

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW BEGINNINGS ADULT DAY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4 CROSSROAD DRIVE, SUITE #108 HAMILTON, NJ 08619		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments Type of Survey: Monitoring/Follow-up Census: 96 (2) Morning Sessions Sample Size: 6 On 9/4/2025, the Department of Health conducted a follow-up survey regarding the Office of the Inspector General's audit that was conducted on 7/30/2024. The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 221	8:43F-3.1(a) Administration The license holder shall appoint an administrator who is a full-time employee of the facility. The administrator, or an alternate who shall be designated in writing to act in the absence of the administrator, shall be available on the premises of the facility during the hours when participant care services are being provided.	M 221		

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

TITLE

(X6) DATE

10/17/25

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M 221	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and observation, it was determined that the facility failed to have an Alternate Administrator documented in writing. This deficient practice was evidenced by the following: At 9/4/25 at 9:00 a.m., upon entrance to the facility, the surveyor was greeted by the Registered Nurse (RN). When the surveyor asked for the Administrator or who was in charge, she stated that the Administrator was on her way, and she was in charge since 7:00 a.m. In the same interview, the surveyor asked for the Alternate Administrator, the RN stated that was the Director of Nursing (DON), who was on her way too. At 9:20 a.m., the DON arrived. When the surveyor asked her who was the Alternate Administrator, the DON stated that she was not, and she was unsure who was the Alternate Administrator. At 9:30 a.m., the Administrator arrived. At 10:05 a.m., during the entrance conference, when the surveyor asked about who the Alternate Administrator was, the Administrator stated it was the RN; however, it was not in writing, but posted at the front entrance. The surveyor did not observe the posting at the front entrance. At the time of survey, there was no documented evidence of an Alternate Administrator in writing.	M 221			

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M 235	Continued From page 2	M 235			
M 235	8:43F-3.3(d)(1) Administration (d) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following: 1. A written statement of the program's philosophy and objectives and the services provided by the facility; This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to develop and implement a Policy and Procedure manual. The deficient practice was evidenced by the following: On 9/4/25, at 2:10 p.m., the surveyor reviewed the Policy and Procedure binder provided but did not see any policies. At 2:42 p.m., the surveyor requested the following policies: Emergency Plan, Personnel Records and Staff Training from the Administrator. When	M 235			

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M 235	Continued From page 3 the surveyor asked about staff training, the Administrator stated that there was no particular document on new hire training, she gave the staff a handbook that had a training section. The Administrator continued to say that she was trained by the previous Administrator, and that the [facility] policies referred to the state regulations. In the same interview, the Administrator continued to say that there was no policy on Maintenance of Personnel Records. When the surveyor asked how staff know what to do if there were no policies and if she was not here, the Administrator stated that she told staff. She stated that the Alternate Administrator told the Director of Nursing (DON) verbally, but it was not in writing. When the surveyor asked about the Emergency Plan Policy, the Administrator showed a list of the emergency team and stated that the facility followed the state regs [regulations] 8:43F. At 3:09 p.m., the Administrator provided on facility letterhead a list of "Title 8: Health Chapter 43F. Standards for Licensure of Adult Day Health Services Facilities" listing the regulations: 8:43F-1.1 to 8:43F-18.3 as her policies. At the time of this 9/4/25 follow up survey and the Office of the Inspector General survey on 7/30/24, the facility did not have any written policies on Maintenance of Personnel Records and the Emergency Plan.	M 235		
M 409	8:43F-6.3(a)(1) General Services "Reasonable efforts" shall include, but not be limited to, an inquiry on the employment	M 409		

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M 409	Continued From page 4 application, reference checks, and/or criminal background checks when necessary for compliance with N.J.A.C. 8:43F-2.1(a)8. This REQUIREMENT is not met as evidenced by: Based on interview and record review, during the 8/13/24 Office of the Inspector General survey, it was determined that the facility failed to ensure that a background check or a check of references were completed upon hire for 5 of 8 sampled employees and a job application for was completed for 1 sampled employee, This deficient practice was evidenced by the following: 1. On 9/4/25 at 10:05 a.m., the surveyor requested the staff list with job title, date of hire and license/certifications with expiration dates on the entrance guide. At 11:00 a.m., the surveyor requested the staff list a 2nd time with the date of hire. At 11:30 a.m., the surveyor received and reviewed the staff list and requested the Administrator to provide the personnel files for eight (8) specified employees. At 11:40 a.m., the Administrator provided the surveyor with personnel files for the 8 employees.	M 409		

