

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2025
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NAME OF PROVIDER OR SUPPLIER MONROE ADULT DAY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 24 DUGANS GROVE ROAD MILLSTONE TWP, NJ 08535
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M 000	<p>Initial Comments</p> <p>Type of Survey: Monitoring/Follow-up to the 8/13/2024 audit survey conducted by the Office of the Inspector General.</p> <p>Census: One Session: 109</p> <p>Sample Size: 3</p> <p>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.</p>	M 000		
M 379	<p>8:43F-5.4(c) Participant Assessment and Plan of Care</p> <p>There shall be a scheduled review and evaluation in each service involved in the initial assessment, and in other areas that the physician, advanced practice nurse or physician assistant, or interdisciplinary team indicates are necessary. Reassessments shall be performed as necessary, based on participant's needs, but at least quarterly for adult participants.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, during the current survey on 9/2/25 and the previous Office</p>	M 379		

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

TITLE

(X6) DATE

10/13/25

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M 379	<p>Continued From page 1</p> <p>of the Inspector General survey on 8/13/24, it was determined that the facility failed to document quarterly reassessments for [redacted] services for a participant reviewed, Participant #2. This deficient practice was evidenced by the following:</p> <p>The surveyor reviewed the medical record (MR) of Participant #2 that revealed a readmission date of [redacted] with diagnoses that included [redacted] and [redacted].</p> <p>Continued review of the Progress Notes (PN) dated [redacted] written by the [redacted] revealed Participant #2 was readmitted on [redacted] and the quarterly care plan was completed on [redacted]. Review of "Quarterly Interdisciplinary Summary" dated [redacted] revealed the [redacted] quarterly assessment was completed.</p> <p>On 9/2/25 at 10:05 a.m., when the surveyor asked about how often reassessments were done, the [redacted] stated that some participants leave the program, go away with their families to a different state, when the participant returned was when the reassessments were done, done quarterly was every 3 months. She continued to say that after a participant was away from the program for a month or 2 months, the [redacted] does a readmission. In the same interview, the [redacted] stated a readmission was a reassessment, she goes by the admission date.</p> <p>During the 8/13/24 survey, there was only one [redacted] assessment documented in the file dated [redacted].</p> <p>At the time of survey, there was no documented evidence of other quarterly reassessments prior to [redacted] in the MR for Participant #2.</p>	M 379		
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M 409	Continued From page 2	M 409		
M 409	<p>8:43F-6.3(a)(1) General Services</p> <p>"Reasonable efforts" shall include, but not be limited to, an inquiry on the employment application, reference checks, and/or criminal background checks when necessary for compliance with N.J.A.C. 8:43F-2.1(a)8.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, during the current survey on 9/2/25 and the previous Office of the Inspector General survey on 8/13/24, it was determined that the facility failed to ensure that a background check, job application and/or reference checks were completed upon hire for 3 of 6 sampled employees, Employee #'s 1, 2, and 3. This deficient practice was evidenced by the following:</p> <p>On 9/2/25 at 10:25 a.m., the surveyor reviewed the staff list and requested the Administrator to provide the personnel files for six (6) specified employees.</p> <p>At 11:00 a.m., the Administrator provided the surveyor with the (6) personnel files requested. Review of the personnel files provided revealed that there was no documented evidence of employees' job applications, reference checks,</p>	M 409		

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M 409	<p>Continued From page 3</p> <p>and/or criminal background checks upon hire for some of the employees. The findings were as follows:</p> <ol style="list-style-type: none"> Employee #1 (Director of Nursing - DON) had a hire date of [REDACTED]. The employee's application did not include documentation of a criminal background check and no references to contact upon hire. Employee #2 had a hire date of [REDACTED] the employee did not have documented evidence of a background check and job application upon hire. Employee #3 had a hire date of [REDACTED], the employee did not have documented evidence of a background check and references to contact upon hire. <p>At 11:18 a.m., when the surveyor asked who was responsible for the employee files, the Administrator stated that she was responsible for the information in them. When the surveyor asked her why the Employee #1's/DON's background check was dated [REDACTED] and that there was no background check upon hire in the file. She stated that at the time of the Employees #1's/DON's hire, there was another Administrator, and that there should have been a background check done upon hire.</p> <p>In the same interview, when the surveyor asked about reference checks, the Administrator stated that the DON was hired prior to her being the Administrator. She continued to say that as an Administrator, she double checks and ensures that all information include employee's background check, reference check, and job application were in the file.</p>	M 409		

