New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A020	A. BUILDING: ______ B. WING ______	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF SHREWSBURY	766 BROAD STREET SHREWSBURY, NJ 07702

(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
A 000	Initial Comments Initial Comments: Type of Survey: Complaint #: NJ 00181536, NJ 00176705, NJ 00183631, NJ 00188336 Census: 83 Sample Size: 6 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administrator's Responsibilities (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/26/25

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00181536 Based on interview, record review and review of facility policy and procedure it was determined that the facility failed to follow their policy titled, "Elopement Management Program" for 1 out of 1 resident (Resident #6) reviewed for NJ Exec Order 26.4b1 This deficient practice was identified as an imminent danger and was evidenced by the following: On 10/17/25 at 10:30 AM, the surveyor reviewed the medical records of Resident # 6 which revealed the resident moved into the facility on NJ Ex Order 26.4(, with diagnoses which included but were not limited to, NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). According to the Resident Evaluation completed by the Registered Nurse Resident Care Coordinator, (RDC) Resident #6 was an NJ Exec Order 26.4b1 , NJ Ex Order 26.4(b) to NJ Ex Order 26.4 and NJ Ex Order 26 NJ Ex Order 26.4(b)(1). Review of the resident service plan had a focus for NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) The goal was for Resident #6 to maintain their current level of NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1). The resident will be NJ Exec Order 26.4b1 through the next review date. One of the interventions was : "Provide me with NJ Ex Order 26.4(b)(1) as needed to ensure that I do not NJ Ex Order 26.4(b)(1)".	A 310		

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A 310	Continued From page 2 Review of a progress Note (PN) date NJ Ex Order 26.4(b) indicated that Resident #6 had a history of NJ Ex Order without staff knowledge and NJ Ex Order 26.4(b)(1) was NJ Ex Order 2 in the NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1) the facility by a care giver. The facility had no functioning NJ Ex Order 26.4(b)(1) . Review of a PN dated NJ Ex Order 26.4(b timed 11:45 AM, reflected that Resident #6 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) without staff knowledge and NJ Ex Order 26.4(b)(1) Staff were unaware unti NJ Ex Order 26.4(b)(1) called the concierge at 11:45 AM and informed the concierge that Resident #6 was NJ Ex Order 26.4(b)(1) . The facility was not aware that the resident NJ Ex Order 26.4(b)(1). The resident was NJ Ex Order 26.4(b)(1) by the NJ Ex Order 2 On 10/16/25 at 10:30 AM, the surveyors asked the Executive Director (ED) for all the reportable for the last 12 months, four reportable were provided and reviewed by the survey team. The incident concerning Resident #6 was not included. On 10/17/25 at 11:05 AM, the surveyor again asked the ED for any incident reports for Resident #6 along with any reportable(s), the ED stated that she did not have any for Resident #6. On 10/17/25 at 11:15 AM, the surveyor interviewed the Director of Clinical Services (RDC) regarding the NJ Ex Order 26.4(b)(1) The RDC stated that she was off that day and declined to elaborate further. The RDC stated that the Wellness Nurse was on duty that day.	A 310		

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A 310	Continued From page 3	A 310		

On 10/17/25 at 11:45 AM, the Patient Care Coordinator (PCC) facilitated a telephone interview with the Wellness Nurse. The Wellness Nurse stated that on NJ Ex Order 26.4(b) around 11:45 AM, the concierge reported to him that Resident #6 NJ Ex Order 26.4(b)(1) and was informed by a NJ Ex Order 26.4(b)(1) who NJ Ex Order 26.4(b)(1) the facility that Resident #6 was NJ Ex Order 26.4(b)(1) and needed to be NJ Ex Order 26.4(b)(1). He attempted to locate the activity staff to NJ Ex Order 26.4 the resident, but the activity staff was not available. At 12:00 PM Resident #6 was NJ Ex Order 26.4(b)(1) by the NJ Ex Order 26.4(b)(1). The Wellness Nurse stated that he reported and discussed the incident with the PCC. He assessed the resident upon NJ Ex Order 26 and documented the incident in the clinical record. When asked if the facility was aware that the resident NJ Ex Order 26.4(b)(1), he stated, "No" and upon inquiry, he stated that could be considered as NJ Ex Order 26.4(b)(1) as the facility was not aware of Resident #6's NJ Ex Order 26.4(b)(1) The surveyor asked if any follow up was done and what measures were put in place following the incident, the Wellness Nurse stated that the Resident Representative was called, the PCC was also called and advised him to transfer Resident #6 to the NJ Ex Order 26.4(b)(1) Unit.