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M 421	Continued From page 6 by: Based on interview and record review, it was determined that the facility failed to do new-hire orientation and/or annual in-service training, during the 9/4/25 survey for 8 of 8 employees reviewed, Employees#s 1, 2 3, 4, 5, 6, 7 & 8 and during the 7/30/24 Office of the Inspector General (OIG) survey 6 of 8 employees (names not provided). This deficient practice as evidenced by the following: 1. On 9/4/25 at 10:05 a.m., the surveyor requested the staff list with job title, date of hire and license/certifications with expiration dates on the entrance guide. At 11:00 a.m., the surveyor requested the staff list a 2nd time with the date of hire. At 11:30 a.m., the surveyor received and reviewed the staff list and requested the Administrator to provide the personnel files for eight (8) specified employees. At 11:40 a.m., the Administrator provided the surveyor with personnel files for the 8 employees. The surveyor reviewed the 8 personnel files and observed that there was no documented evidence of new-hire orientation and/or annual in-service trainings done. The findings were as follows: 1. Employee #1 was hired on NJ Ex Order 26.4 and there was no documented evidence of a new-hire orientation done.. 2. Employee #2 was hired on NJ Ex Order 26.4(b) and there was no documented evidence of a new-hire orientation done.	M 421		

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M 421	Continued From page 7 3. Employee #3 was hired on [NJ Ex Order 26.4] and there was no documented evidence of a new-hire orientation done. This employee was the Director of Nursing (DON). 4. Employee #4 was hired on [NJ Ex Order 26.4] and there was no documented evidence of a new-hire orientation done. 5. Employee #5 was hired on [NJ Ex Order 26] and the in-service and there was no annual trainings conducted in 2023 done. 6. Employee #6 was hired on [NJ Ex Order 26.4] and there was no documented evidence of a new-hire orientation done. 7. Employee #7 was hired on [NJ Ex Order 26] and there was no documented evidence of a new-hire orientation done. 8. Employee #8 was hired on [NJ Ex Order 26.4] and there was no documented evidence of a new-hire orientation and annual in-service trainings done for [NJ Ex Order 26.4]. This employee was the Administrator. At 9:20 a.m., when the surveyor asked about trainings due, the Director of Nursing (DON) stated that trainings were done on paper and [staff] sign off when done. She continued to say that trainings were frequent, infection control [training] was every 3 months. At 10:05 a.m., during the entrance conference, the Administrator stated that the trainings and in-services were done on paper. In the same interview, when the surveyor asked her who was responsible for the employee files, the Administrator stated that she was responsible.	M 421		

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M 421	Continued From page 8 At 11:15 a.m., the surveyor asked how the Adminsitrator knew if staff was due for training, the Administrator stated that she visually observed staff, for example, if hand washing was needed, she did training. She continued to say that the fire [drill] was annual training, hand washing was quarterly, and she did new hire employee mandatory training during orientation and yearly. At 12:13 p.m., the Administrator stated that staff hired before she started as the Administrator, she did not touch [update] their employee files. At 2:42 p.m., when the surveyor asked about the new-hire orientation, the Administrator stated that there was no particular document that says new hire training and the mandatory training was also in the employee handbook, she just gave staff an [employee] handbook that had a training section. In the same interview, when the surveyor requested Maintenance of Personnel Records and Staff Training Policies, the Administrator stated the facility did not have these policies. At 3:35 p.m, the surveyor observed the annual in-service trainings binder for the mandatory in-services done in 2019, 2020; May, June, August & September of 2024 and August of 2025. 2. At the time of the 7/30/24 OIG survey, 6 of 8 employees (no names provided) selected did not have a new hire orientation and no annual trainings were provided for any of the employees.	M 421			
M 423	8:43F-6.3(f) General Services Employee health records as required by these rules shall be maintained for each employee.	M 423			

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M 423	Continued From page 9 Employee health records shall be confidential and kept separate from personnel records and shall include documentation of all medical screening tests performed and the results. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that employees were provided a physical examination and/or were screened for NJ Ex Order 26.4(b)(1) upon hire for 3 employees selected for review on the 7/30/24 Office of the Inspector General (OIG) survey. This deficient practice was evidenced by the following: 1. On 9/4/25 at 10:05 a.m., the surveyor requested the staff list with job title, date of hire and license/certifications with expiration dates on the entrance guide. At 11:00 a.m., the surveyor requested the staff list a 2nd time with the date of hire. At 11:30 a.m., the surveyor received and reviewed the staff list and requested the Administrator to provide the personnel files for eight (8) specified employees. At 11:40 a.m., the Administrator provided the surveyor with personnel files for the 8 employees. The surveyor reviewed the 8 personnel files and observed that there was documented evidence that the (8) employees had received a physical examination and/or NJ Ex Order 26.4(b)(1). 2. During the OIG survey on 7/30/24, (1)	M 423		