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M 421	<p>Continued From page 5</p> <p>#s 1, 4, 5 and 6. This deficient practice was evidenced by the following:</p> <p>On 9/2/25 at 10:25 a.m., the surveyor reviewed the staff list and requested the Administrator to provide the personnel files of six (6) specified employees.</p> <p>At 11:00 a.m., the Administrator provided the surveyor with personnel files for the six employees. The surveyor reviewed the six personnel files and observed that there was no documented evidence of new hire orientation and annual in-services which included emergency plan and procedure trainings that were provided to some employees. The findings were as follows:</p> <p>1. Employee #1, the Director of Nursing (DON), was hired on [redacted] and she did not have documented evidence that she received an orientation upon hire and annual trainings. The surveyor observed "Inservice College (IC)" orientation trainings, which included emergency plans and procedures, documented in her file dated 12/2/2022.</p> <p>2. Employee #4, the Social Worker (SW) was hired on [redacted]. The SW personnel file did not include documented evidence that she received ongoing trainings. The IC orientation training on file which included emergency plans and procedures, was dated 12/1/2022.</p> <p>3. Employee #5 was hired on [redacted] as the Administrator and she did not have documented evidence that she received an orientation upon hire and ongoing trainings done. The surveyor observed that the last IC orientation trainings which included emergency plans and procedures, documented in her file, was dated 12/1/2022.</p>	M 421		

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M 421	<p>Continued From page 6</p> <p>4. Employee #6, the Activity Director (AD) was hired on [REDACTED] and she did not have documented evidence that she received an orientation upon hire and ongoing trainings done. The IC orientation trainings which included emergency plans and procedures, documented in her file, was dated 12/29/22, and with a job "Title" as Administrative Assistant at that time.</p> <p>At 11:18 a.m., when the surveyor asked about staff trainings, the Administrator stated that she, the AD, the DON, and the SW do Continuing Education Units (CEUs), and that they don't do annual trainings and she does in-services for all staff, not individual staff trainings.</p> <p>In the same interview, the Administrator stated there were no annual trainings done for herself, the AD, the DON and the SW. She continued to say that they were not required, and she stated that she never heard of doing annual trainings for them, they only do infection control trainings as needed.</p> <p>At the time of the 8/13/24 survey, there was no documented evidence of trainings done for 2022 and 2023 for Employee #s 1 & 4. There was no minimum required topics in the annual trainings for Employee #s 5 & 6, nor were there any ongoing in services or trainings on file.</p> <p>Surveyor review of an undated facility policy titled, "Staff Development In-Service Training-General Policies" revealed "Policy Statement [:] All personnel must attend and participate in regularly scheduled in-service training programs ...Policy Interpretation and Implementation [:] ...We are an equal employment organization and our in-service training programs apply equally to all</p>	M 421		

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M 421	Continued From page 7 personnel...." Surveyor review of an undated facility policy titled "In-Service Training Program" revealed "Policy Statement [:] Our facility has developed an effective in-service training program. Policy Interpretation and Implementation [:] 1. Our staff development program is divided into two classifications, one being orientation and the other in-service training (staff development) ...3. Our in-service training program (staff development) is planned and conducted for the development and improvement skills of all our personnel. 4. In-service training programs are on-going, and classes are scheduled by the in-service coordinator"	M 421		
M 653	8:43F-14.11(a)(1-3)(i-ii),(4-7) Physical Plant Requirements (a) The construction, equipment, and installation of food service facilities shall meet the requirements of the functional program. Services may consist of an on-site conventional food preparation system, a convenience food service system, a catering service or an appropriate combination thereof. The following facilities shall be provided to implement the food service selected: 1. A control station for receiving food supplies; 2. Storage facilities for food supply, including cold storage items; 3. Food preparation facilities as follows: i. A conventional food preparation system	M 653		

