours are as follows: For the week of 08/24/25 Required Staffing Hours: 387.75 -08/24/25 had 300 actual staffing hours, for a difference of -87.75 hours.	S1680		10/10/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/26/2025 in relation to the 9/11/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		12/26/2025

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

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/26/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/26/2025 in relation to the 9/11/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		12/26/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315518	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - VENETIAN** B. WING	(X3) DATE SURVEY COMPLETED **09/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 09/09/25 and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 existing Health Care Occupancies. Venetian Care & Rehabilitation Center is a four-story building built in 2007. It is composed of Type I protected construction. The facility is divided into 12 - smoke zones. The generator powers 100% of the building per the U.S. FOIA (b)(6). The current occupied beds are 136 of 180.	K0000		10/15/2025
K0311 SS = F Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure stairway	K0311	There was no adverse reaction due to the door having the incorrect hardware installed. All residents have the potential to be harmed by the deficient practice. The facility contracted a vendor to install the correct hardware to the door. The installation was completed on 9/26/2025. The administrator or designee will audit all fire doors monthly to ensure that the correct hardware is present. The audits will take place x 3 months. The results of the audit will be presented during the QAPI meetings.	09/26/2025

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

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K0311 SS = F Bldg. 01	Continued from page 1 fire doors were equipped with fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) section 7.2.1.7.2 and NFPA 80 for one of 12 stairway fire doors. This deficient practice had the potential to affect all 136 residents and was evidenced by the following: An observation on 09/09/25 from 12:30 PM to 5:00 PM revealed that panic hardware was installed on one of 12 stairway fire doors and not the required fire exit hardware. The one stairway fire door with the incorrect hardware installed was the stairway on the first floor across from the recycle room. During an interview at the time of observations, the U.S. FOIA (b)(6) confirmed that the panic hardware was on the fire door. NJAC 8:39-31.2(e) NFPA 80	K0311		09/26/2025
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K0324	There was no adverse reaction due to the kitchen automatic extinguishing system not having been inspected. All residents have the potential to be harmed by the deficient practice. The facility contacted a vendor to conduct the inspection of the kitchen automatic extinguishing system. The inspection will take place by 10/15/25. The administrator or designee will monitor the life safety book monthly x 3 months to ensure that all the documentation is there. The results of these audits will be reviewed by the QAPI meeting.	11/06/2025

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VENETIAN CARE & REHABILITATION CENTER, THE	**275 JOHN T O'LEARY BOULEVARD , SOUTH AMBOY, New Jersey, 08879**

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K0324 SS = F Bldg. 01	Continued from page 2 This STANDARD is NOT MET as evidenced by: Based on document review, and interview, it was determined that the facility failed to ensure the kitchen's automatic extinguishing system (AES) was inspected and tested every six months in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition) section 11.2.1. This deficient practice had the potential to affect all 136 residents and was evidenced by the following: A review of the facility's fire safety binder for 2024 and 2025 revealed the kitchen automatic extinguishing system was inspected on 08/15/24 and 12/19/24 but no inspection was conducted in 2025. During an interview on 09/09/25 at 4:30 PM, the U.S. FOIA (b)(6) confirmed the automatic extinguishing system was not tested in 2025. The U.S. FOIA (b)(6) stated that they were having an issue with the automatic extinguishing system contractor for the first part of the year. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K0324		11/06/2025
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K0353	There was no adverse reaction to the facility having not conducted the quarterly sprinkler inspection or the annual inspection of the standpipe system. All residents have the potential to be harmed by the deficient practice. The facility contacted a vendor to conduct the annual inspection of the standpipe system. The inspection will take place by 10/15/2025. The facility can't retroactively conduct the inspection of the quarterly sprinkler inspection that was missing for the first quarter of 2025. The administrator or designee will monitor the life safety book monthly x 3 months to ensure that all the documentation is there. The results of these audits will be reviewed by the QAPI meeting.	10/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315518	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - VENETIAN** B. WING	(X3) DATE SURVEY COMPLETED **09/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0353 SS = F Bldg. 01	Continued from page 3 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on document review and interview, it was determined that the facility failed to ensure the sprinkler system's control valves, water flow alarms, and tamper switches or supervisory signals were inspected and/or tested quarterly, standpipe systems shall be inspected annually in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems (2011 Edition) section 5.1.1.2, 5.1.1.2 Table and 6.1.1.2 Table. This deficient practice had the potential to affect all 136 residents and was evidenced by the following: A review of the facility's fire safety binder for 2024 and 2025 revealed the sprinkler system had an annual inspection on 07/28/25, quarterly inspections on 05/21/25 and 12/18/24; however, there was no documented evidence a quarterly inspection was completed for the first quarter of 2025. Further review of the facility's fire safety binder for 2024 and 2025 revealed the standpipe system had an annual inspection of 01/2024; however, there was no documented evidence that an annual inspection was completed in the first quarter of 2025. During an interview on 09/09/25 at 4:30 PM, the U.S. FOIA (b)(6) confirmed the sprinkler system was not tested in the first quarter of 2025, and the standpipe system was not inspected in the first quarter of 2025. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K0353		10/15/2025
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is	K0712	No adverse reaction was noted due to the facility having failed to conduct the fire drills on the third shift of the second quarter, first shift of the second quarter and the third shift of the third quarter of 2025. All residents have the potential to be affected by the deficient practice.	10/15/2025

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K0712 SS = F Bldg. 01	Continued from page 4 aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure fire drills were conducted quarterly on each shift in accordance with NFPA 101 Life Safety Code (2012 Edition) sections 19.7.1.6 and 19.7.1.4. This deficient practice had the potential to affect all 136 residents and was evidenced by the following: A review of the facility's untitled fire drill records revealed for the third shift of the second quarter, first shift of the second quarter and the third shift of the third quarter of 2025, there was no documented evidence that fire drills were conducted. During an interview on 09/09/25 at 4:30 PM the U.S. FOIA (b)(6) confirmed that the fire drills were not conducted on the third shift for the second and third quarter and the first shift of the second quarter. NJAC 8:39-31.2(e)	K0712	Continued from page 4 The facility can't retroactively conduct the fire drills that were missing. The U.S. FOIA (b)(6) was educated by the Administrator on the importance of conducting fire drills on all shifts for all quarters. The facility is currently up to date on their fire drill schedule. The Administrator or designee will audit the fire drills monthly x 3 months to ensure that the fire drills are being conducted on all shifts. Results of the audits will be discussed by the Administrator at the monthly QAPI meetings for a period of three months, any variances will be reviewed by the team.	10/15/2025

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 09/09/25. The facility was found to be in compliance with 42 CFR 483.73	E0000		10/15/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315518	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - VENETIAN** B. WING	(X3) DATE SURVEY COMPLETED **02/11/2026**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 2/11/2025 in relation to the 9/11/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		02/11/2026

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

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