10/17/25 at 12:00 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who worked that day. She stated that on NJ Ex Order 26.4(at 11:00 AM, she observed Resident #6 by the NJ Ex Order 26.4(b)(1), and she NJ Exec Order 26.4b them to their room. She was not aware that Resident #6 was NJ Ex Order 26.4(b until the Wellness nurse received the call from the concierge. The LPN stated that Resident #6 was always NJ Ex Order 26.4(b)(1) and exhibited NJ Ex Order 26.4(b)(1) The surveyor asked what measures were implemented to keep the resident safe, she

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A 310	Continued From page 4 declined to comment. She stated there was no NJ Exec Order 26.4b1 to alert the staff that Resident #6 was a NJ Ex Order 26.4(b)(1) On 10/17/25 at 12:15 PM, the surveyor interviewed the ED and inquired about what was considered NJ Ex Order 26.4(b)(1) according to the facility policy. The ED stated, "NJ Ex Order 26.4(b)(1) is anytime a resident NJ Ex Order 26.4(b)(1) did not know where NJ Ex was." The surveyor re-reviewed the NJ Ex Order 26.4(, PN in the presence of the ED who stated that the residents were allowed to NJ Ex Order 26.4(b)(1). On 10/17/25 at 12:47 PM, the surveyor re-reviewed the NJ Ex Order 26.4(b)(1) PN with the ED who stated that could be considered as NJ Ex Order 26.4(b)(1) or a NJ Exec Order 26.4b1. The ED then added that she was in training out of state and declined to comment further on the incident. The ED provided the surveyor with a notice letter which confirmed that the PCC oversaw the building during the time the incident occurred. On 10/17/25 at 12:50 PM, the surveyor interviewed the ED who stated if a resident NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) without staff's knowledge and supervision an investigation should have been completed, statements should have been collected, and the incident should have been reported to the New Jersey Department of Health. The surveyor then asked if an investigation was completed for the above incident, the ED stated that she did not have any investigation to provide as the PCC was in charge.	A 310		

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A 310	Continued From page 5 On 10/17/25 at 12:25 PM, the surveyor interviewed the PCC who oversaw the facility on NJ Exec Order 26.4, the day of the incident. He stated he did not have any knowledge of the incident and could not provide an investigation. On 10/17/25 at 12:30 PM, the surveyor requested the timecard for the concierge assigned on NJ Exec Order 26.4b along with the phone number. During a telephone interview with the concierge at 12:34 PM, she confirmed that the resident NJ Ex Order 26.4(b)(1) the facility. She stated that there was a lot going on that day and she did not NJ Ex Order 26.4(b) the resident NJ Ex Order 26.4(b)(1). She stated that she received a call on NJ Ex Order 26.4(around 11:45 AM, from NJ Ex Order 26.4(b)(1) who informed her that Resident #6 was NJ Ex Order 26.4(b)(1) and needed to NJ Ex She reported the incident to the Wellness Nurse. When asked if she was asked to provide a statement, she replied, "yes". The concierge stated that she spoke and provided a statement to the PCC. The concierge added, the facility was aware that Resident #6 was at risk for NJ Ex Order 26.4(b)(1) and should have been NJ Ex Order 26.4(b)(1) On 10/17/25 at 12:45 PM, the surveyor conducted a telephone interview with the Wellness Nurse who stated that the concierge reported to him that Resident #6 NJ Ex Order 26.4(b)(1) the facility on NJ Ex Order 26.4(b) and was informed by NJ Ex Order 26.4(b)(1) that Resident #6 was NJ Ex Order 26.4(b)(1) and needed to be NJ Exec Order 26.4b1. He attempted to locate the activity staff to NJ Ex Order 26.4(b the resident, but the activity staff was not available. The Wellness Nurse further stated that on NJ Ex Order 26.4(at 12:00 pm, Resident #6 was NJ Ex Order 26.4(b)(by the NJ Ex Order 26.4(b)(1) He informed the Patient Care Coordinator of the incident, he assessed the	A 310		

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A 310	Continued From page 6	A 310		

resident NJ Ex Order 26.4(b)(1) and documented the incident in the clinical record. When asked if the facility was aware that the resident NJ Ex Order 26.4(b)(1) , he stated, "No" and further stated that could be considered NJ Ex Order 26.4(b)(1)

On 10/17/25 at 12:59 PM, the surveyor again interviewed the PCC regarding the NJ Ex Order 26.4(b) incident.