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M 653	<p>Continued From page 8</p> <p>with space and equipment for preparing, cooking and baking; and</p> <p>ii. A convenience food system, such as frozen prepared meals, bulk packaged entrees, individually packaged portions, and contractual commissary services with space and equipment for thawing, portioning, cooking, and/or baking;</p> <p>4. Handwashing facility(ies), located in the food preparation area;</p> <p>5. Warewashing space, which shall be located in the kitchen or an alcove separate from the food preparation and serving area;</p> <p>6. Waste storage facility(ies), which shall be located in a separate room easily accessible to the outside for direct waste pickup or disposal; and</p> <p>7. Office(s) or desk space(s) for dietitian(s) or the food service manager.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and observation during the 9/2/25 survey and the previous 8/13/24 Office of</p>	M 653		

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M 653	<p>Continued From page 9</p> <p>the Inspector General survey, it was determined that the facility failed to properly store perishable foods, two boxes of fruit. This deficient practice was evidenced by the following:</p> <p>On 9/2/25 at 9:42 a.m., the surveyor toured the facility and observed two boxes of fruits, one apple and one orange on the floor in the back hallway which was also observed on the 8/13/24 survey with photographs provided of the fruit boxes, one apple and one orange in the same location in the back hallway.</p> <p>During the tour, when the surveyor asked about the fruit, the Activity Director (AD), who previously worked in the kitchen, stated that the fruit was delivered yesterday but not distributed yet due to the facility closed for the holiday.</p> <p>At 10:13 a.m., when the surveyor asked the AD where the perishable foods should be stored, she replied that they should be stored in the refrigerator.</p> <p>At 10:43 a.m., the surveyor informed the Administrator that there was perishable food, two boxes of fruit in the back hallway on tour this morning, she stated that it was delivered yesterday for today and it [fruit] should be kept [stored] in the fridge [refrigerator].</p> <p>At 12:15 p.m., the Administrator stated that the facility did not have policies on Food Delivery or Food Storage.</p>	M 653		
M 703	<p>8:43F-15.3(a)(2) Medical Records</p> <p>(a) The participant's complete medical record shall include, but not be limited to, the following:</p>	M 703		

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M 703	<p>Continued From page 10</p> <p>2. The participant's signed acknowledgment that the participant or the participant's legally authorized representative has been informed of, and given a copy of, participant's rights.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, during the Office of the Inspector General's survey on 8/13/24, the facility failed to provide signed acknowledgements for a participant reviewed, Participant #1. This deficient practice was evidenced by the following:</p> <p>During the 8/13/24 survey, review of Participant #1's Medical Record (MR) revealed there were signed acknowledgements missing from the file.</p> <p>On 9/2/25 at 12:53 p.m., surveyor review of the MR for Participant #1 revealed a "Participation Agreement" signed by Participant #1 on NJ Ex Order 26.4(b) his/her readmission date.</p> <p>At 1:44 p.m., during an interview, when the surveyor asked about the signed acknowledgment in the file, the Administrator stated that the signed acknowledgment was the Participation Agreement.</p>	M 703		

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M 805 M 805	<p>Continued From page 11</p> <p>8:43F-16.5(a)(b)(c) Infection Control, Santation, Housekeeping</p> <p>(a) The facility shall provide and maintain a sanitary and safe environment for participants.</p> <p>(b) The facility shall provide housekeeping and pest control services.</p> <p>(c) Written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for housekeeping, sanitation, and safety services shall be developed and implemented.</p> <p>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 for the participants when wires were observed hanging from a television (TV) in a quiet room (a room where participants rest or recline) during the 9/2/25 survey and during the previous Office of the Inspector General survey of 8/13/24, there were observed extension cords on the floor without protection and multiple instances of water damage on the ceiling tiles. This deficient practice was evidenced by the following:</p> <p>On 9/2/25 at 9:50 a.m., while on tour, the surveyor observed TV wires hanging from the wall to the floor behind recliners in quiet room #1. The surveyor did not observe extension cords on</p>	M 805 M 805		

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M 805	<p>Continued From page 12</p> <p>the floor without protection or water damage to any ceiling tiles as previously observed on the 8/13/24 survey.</p> <p>At 10:43 a.m., when the surveyor showed and asked the Administrator about the hanging wires from the wall TV and safety for participants, she stated that the fire department inspected the facility last month and she got an all clear and she was not allowed any extension cords. She continued to say that the participants cannot trip because the wires were behind the back of the couch [recliners].</p> <p>At 11:18 a.m., the Administrator stated to the surveyor that she got an all clear and there were no violations from the fire department and provided the surveyor with a copy of the fire inspection certificate.</p> <p>In the same interview, when the surveyor asked was there documented proof that the TV wires were present upon the fire department inspection, the Administrator did not know how long the TV wires were hanging on the wall in the quiet room.</p>	M 805		
M 813	<p>8:43F-16.7(a)(1-23) Infection Control, Santation, Housekeeping</p> <p>(a) The following housekeeping, sanitation, and safety conditions shall be met:</p> <ol style="list-style-type: none"> 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	<p>Continued From page 13</p> <p>3. All rooms shall be ventilated to help prevent condensation, mold growth, and noxious odors;</p> <p>4. All participant areas shall be free of noxious odors;</p> <p>5. Throw rugs or scatter rugs shall not be used in the facility;</p> <p>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;</p> <p>7. All equipment shall have unobstructed space provided for operation;</p> <p>8. All equipment and materials necessary for cleaning, disinfecting, and sterilizing shall be provided;</p> <p>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;</p> <p>10. Pesticides shall be applied in accordance with N.J.A.C. 7:30;</p> <p>11. Articles in storage shall be elevated from the floor and away from walls;</p> <p>12. All poisonous and toxic materials shall be</p>	M 813		

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M 813	<p>Continued From page 14</p> <p>identified, labeled, and stored in a locked cabinet or room that is used for no other purpose;</p> <p>13. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement;</p> <p>14. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in closed metal cabinets or containers;</p> <p>15. Unobstructed aisles shall be provided in storage areas;</p> <p>16. A program shall be maintained to keep rodents, flies, roaches, and other vermin out of the facility;</p> <p>17. Toilet tissue, soap dispenser, paper towels or air dryers, and waste receptacles shall be provided in each bathroom at all times;</p> <p>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</p>	M 813		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2025
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NAME OF PROVIDER OR SUPPLIER MONROE ADULT DAY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 24 DUGANS GROVE ROAD MILLSTONE TWP, NJ 08535
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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	<p>Continued From page 15</p> <p>of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24;</p> <p>19. Garbage compactors shall be located on an impervious pad that is graded to a drain. The drain shall be unobstructed and connected to the sanitary sewage disposal system;</p> <p>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;</p> <p>21. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof;</p> <p>22. Wastebaskets and ashtrays shall be made of noncombustible materials;</p> <p>23. Latex foam pillows shall be prohibited.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure a safe</p>	M 813		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2025
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NAME OF PROVIDER OR SUPPLIER MONROE ADULT DAY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 24 DUGANS GROVE ROAD MILLSTONE TWP, NJ 08535
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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M 813	<p>Continued From page 16</p> <p>environment for the participants 1.) when three scattered rugs/carpets were observed upon entrance to the facility on 9/2/25 and on entrance during the previous Office of the Inspector General survey on 8/13/24; and 2.) on 8/13/24, there were observations of roaches crawling in coffee bins near the cabinets, a broken television (TV) behind a chair and <small>NJ Ex Order 26.4(b)(1)</small> in the quiet room near the window, and poisonous, toxic and flammable materials observed in unlocked cabinets. This deficient practice was evidenced by the following:</p> <p>1. On 9/2/25 at 9:07 a.m., the surveyor observed a set of three rectangular scattered rugs/carpets upon entrance into the facility.</p> <p>At 9:15 a.m., when the surveyor asked the Administrator about the entrance rugs/carpets, she stated that when feet were wet, the carpets were there.</p> <p>At 9:50 a.m., when the surveyor asked the Administrator about the storage of paint and flammable, toxic materials, she stated that there was no storage at the facility, if the contractors painted, they would take them [materials] with them.</p> <p>At 10:30 a.m., the surveyor interviewed the Administrator a 2nd time about the entrance rugs/carpets, when feet were not wet, she stated that the housekeeper put the carpets there after her daily mopping. The surveyor asked to see the housekeeper when she arrived.</p> <p>At 1:15 p.m., the Administrator informed the surveyor that the carpets were her responsibility, not the housekeeper. She continued to say that</p>	M 813		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2025
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NAME OF PROVIDER OR SUPPLIER MONROE ADULT DAY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 24 DUGANS GROVE ROAD MILLSTONE TWP, NJ 08535
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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	<p>Continued From page 17</p> <p>the carpets were there so the participants don't fall, especially in wet weather.</p> <p>2. On 8/13/24, the surveyors observed roaches crawling in coffee bins near the cabinets, a broken television (TV) behind a chair and () in the quiet room near the window, and poisonous, toxic and flammable materials observed in unlocked cabinets. At the time of the 9/2/25 survey, there were no observations noted of (), a broken TV or poisonous, toxic and flammable materials in unlocked cabinets.</p> <p>Surveyor review of an undated facility policy titled, "General Cleaning Procedures" revealed " ...Carpets will be vacuumed daily and spot cleaned as necessary ..."</p>	M 813		
M 825	<p>8:43F-17.1(c)(d)(e) Transportation Services</p> <p>(c) Vehicles shall be maintained in safe operating order.</p> <p>(d) The facility shall maintain insurance on the vehicles.</p> <p>(e) The facility shall comply with all applicable Department of Transportation rules promulgated under N.J.S.A. 39:1-1 et seq.</p>	M 825		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2025
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NAME OF PROVIDER OR SUPPLIER MONROE ADULT DAY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 24 DUGANS GROVE ROAD MILLSTONE TWP, NJ 08535
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M 825	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, during the Office of the Inspector General survey on 8/13/24, it was determined that the facility failed to ensure all vehicles inspections were up to date. This deficient practice was evidenced by the following:</p> <p>On 8/13/24, the surveyors observed a vehicle in the parking lot with an expired inspection sticker with the date of 6/2024 on the windshield.</p> <p>On 9/2/25 at 9:05 a.m., the surveyor observed (5) facility vehicles/vans in the parking lot, all with updated inspection stickers revealing next due dates of 2026.</p> <p>During the entrance, on 9/2/25 at 9:15 a.m., the surveyor asked the Administrator if the vehicles were contracted, she stated that the transportation was the facility's and not contracted. When the surveyor asked about the inspection stickers, the Administrator continued to say that the facility had a software for the inspection stickers for the vehicles, the drivers were aware and she got an alert on the computer.</p>	M 825		



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VOL 5
Accepted
12/11/25

Plan of Corrections for Monroe Adult Day Care-Survey dated 9/2/2025

St-M-0379-8:43f-5.4 (c)-Participant Assessment and Plan of Care: (Element #1) Participant

number 2 was discharged in [NJ Ex Order 26.4(b)(1)] and re-admitted on [NJ Ex Order 26.4(b)(1)]. When we discharge a client, we put the old medical records in an envelope and put them in a locked cabinet. Once the client returns to center, we do a re-admission. Participant number 2 was re-admitted on [NJ Ex Order 26.4(b)(1)] due to being [NJ Ex Order 26.4(b)(1)] for about [NJ Ex Order 26.4(b)(1)] and due to this, a reassessment was completed by the DON, Social Worker, and Activities Director on [NJ Ex Order 26.4(b)(1)]. Participant number 2 is currently a participant at Monroe Adult Day Care. **(Element #2)** All Participants will have the potential to be affected by this deficiency. **(Element #3)** The DON, Social Worker, and Activities director will work together to check on the charts to make sure that they are up to date on quarterlies and assessments, along with make any changes and updates to their care when necessary. The discharged and thin charts are kept in Medical Records cabinets. Will review/re-assess charts as needed. The DON, Social Worker, and Activities Director will work together to makes sure charts are reviewed and reassessed. This will be implemented on 9/3/2025.

(Element #4) The Quarterly Care Plans will be completed every 3 months and reassessments will be completed as necessary and upon re-admissions. When any new information is given to any staff member, this will be documented in that disciplinary section of the chart such as the social work or nursing section and changed that day. These corrections will be completed and implemented on 9/3/2025.

St-M-0409-8:43f-6.3 (a)(1)-General Services: (Element #1) Employee #1-since survey done on 08/13/24, which was when the administrator came to know that this employee doesn't have criminal background check, investigated this matter before completing it on 03/24/2025. This employee is currently employed still at Monroe Adult Day Care. **Employee#2**-Background check done on [NJ Ex Order 26.4(b)(1)] upon hire. Application was completed on [NJ Ex Order 26.4(b)(1)]. This employee is currently employed still at Monroe Adult Day Care. **Employee #3**-Date of correction for references was done on 9/3/2025. Employee is still currently hired at Monroe Adult Day Care.



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(Element #2) All staff members will have the potential to be affected by this deficiency.

(Element #3) Going forward, the administrator will go through the hiring check list and make sure all currently hired are up to date with all the requirements; this was implemented on 9/3/2025. **(Element #4)** The staff member who did and will be implementing this going forward is the Administrator. Upon hiring, the background check and references will be check along with the other required documents. The completion date of these implementations was on 9/3/2025

St-M-0421-8:43f-6.3 (e)(1)(i)-General Services: **(Element #1)** Since survey that was completed on 9/2/2025, all new hire orientations are up to date and current. Annual trainings were done on 9/4/2025 for all employees including the DON (Employee 1), Social Worker (Employee 4), Activities Director (Employee 6), and Administrator (Employee 5). **(Element #2)** All staff will have the potential to be affected by this deficiency. **(Element #3)** Currently and going forward will do quarterly and annual in-services for staff and Interdisciplinary Team members (DON, Social Worker, Activities Director, and Administrator) starting on 9/3/2025. The Administrator will be updating the employee files, doing in-services, and also implementing the corrections being made going forward starting on 9/3/2025. **(Element #4)** The DON or Social Worker will also keep track of In-Services and implement them depending on the subject matter but overall, the Administrator will oversee and make sure everything is implemented correctly. This was completed and implemented on 9/3/2025.

St-M-0653-8:43f-14.11 (a)(1-3)(i-ii), (4-7)-Physical Plant Requirements: **(Element #1)** No participants were mentioned in deficiency. Starting on 9/3/2025 and going forward the delivery of fruits are going to be coming every day and the fruits will be distributed that same day. Due to holiday, had 2 days' worth of delivery during day of survey (9/2/2025). **(Element #2)** The fruit in question during this deficiency were all fruits that can be left out of the refrigerator. When the fruit needs to be refrigerated, we will put them in the refrigerator and not leave them out. The only way this could have affected the other participants was if the fruit in question went bad. **(Element #3)** The kitchen coordinator will make sure that the fruit



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deliveries are ordered on a daily bases and disturbed that day. Any leftover fruit will be stored accordingly. **(Element #4)** The Kitchen Coordinator will be the one to complete the measures taken and make sure it is implemented going forward and starting on 9/3/2025. The administrator will check daily how much fruit is being ordered and delivered during the day and make sure the fruit is stored properly. This will be completed and implemented on 9/3/2025.