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M 423	Continued From page 10 employee had no evidence of a physical examination performed and (3) employees selected for review had no evidence of NJ Exec Order 26.4(b)(1) . Employee names were not provided for further review.	M 423		
M 679	8:43F-14.17(b) Physical Plant Requirements The facility shall maintain emergency equipment, including at a minimum, oxygen, suction, airway and ambubag. This REQUIREMENT is not met as evidenced by: Based on interview and observation, during the 7/30/24 Office of the Inspector General (OIG) survey, it was determined that the facility failed to have an NJ Exec Order bag (a device used for positive pressure ventilation to help patients breathe by delivering room air or oxygen into their lungs) available and attached to the emergency equipment. This deficient practice was evidenced by the following: 1. During the 9/4/25 survey, while on tour, the surveyor observed an NJ Exec Order bag attached to the oxygen tank on the emergency equipment. At 9:50 a.m., when the surveyor asked the Director of Nursing (DON) about the protocol for the NJ Exec Order bag, she stated that she checked the emergency equipment daily and that there was no log maintained.	M 679		

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M 679	Continued From page 11 2. In the same interview, the DON stated at the time of the 7/30/24 OIG survey, she informed the federal surveyors that the [redacted] bag was cracked, and was on order and the facility had a manual [redacted] bag on the [medication] cart and that the staff would call 911 and send participants to the hospital down the street.	M 679		
M 701	8:43F-15.3(a)(1) Medical Records (a) The participant's complete medical record shall include, but not be limited to, the following: 1. Participant identification data, including name, date of admission, address, date of birth, race, religion (optional), sex, referral source, payment plan, marital status, and the name, address, and telephone number of the person(s) to be notified in an emergency, and travel directions to the participant's home; This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that during the 7/30/24 Office of the Inspector General (OIG) survey, the facility failed to provide an emergency contact information for 1 participant (no name provided) selected, failed to provide a participant rights document for 1 participant (no name provided) selected and failed to provide 3 out of 4 participants (no names	M 701		

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M 701	Continued From page 12 provided) selected photographs in their files. This deficient practice was evidenced by the following: 1. 9/4/25 at 10:05 a.m., the surveyor requested a census for the participants. At 11:39 a.m. the surveyor received the participant roster. At 12:07 p.m., when the surveyor asked about the participant files, the Social Worker (SW) stated that he ensured the emergency contact information, and the Participant Rights document was signed. He continued to say that Activities staff did the [participant] photo. At 2:00 p.m., the surveyor reviewed 6 of 6 participant, Participant#s 1, 2, 3, 5, & 6 files and each participant had a photograph, an emergency contact to include: name, address and phone number and a signed "Participant Rights Agreement."	M 701			
M 813	8:43F-16.7(a)(1-23) Infection Control, Santation, Housekeeping (a) The following housekeeping, sanitation, and safety conditions shall be met: 1. The facility and its contents shall be free of dirt, debris, and insect and rodent harborages; 2. Nonskid wax shall be used on all waxed floors;	M 813			

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M 813	Continued From page 13 3. All rooms shall be ventilated to help prevent condensation, mold growth, and noxious odors; 4. All participant areas shall be free of noxious odors; 5. Throw rugs or scatter rugs shall not be used in the facility; 6. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Equipment shall be kept covered to protect from contamination and accessible for cleaning and inspection. Broken or worn items shall be repaired, replaced, or removed promptly; 7. All equipment shall have unobstructed space provided for operation; 8. All equipment and materials necessary for cleaning, disinfecting, and sterilizing shall be provided; 9. Thermometers which are accurate to within three degrees Fahrenheit shall be maintained in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration; 10. Pesticides shall be applied in accordance with N.J.A.C. 7:30; 11. Articles in storage shall be elevated from the floor and away from walls; 12. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room that is used for no other purpose;	M 813		

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M 813	Continued From page 14 13. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement; 14. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in closed metal cabinets or containers; 15. Unobstructed aisles shall be provided in storage areas; 16. A program shall be maintained to keep rodents, flies, roaches, and other vermin out of the facility; 17. Toilet tissue, soap dispenser, paper towels or air dryers, and waste receptacles shall be provided in each bathroom at all times; 18. All solid or liquid waste that is not regulated medical waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey Department of Environmental Protection and the New Jersey Department of Health and Senior Services. Solid waste shall be stored in insect-proof, rodent-proof, and fire-proof, non-absorbent, watertight containers with tight-fitting covers and collected from storage areas regularly, so as to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24; 19. Garbage compactors shall be located on an	M 813			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
M 813	Continued From page 15 impervious pad that is graded to a drain. The drain shall be unobstructed and connected to the sanitary sewage disposal system; 20. Plastic bags shall be used for solid waste removal. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal; 21. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof; 22. Wastebaskets and ashtrays shall be made of noncombustible materials; 23. Latex foam pillows shall be prohibited; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure a safe environment was provided to its participants, including trip-hazards, flammable, accessible toxic/poisonous chemicals, and broken/damaged materials inside the facility building. This was evidenced by the following:	M 813			