On 10/17/25 at 1:15 PM the PCC provided two statements and stated that the statements were placed in the wrong mailbox. The facility could not provide documentation to indicate that the incident was investigated and reported to the New Jersey Department of Health.

On 10/17/25 at 1:45 PM, the surveyor met with the ED and the PCC regarding the above concern. The ED provided a copy of the letter to confirm that she was out of state and the incident occurred when the PCC was in charge. The ED could not provide documentation to indicate that staff were reeducated on NJ Ex Order 26.4(b)(1) and evaluate their current policies and procedures.

On 10/17/25 at 1:55 PM, the surveyor reviewed the facility policy titled, "Elopement Management Program" which included:
Elopement Definition: Elopement-when a resident who exhibits symptoms or behaviors associated with cognitive impairment leaves the community perimeter, including the building and parking lot, unsupervised, unnoticed, and out of line of sight.
Resident Risk Assessment.
In Assisted Living, residents are assessed for elopement risk and cognitive status as part of the comprehensive assessment upon move-in every six months or as required by the state/province regulations and with a significant change in

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A 310	Continued From page 7 condition. Post Event Evaluation The Wellness team (licensed nurse, neighborhood coordinator) completes the Elopement Evaluation following an elopement. Follow-up progress notes using the Health Status Progress Notes are completed daily for 72 hours. Tracking All elopements must be entered into the event management system. Exit-seeking behavior are entered into Riskonnect as well.	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint # NJ 00181536 Based on interview, record review and review of pertinent documents provided by the facility, it was determined that the facility failed to provide a safe environment for 1 of 2 NJ Ex Order 26.4(b)(1)	A 401		

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A 401	Continued From page 8 residents (Resident #2) reviewed for accidents and incidents. Resident #2 was NJ Exec Order with their NJ Ex Order 26.4(b)(1) in an NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)). The deficient practice resulted in an imminent danger and was evidenced by the following. The surveyor reviewed a Facility Reportable Event (FRE) that was reported to the New Jersey Department of Health (NJDOH) on 12/13/24, which indicated that on NJ Ex Order 26.4(b)(1) at 7:42 AM, Resident #2 was NJ Exec Order in the room with NJ Ex Order which was NJ Ex Order 26.4(b) by the family without the facility's knowledge. The facility did not report the incident until 12/13/24 (NJ Ex Order 26.4(b) later). On 10/16/25 at 9:46 AM, surveyor #1 interviewed the Executive Director (ED) and requested all reportable events and incident reports from NJ Ex Ord through NJ Ex Order 26.4(b)(1). On 10/16/25 at 10:45 AM, the ED provided three investigations. There was no investigation for the FRE dated NJ Ex Order 26.4(which was reported 12/13/24. On 10/16/25 at 10:00 AM, surveyor #1 reviewed the Electrical Medical Record (EMR) for Resident #2 which indicated that the resident moved into the facility on NJ Ex Order 26.4(b), and had diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1)	A 401		

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A 401	Continued From page 9 A review of the Service Plan Report dated NJ Ex Order 26.4(, did not have a focus area for the NJ Ex Order 26.4(b)(1). A review of the nursing Progress Notes (PN) dated NJ Ex Order 26.4(timed 7:40 AM, indicated that Resident #2 had NJ Ex Order 26.4(b)(1), Resident #2 was NJ Ex Order 26.4(b)(1) the event. There was no documentation in the medical record to corroborate the FRE that was reported to the NJDOH. On 10/16/25 at 12:03 PM, surveyor #1 requested all incidents, accidents, investigations and reportable for Resident #2 from the ED but none was provided. On 10/16/25 at 2:00 PM, in the presence of the survey team, the ED informed surveyor #1 that she could not locate any reportables or incidents for Resident #2. On 10/17/25 at 11:15 AM, surveyor #2 interviewed the Certified Medication Administration (CMA) who found the resident's NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(The CMA stated that she entered the room and observed the resident with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). She called the nurse Licensed Practical Nurse (LPN) immediately and remained in the room with the resident. The CMA stated that the nurse did not answer the call, after 10 minutes had elapsed, she asked another Certified Nursing Assistant (CNA) to assist her to NJ Ex Order the resident NJ Ex Order 26.4(b)(1). She placed NJ Ex Order 26.4(underneath the resident's NJ Ex Order and stayed until the LPN arrived. On 10/17/25 at 11:30 AM surveyor #2 discussed the above concerns regarding Resident #2 with	A 401		