St-M-0703-8.43f-15.3 (a)(2)-Medical Records: **(Element 1)** Participant #1 is currently our client. **(Element 2)** All Participants will have the potential to be affected by this deficiency. **(Element 3)** The social worker implemented monitoring the corrective actions of checking the charts while doing her quarterly care plans and also her notes on 9/3/2025. **(Element 4)** Upon admission to the facility, the social worker will make sure the client being admitted will sign the required documents but if missed during the admission/intake, the social worker will check while doing notes or care plans. This was completed on 9/4/2025 and will be implemented going forward.

St-M-0805-8:43f-16.5 (a)(b)(c)-Infection Control, Sanitation, Housekeeping: **(Element #1)** No participants were mentioned in this deficiency. **(Element #2)** All Participants will have the potential to be affected by this deficiency. Due to having the wires visible, this could have been a potential fall risk. **(Element #3)** We unplugged the wires on 9/3/2025 and moved them behind the TV, for our participants safety. **(Element #4)** We will monitor this by making sure the TV plug/wire stays behind the TV. Completed on 9/3/2025.

St-M-0813-8:43f-16.7 (a)(1-23)-Infection Control, Sanitation, Housekeeping: **(Element #1)-** No participants were mentioned in the deficiency. **(Element #2)** All Participants will have the potential to be affected by this deficiency. The other participants at the center could have been affected by this deficiency by a possible fall incident occurring. **(Element #3)** This concern was immediately taken care of on 9/3/2025 by removing the rugs so we won't have any fall incidents. **(Element #4)** During rainy or slippery weather, staff will observe participants closely when entering building for their safety and to avoid any falls. Immediate action was taken by removing the rugs on the 9/3/2025.



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St-M-0825-8:43f-17.1(c)(d)(e)-Transportation Services: (Element #1) No participants were mentioned in this deficiency. **(Element #2)** All Participants will have the potential to be affected by this deficiency. The participants would possibly be affected by this deficiency by if one of the drivers got pulled over for their registration or inspection being expired, they would be late to going home or to the center and also possibly scared/upset. **(Element 3)** We have been using a software system that was put into place after the initial survey completed on 08/13/2024. This software helps us keep track of the registrations and anything else related to the vehicles such as inspections, registrations, etc. This software was implemented in October of 2024. **(Element 4)** This will be monitored monthly from September 2025 by administrator. This was completed on 9/3/2025 and will be implemented going forward.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 13009	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/11/2025
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NAME OF FACILITY MONROE ADULT DAY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 24 DUGANS GROVE ROAD MILLSTONE TWP, NJ 08535
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0379	Correction	ID Prefix M0409	Correction	ID Prefix M0421	Correction
Reg. # 8:43F-5.4(c)	Completed	Reg. # 8:43F-6.3(a)(1)	Completed	Reg. # 8:43F-6.3(e)(1)(i)	Completed
LSC	09/03/2025	LSC	09/03/2025	LSC	09/03/2025
ID Prefix M0653	Correction	ID Prefix M0703	Correction	ID Prefix M0805	Correction
Reg. # 8:43F-14.11(a)(1-3)(i-ii),(4-7)	Completed	Reg. # 8:43F-15.3(a)(2)	Completed	Reg. # 8:43F-16.5(a)(b)(c)	Completed
LSC	09/03/2025	LSC	09/03/2025	LSC	09/03/2025
ID Prefix M0813	Correction	ID Prefix M0825	Correction	ID Prefix	Correction
Reg. # 8:43F-16.7(a)(1-23)	Completed	Reg. # 8:43F-17.1(c)(d)(e)	Completed	Reg. #	Completed
LSC	09/03/2025	LSC	09/03/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 9/2/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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