New Jersey Department of Health

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M 813	Continued From page 16 1. During the survey tour on 9/4/25, the surveyor observed the following: a) At 9:07 a.m., a large black rectangular throw rug upon entrance into the facility and wires hanging from the time clock in the entry area. b) At 9:15 a.m., while on tour with the Registered Nurse (RN), the surveyor observed a can of paint in an unlocked coat closet in the hallway. c) At 9:18 a.m., the surveyor observed wires hanging from the TV in the participant area. d) At 9:30 a.m., the tour continued with the Director of Nursing (DON) and Administrator, the surveyor observed quiet room #1 with an unlocked cabinet filled with ladders and electrical wires. e) At 9:40 a.m., when the surveyor asked why the closet was unlocked, the Administrator stated that it was always unlocked by the landlord, who came twice a week to inspect it. f) At 9:43 a.m., the surveyor observed an unlocked janitor closet, located in the auditorium/activity area. The surveyor observed the following products inside the unlocked janitor closet: multiple bottles of multi-surface cleaner, rust stain remover, degreaser, (3) bottles of bactericide, bottle of heavy duty drain cleaner, (2) rags, bucket and (2) mops. g) At 9:46 a.m., when the surveyor asked why the janitor closet was unlocked, the DON stated that she did not know. h) At 9:50 a.m., when the surveyor asked about if	M 813		

New Jersey Department of Health

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M 813	Continued From page 17 she saw a broken handle on a cabinet door, what would she do, the DON stated that she told the Administrator and there was no log. i) At 10:05 a.m., during an interview with the Administrator, she stated that if anything was broken, staff told her and the owner came every 2 weeks to do repairs and there was no log. j) At 3:09 p.m., the surveyor asked the Administrator about the paint in the unlocked coat closet in the hallway, she stated that the paint should not be in the closet, and she thought the owner left the paint there as she was not aware of it. In the same interview, when the surveyor requested policies, the Administrator stated that the facility policies followed the [state] regulations. k) At 4:06 p.m., when the surveyor asked the Administrator about the entrance rug, she stated that it was a new rug, and it was not always there. In the same interview, when the surveyor asked about the unlocked janitor closet, the Administrator stated that she agreed the janitor closet should be locked. 2. On 7/30/24, the surveyors provided a photograph of their observations: throw rugs throughout the facility, broken cabinet doors, missing or damaged cabinet door handles, an open closet with various toxic chemicals: car coolant, deicer, brake/power steering fluid and all-purpose cleaner and multiple bottles of Butane fuel in the activity area.	M 813			
M 825	8:43F-17.1(c)(d)(e) Transportation Services (c) Vehicles shall be maintained in safe operating order.	M 825			

New Jersey Department of Health

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M 825	Continued From page 18 (d) The facility shall maintain insurance on the vehicles. (e) The facility shall comply with all applicable Department of Transportation rules promulgated under N.J.S.A. 39:1-1 et seq. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, it was determined during the 7/30/24 Office of the Inspector General (OIG), it was determined that the facility failed to update inspection stickers on all vehicles and during the 9/4/25 survey, the facility failed to provide fire extinguishers on all transit buses and on the 7/30/24 OIG survey failed to provide a current fire extinguisher. This deficient practice was evidenced by the following: At 9:20 a.m., when the surveyor asked about the vehicles, the Director of Nursing (DON) stated that the vehicles were the facility's, and they were not contracted. At 10:05 a.m., during the entrance conference, the Administrator stated that the transportation is the facilities, not contracted. She continued to say that there are (13) vehicles that included (4) transit buses.	M 825			

New Jersey Department of Health

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M 825	Continued From page 19 At 10:38 a.m., in the presence of the Driver and the Administrator, the surveyor observed a grey transit bus and a minivan without fire extinguishers. At the same time, the surveyor observed both vehicles were current with their inspection stickers. At 10:40 a.m., when the surveyor asked about the fire extinguishers, the Administrator stated that there should be a fire extinguisher on the bus, and she did not know why there was not one. At 10:44 a.m., the surveyor interviewed the Operations Manager (OM), who was previously the Transportation Manager, she stated that she was responsible for the inspection stickers, the next due date was 11/2025 and she had a copy of each of the registrations for each vehicle. At 10:56 a.m., the Administrator provided a list of (13) vehicles with Vehicle Identification Numbers (VIN). At 11:00 a.m., the OM stated that she was not in charge of the fire extinguishers on the vehicles. She continued to say that the drivers would know if a fire extinguisher was not on a vehicle. When the surveyor asked about the grey transit bus without the fire extinguisher, the OM stated that the bus was new and only a year old, so there was no fire extinguisher on the bus since January 2025. The OM continued to say that it would be kept in the trunk area. At 11:15 a.m., the surveyor requested a list of the vehicles with inspection dates. At 11:22 a.m., the surveyor interviewed the driver of the mini-van about the inspection sticker, he	M 825			