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A 401	Continued From page 10 the ED and the Patient Care Coordinator (PCC) Registered Nurse (RN). The ED informed the surveyor that she was not employed by the facility at that time and could not locate any investigation. The PCC stated that he did not have an investigation for Resident #2. On 10/17/25 at 12:15 PM surveyor #2 interviewed the Licensed Practical Nurse (LPN) who worked the 7:00 AM-3:00 PM shift on NJ Exec Order 26.4b1. The LPN stated that she received a call from the CMA but could not respond immediately because she was attending to an emergency on the first floor as she was the only nurse in the building until 9:00 AM. She stated that when she entered the room, she observed the resident NJ Ex Order 26.4(b)(1), she concluded that Resident #2 had NJ Exec Ord. She assessed Resident #2 and cared for the NJ Ex Order 26.4(b)(noted on their NJ Ex Order 26.4(. The resident's NJ Ex Order 2, she contacted the physician and she obtained an order to transfer the resident to the Emergency Department for evaluation and treatment. The surveyor then inquired if she collected any statement(s) or spoke to the CMA regarding the incident, the LPN stated, "No". On 10/17/25 at 1:15 PM, surveyor #2 requested the New Jersey Universal Transfer Form (NJUTF) dated NJ Ex Order 26.4(for review. The PCC indicated that he could not locate the NJUTF. On 10/17/25 at 12:07 the facility provided the hospital record dated NJ Ex Order 26.4(b), which revealed under History of Present Illness that Resident #2 was admitted with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) On 10/17/25 at 12:10 PM, surveyor #2 interviewed the ED regarding the facility's process	A 401		

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A 401	Continued From page 11 for any investigation. The ED stated, that the facility would conduct an internal investigation, collect statements, analyze data, educate the staff and final phase would be to review the incident in QAPI (Quality Assurance and Performance Improvement; a systematic approach to maintain and improve quality in nursing homes). The ED added that she reviewed the prior QAPI from the former ED, and the incident regarding Resident #2 was not discussed. Further review of the 12/13/24, FRE revealed the following: Today's Date: NJ Ex Order 26.4(b)(1) Date of Event: NJ Ex Order 26.4(b)(1) Time of Event: 7:35 AM Exact Location of incident: NJ Ex Order 26.4(b)(1). Under the narrative section, the FRE indicated that the facility was unaware when the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b) by the resident's family member. At 4:42 AM and 6:10 AM, the staff interacted with the resident and did not report any concerns. At 7:35 AM, certified medication technician (CMT) entered the resident's room to give medications where she found the resident NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with their NJ Ex Order 26.4(b)(1). The facility reported that the NJ Ex O was not NJ Ex Orde the resident's NJ Ex Orde and was NJ Ex Order 26.4(b)(1) Under the intervention section, the facility documented that they audited all resident rooms in the facility to ensure there were no other NJ Ex Order 26.4(b)(1). All staff in-servicing was held training team members on	A 401		

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	13A020	A. BUILDING: ______ B. WING ______	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF SHREWSBURY	766 BROAD STREET SHREWSBURY, NJ 07702

(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
A 401	Continued From page 12 the different types of NJ Ex Order 26.4(b)(1), what are approved, and what are not. The staff were also informed that they should inform their supervisor if they find one of the NJ Ex Order 26.4(b)(1) added onto a resident's bed. Resident #2's family was also notified that NJ Ex Order 26.4(b)(1) was not approved and was removed.	A 401		

POC#2 received 12/1/25
Accepted 12/1/25

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Plan of Correction – Complaint Survey of 10/16/2025

A – 000 Initial Comments

The facility acknowledges the findings cited in the complaint survey dated October 16, 2025, regarding the incident involving Resident #6 on October 5, 2025.