New Jersey Department of Health

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M 825	Continued From page 20 stated that he looked at the inspection sticker before driving the vehicle and he notified the OM if it was due. At 11:30 a.m., the Administrator stated that she bought fire extinguishers today for all of the vehicles and there was no master list kept of the inspection stickers. At 11:40 a.m., the OM confirmed to the surveyor that none of the transit buses had fire extinguishers; she did not know why. She continued to say that she purchased fire extinguishers today. In the same interview when the surveyor asked if fire extinguishers were needed on the vehicles, the OM stated that yes, transit buses needed fire extinguishers, (2) of the buses were fairly new and it was her fault that she did not think of it. At 12:39 p.m., the surveyor in the presence of the OM, observed all the inspection stickers of the vehicles were current. The OM stated she kept all the inspection stickers up to date. During the 7/30/24 OIG survey, a white vehicle was observed with an expired inspection sticker of 6/2024. At 1:15 p.m., when the surveyor asked the OM about this vehicle, she stated that the inspection sticker was not updated because the car was not in use, and it was being sold as junk due to not having a good transmission.	M 825			



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Participants Chart

Plan of Correction (POC)

Facility Name: New Beginnings Adult Day Care

Administrator: NJ Ex Order 26.4(b)(1)

Date Submitted: 12/02/2025

The following Plan of Correction is submitted in response to the deficiencies cited by the New Jersey Department of Health. All corrections and monitoring activities will be under the supervision of the Administrator.

1) Plan of Correction for - M221 (Alternate Administrator)

1. Corrective Action Taken for the Deficient Practice: Although no participants experienced actual harm, participants were affected because the deficient practice had the potential to impact their health, safety, and well-being due to the lack of a clearly documented Alternate Administrator in the Administrator's absence. Hence, the facility's administrative coverage policy has been revised to include formal, written documentation of chain-of-command and Alternate Administrator assignments. This documentation is now part of the facility's emergency preparedness and organizational policies. All relevant leadership staff have been educated on the new procedure. These policies are reviewed on 9/5/2025. The written delegation was discussed with the staff on 9/8/2025 wherein all staff are present and signed the organizational structure and Chain of command in the absence of the Administrator. Signed copy of this organizational structure is kept in the employee's personnel file.

2. How the Facility Identified Others Who Could Be Affected: The deficiency was systemic in nature and did not directly impact the participants. However, the leadership structure and coverage policies were reviewed to ensure there are no other roles lacking written delegation.

3. Systemic Changes Made to Prevent Recurrence: The facility immediately documented in writing on 9/5/2025 that the Registered Nurse (RN) will serve as the Alternate Administrator in the absence of the Administrator. Additionally, it

POC # 94
accepted
12/2/25



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Participants Chart

was documented that the Director of Social Services will serve as a secondary alternate when both the Administrator and RN are unavailable in the building again on 9/5/2025. The facility's administrative coverage policy has been revised to include formal, written documentation of chain-of-command and Alternate Administrator assignments. This documentation is now part of the facility's emergency preparedness and organizational policies. All relevant leadership staff have been educated on the new procedure. These policies are reviewed on 9/5/2025. The written delegation was discussed with the staff on 9/8/2025 wherein all staff are present and signed the organizational structure and Chain of command in the absence of the Administrator

4. Monitoring to Ensure Ongoing Compliance: A copy of the signed designation will be kept in the Administrator's office and updated as every time there is an absence of the Administrator or the RN.

Date of Completion: 09/08/2025



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Participants Chart

2) Plan of Correction for- M235 (Policy manual & procedures/Organizational Documents)

1. Corrective Action Taken for the Deficient Practice:

No participants were referenced in the cited deficiency. Although no participant experienced actual harm, participants were affected because the absence of a complete and accessible policy manual created the potential for inconsistent practices that could compromise the safety, quality, and reliability of services delivered. On 09/16/2025, the Administrator developed and organized a comprehensive written statement outlining the facility's program, philosophy, objectives, vision, mission and services provided. In addition, a complete policy and procedure manual was developed, including key policies such as emergency planning, personnel records, and staff training. The manual is now available on-site for Department of Health to review at any time.

2. How the Facility Identified Others Who Could Be Affected:

This was a facility-wide systemic issue. Although no participants experienced harm, all participants had the potential to be affected because the absence of a complete and accessible policy manual could impact consistent application of procedures related to safety, emergency response, documentation, and service delivery. The Administrator conducted a full review of all operational areas to ensure no other critical policies or procedures were missing or outdated.

3. Systemic Changes Made to Prevent Recurrence:

A formal policy review schedule has been implemented, requiring the Administrator or designee to review the policy manual every year in December or sooner if changes occur or if there are any amendments or any newsletter received or changes implemented directly from Department of Health. Each review will be documented in a tracking log. In addition, the updated manual has been placed on the internal shared drive and a physical copy is stored in the Administrator's office for immediate access by staff.



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Participants Chart

4. Monitoring to Ensure Ongoing Compliance:

The Administrator will conduct yearly audits to ensure the policy manual remains current, accessible, and reflective of operational practices. Documentation of each review will be maintained and made available for Department verification.

Date of Completion: 09/16/2025



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Participants Chart

3) Plan of Correction for-M409 (Background Checks)

1. Corrective Action Taken for the Deficient Practice: On 09/16/2025, the Administrator conducted a full review of all current employees' files. Criminal background checks were obtained for all staff who did not previously have documentation on file, and copies were placed in each employee's personnel file.

2. How the Facility Identified Others Who Could Be Affected: As this was a facility-wide oversight based on a misunderstanding of the regulatory requirements, all current staff were considered potentially affected. A complete audit of personnel files was conducted to ensure compliance for every employee.

3. Systemic Changes Made to Prevent Recurrence:

The Administrator has implemented a policy requiring that all employees — not just key staff — must have a completed criminal background check on file prior to their first day of employment. This policy aligns with the requirements of 8.43F and is now part of the facility's hiring checklist and onboarding process.

4. Monitoring to Ensure Ongoing Compliance:

The Administrator or Alternative Administrator will review personnel files during the first month of new hires and then onwards every year for all employees at New Beginnings adult Day Care. A hiring compliance checklist log will be maintained and will be accessible to the department at all times. This log will include but not limited to their license's expiration dates or any renewals.

Date Of Completion:09/16/2025



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Participants Chart

4) Plan of Correction- M421(Orientation and training)

1. Corrective Action Taken for Affected Individuals: No participants were referenced in the cited deficiency. Although no participant experienced actual harm, participants were affected because the deficient practice created the potential for inconsistent staff preparedness, which could impact the safety, quality, and continuity of participant services.

The Administrator conducted and documented in-service training for all current employees to address gaps in orientation and ongoing education. Training included core topics such as participant care, client rights, abuse and neglect prevention, safety practices, facility protocols, and emergency procedures.

2. Identification of Others Potentially Affected:

All staff were identified as potentially affected, as the absence of a formal orientation and in-service training program had the potential to impact the quality and consistency of services provided to all participants. The Administrator ensured that all departments participated in the corrective training process.

3. Systemic Changes Made to Prevent Recurrence:

The Administrator developed and implemented a formal written policy outlining the staff training and orientation program, which includes:

- Initial new-hire orientation
- Quarterly in-service training sessions
- Annual mandatory training for all staff

The policy designates the Administrator (or Alternate Administrator) as responsible for coordinating, scheduling, and tracking staff training and education.

All training records and related policies are now maintained in a centralized binder located in the Administrator's office and are accessible to the Department of Health and Senior Services at all times.



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Participants Chart

4. Monitoring to Ensure Ongoing Compliance:

The Administrator will maintain the training log and conduct monthly audits to ensure compliance with orientation and training requirements.

A checklist has been implemented to ensure each new employee receives orientation within their first week, and a quarterly training calendar has been established to ensure required in-service sessions occur consistently.

Date of Completion: 09/20/2025



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Participants Chart

5) Plan of Correction- M423 (Health Records)

1. Corrective Action Taken for Affected Individuals:

No participants were referenced in the cited deficiency. Although no participant experienced actual harm, participants were affected because the deficient practice had the potential to impact the confidentiality and integrity of staff documentation, which supports proper staff qualifications and overall participant safety. All employee health records were immediately removed from personnel files and placed in a locked, confidential cabinet located in the Director of Nursing's office. Access to employee health records is now restricted solely to the Administrator, Alternate Administrator, and Director of Nursing. Each employee health record was reviewed to confirm documentation of all required pre-employment and annual health screenings, including NJ Ex Orde testing results.

2. How the Facility Identified Others Who Could Be Affected:

All staff health records were reviewed to ensure proper maintenance and storage of their health records. While no employee's records were directly affected, participants had the potential to be impacted if staff health documentation was not complete or accessible to verify qualifications and safety compliance.

The Administrator conducted a facility-wide review to ensure all employee health records met the new confidentiality and documentation standards.

3. Systemic Changes Made to Prevent Recurrence:

A new policy titled "Employee Health Record Maintenance" was developed and implemented on 9/15/2025, including:

Health records must be maintained in a separate, clearly labeled folder apart from personnel files.

Records must be stored in a locked cabinet with controlled access.

Only the Administrator, Alternate Administrator, and Director of Nursing may access or release information.



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Participants Chart

Staff were in-serviced on 9/15/2025 regarding this policy, including definitions of confidentiality, HIPAA compliance, and DOH documentation standards. The Administrator and Director of Nursing conducted the in-services.

Moreover, The Administrator (or designee) will conduct a quarterly audit of all employee records to ensure separation and confidentiality are maintained. Any future breach or improper storage will be reported immediately to the Administrator and corrected within 24 hours. Audit results will be reviewed during quarterly Quality Assurance meetings and documented in QA minutes.

4. Monitoring to Ensure Ongoing Compliance:

To ensure no future incompliance occurs, The Administrator will be responsible for Implementing and maintaining compliance with this regulation. Alternate Administrator will be responsible for oversight when the Administrator is absent.

Date of Completion: 09/15/2025



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Participants Chart

6) Plan of Correction: M679(Emergency Equipment)

1. Corrective Action Taken for Affected Individuals:

No participants were referenced in the cited deficiency. Although no participant experienced actual harm, participants were affected because the deficient practice had the potential to compromise timely access to functioning emergency equipment in the event of an emergency. The facility currently has two Ambu bags, two oxygen cylinders, and one manual suction machine available on site. All emergency equipment was inspected and confirmed to be in working condition and readily accessible for immediate use.

2. How the Facility Identified Others Who Could Be Affected:

This was a facility-wide systems issue and did not directly affect any individual participants at the time of the OIG survey. However, the Administrator conducted a review to ensure emergency equipment was available and properly distributed across all relevant care areas.

3. Systemic Changes Made to Prevent Recurrence:

The Administrator has implemented a formal Emergency Equipment Protocol, which includes:

A written checklist of all required emergency equipment, maintained monthly.

A log for routine inspections, including:

Weekly equipment checks

Visual monitoring monthly

Quarterly detailed assessments of all medical equipment

Designated staff (DON or RN) are responsible for checking the presence, functionality, and readiness of oxygen tanks, suction devices, Ambu bags, and airway supplies.



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Participants Chart

This protocol has been added to the facility's Emergency Preparedness and Safety Manual to ensure consistent application.

4. Monitoring to Ensure Ongoing Compliance:

The Director of Nursing will visually audit all emergency equipment monthly. The Administrator or designee will oversee quarterly audits to ensure continued compliance. A log will be maintained, reviewed every Friday afternoon, and any issues will be corrected immediately.

Date of Completion: 09/30/2025



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Participants Chart

7) Plan of Correction: M701(Medical Records)

1. Corrective Action Taken for Affected Individuals: The Administrator and Director of Social Services implemented a **Medical Record Documentation Checklist**, which is now used at the time of admission and reviewed quarterly. This checklist ensures that each chart includes all required participant identification data, including a photo and atleast one emergency contact details. The intake process has also been updated to include verification of all required fields before a participant is fully admitted. All Participants were indirectly affected by this deficiency due to its importance in acknowledging the member during assessment or any follow up assessment or Documentation.

2. How the Facility Identified Others Who Could Be Affected:

All participant records were reviewed to ensure that no other charts were missing required demographic or emergency contact information. This review ensured that all participants are now in compliance with the required documentation.

3. Systemic Changes Made to Prevent Recurrence:

Following the citation, the Administrator met with the Director of Social Services to immediately address deficiencies in participant records. A full audit of all medical records was conducted. For participants missing photographs, those were added to their charts. Emergency contact information, names, addresses, and phone numbers were reviewed and updated to ensure completeness and accuracy.

4. Monitoring to Ensure Ongoing Compliance: The Director of Social Services will conduct a quarterly audit of 100% of participant records to ensure all required identification and contact fields are complete and up to date. Audit results will be reviewed with the Administrator and logged for tracking and continuous improvement.

Date of Completion: 09/23/2025



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Participants Chart

8) Plan of Correction: M813(Infection Control & Hazardous Material)

1. Corrective Action Taken for Affected Individuals:

No participants were referenced in the cited deficiency. Although no participant experienced actual harm, participants were affected because the deficient practice had the potential to compromise environmental safety, creating risks for injury or exposure to hazardous materials. Immediately following the survey, the Administrator ensured the removal of all hazardous items cited by the Department of Health, including:

- A) Car coolant, brake fluid, and steering fluid
- B) Multiple bottles of butane fuel
- C) All-purpose cleaners and other flammable or toxic chemicals

Additionally, the broken cabinet door was repaired, and a rug that posed a tripping hazard at the entrance was removed on 9/5/2025.

2. How the Facility Identified Others Who Could Be Affected:

The Administrator conducted a full facility-wide environmental inspection to identify and address any additional safety risks, including unsecured chemicals, damaged furniture, or structural hazards. This review ensured that all participants had the potential to be protected from environmental hazards.

3. Systemic Changes Made to Prevent Recurrence:

The Administrator has implemented a Hazardous Materials and Environmental Safety Log, which includes:

A checklist for bi-weekly review of all chemical storage areas



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Participants Chart

Immediate reporting and correction of any broken or damaged furniture or structural issues

Designation of locked storage for all flammable, toxic, or cleaning chemicals

Staff education on updated procedures for reporting and logging hazards

Additional measures completed between 9/5/2025 and 9/9/2025:

- 1) Initial staff education regarding hazardous materials and environmental safety protocols
- 2) Inspection and reorganization of chemical storage areas to ensure compliance
- 3) Repairs to identified structural hazards
- 4) This log is maintained to ensure ongoing compliance and documentation of all safety measures.

4. Monitoring to Ensure Ongoing Compliance:

The Administrator or Alternate Administrator will conduct weekly walk-throughs of the facility to ensure compliance with environmental safety protocols.

The Hazardous Materials and Environmental Safety Log will be reviewed monthly and kept on file for Department of Health review. Any identified safety hazards will be corrected immediately and documented in the log.

Date of Completion: 09/24/2025



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Participants Chart

9) Plan of Correction: M825 (Vehicle Fire Safety & Maintenance Log)

1. Corrective Action Taken for Affected Individuals:

No participants were directly affected by this deficiency. However, this issue had the potential to compromise emergency response and safety during transport. As a corrective measure, all facility vehicles were inspected on 09/05/2025 to ensure fire extinguishers were present and accessible.

2. How the Facility Identified Others Who Could Be Affected:

This was a systemic issue impacting all facility-owned vehicles. A full inspection of the 13 vehicles was conducted by the Administrator on 09/05/2025 to confirm the presence and correct placement of fire extinguishers. No participants were harmed, but they could have been at risk if vehicles lacked functional fire safety equipment during transport. Most of our vehicles in the facility's fleet are new (2020–2025), providing additional assurance of safety compliance.

3. Systemic Changes Made to Prevent Recurrence:

The Administrator has implemented a Transportation Safety Compliance Program, on 9/6/2025 and gave in-service to the Director of Transportation, Operations Manager and all drivers, which includes the following key actions -

- Monthly inspections of all vehicles to ensure fire extinguishers are present and operational.
- Centralized Vehicle Maintenance Log that tracks safety equipment, cleaning schedules, inspections, registration renewals, and inspection sticker due dates.
- Logs are maintained by each driver for their assigned vehicle; these logs will be accessible to the Director of Transportation and the Operations Manager for oversight.
- Upon discovering the deficiency, fire extinguishers were purchased on 09/05/2025 and installed on 09/06/2025. The Operations Manager, along with the assistance of a driver, securely placed one fire extinguisher in the middle section of each vehicle to ensure easy access during emergencies.

4. Monitoring to Ensure Ongoing Compliance:

The Director of Transportation will conduct monthly audits of all vehicles to verify fire extinguishers are in place and fully functional. The Administrator will review



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Participants Chart

audit results quarterly to ensure continued compliance. Any deficiencies will be corrected promptly, with all actions logged. The Vehicle Maintenance Log will be maintained by the Director of Transportation, who will be in charge of maintaining compliance, and the logs will be made available to the Department of Health upon request.

Date of Completion: 09/06/2025

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 12043	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/2/2025
NAME OF FACILITY NEW BEGINNINGS ADULT DAY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4 CROSSROAD DRIVE, SUITE #108 HAMILTON, NJ 08619	

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0221	Correction	ID Prefix M0235	Correction	ID Prefix M0409	Correction
Reg. # 8:43F-3.1(a)	Completed	Reg. # 8:43F-3.3(d)(1)	Completed	Reg. # 8:43F-6.3(a)(1)	Completed
LSC	09/08/2025	LSC	09/16/2025	LSC	09/16/2025
ID Prefix M0421	Correction	ID Prefix M0423	Correction	ID Prefix M0679	Correction
Reg. # 8:43F-6.3(e)(1)(i)	Completed	Reg. # 8:43F-6.3(f)	Completed	Reg. # 8:43F-14.17(b)	Completed
LSC	09/20/2025	LSC	09/15/2025	LSC	09/30/2025
ID Prefix M0701	Correction	ID Prefix M0813	Correction	ID Prefix M0825	Correction
Reg. # 8:43F-15.3(a)(1)	Completed	Reg. # 8:43F-16.7(a)(1-23)	Completed	Reg. # 8:43F-17.1(c)(d)(e)	Completed
LSC	09/23/2025	LSC	09/24/2025	LSC	09/06/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/4/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			