A – 310 Element # 1 Corrective Action for the Identified Resident

Resident #6 was relocated to NJ Ex Order 26.4(b)(1) with NJ Exec Order 26.4b1 on NJ Ex Order 26.4(b)(1) to ensure a NJ Exec Order 26.4b1 with appropriate NJ Ex Order 26.4(b)(1) Resident continues to reside in the NJ Exec Order 26.4b1 unit.

Element #2 Identification of Other Residents Who May Be Affected

All residents have the potential for harm. A review was completed by the RCD (Resident Care Director) to ensure that all residents identified as wander risks are appropriately assessed, monitored, and care planned.

Element #3 Monitoring to Ensure Ongoing Compliance

Following the complaint survey of 10/16/2025, the Executive Director (ED) and Resident Care Director (RCD) reviewed the Elopement Management Program with all Wellness Staff and Concierge personnel.

- The Wellness Nurse was retrained on 10/17/2025 by the ED (Executive Director) on the requirement to complete incident reports for *any* event involving resident safety.
- The Resident Care Coordinator (RCC) was retrained on 10/17/2025 by the E.D. regarding follow-up, documentation, and timely reporting to the NJDOH.
- Staff were educated on immediate notification protocols, documentation expectations, and proper activation of the Missing Person Policy by the ED on 10/17/2025. In addition, ED/BOC (Business Office Coordinator) reminded Concierge to utilize the Resident Emergency Binder at the front desk to ensure the identity of residents leaving the building.

Element #4 Monitoring to Ensure Ongoing Compliance

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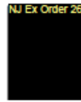
Elopement Drills are conducted monthly per company policy to review the Elopement Management Program. All elopement related incidents are reviewed by the ED or designee to confirm compliance with policy. No revisions to the Missing Person Policy were necessary. Ongoing education will occur through in-services conducted by the ED/RCD as needed. Additionally, the results of all elopement audits and drill reviews will be analyzed and reviewed quarterly during QAPI to ensure continued compliance and identify opportunities for improvement.

Completion Date: 10/17/2025  NJ Ex Order 26. approved 12/1/25

A – 401 Element #1 Corrective Action for the Identified Resident

Resident #2 moved out of the community on NJ Ex Order 26.4(b)(1) therefore no further resident-specific corrective action is required.

Element #2 Identification of Other Residents Who May Be Affected

All residents have the potential for harm. A comprehensive audit was conducted by the RCD and RCC on 10/18/2025 to identify any unapproved bed canes or other unapproved assistive devices.

Element #3 Monitoring to Ensure Ongoing Compliance

Bed Cane mobility devices are approved on a case by case basis for Assisted Living residents who demonstrate appropriate cognitive ability for safe usage. At the time of the survey, three residents had approved bed canes. Monthly safety inspections by the MC (Maintenance Coordinator) continue per Sunrise policy.

On 10/18/25, the RCD and RCC inspected all resident suites. One additional unapproved NJ Exec Order 26.4b1 was found. The family was contacted that day and they immediately removed the device.

All staff members were in-serviced by the RCD on 10/20/2025 regarding the requirement to report any NJ Exec Order 26.4b1 or unapproved equipment found in resident rooms.

Documentation Practices:

- The ED maintains a complete binder of State Reportable Events.
- A comprehensive search confirmed no additional missing documentation.
- All AAS-45 forms include supporting statements, summaries, and attachments.
- On 10/17/2025, the Wellness Team was retrained on proper use of the Uniform Transfer Form (UTF) whenever a resident is sent to the hospital.

Element #4 – Monitoring to Ensure Ongoing Compliance

The ED brings the State Reportable Event Binder to monthly QAPI meetings for review and discussion of reportable events and related policies.

Additionally, results from monthly bed cane safety inspections, state reportable event audits, and UTF compliance reviews will be compiled and formally reviewed quarterly during QAPI to ensure ongoing compliance and identify needed corrective actions.

Completion Date: 10/20/2025 approved 12/1/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
13A020	A. Building B. Wing	12/1/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF SHREWSBURY	766 BROAD STREET SHREWSBURY, NJ 07702

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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 10/17/2025	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 10/20/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
10/16/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO