

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13A022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/30/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VILLAS OF HOLMDEL, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 COMMONS WAY HOLMDEL, NJ 07733</b>
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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
A 000	<p><b>Initial Comments</b></p> <p>Initial Comments: Type of Survey: Complaint</p> <p>Complaint #'s : NJ00188275, NJ00186485</p> <p>Census: 99</p> <p>Sample Size: 4</p> <p>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.</p>	A 000		
A 475	<p><b>8:36-5.1(h) Types of Services Provided to Residents</b></p> <p>(h) In accordance with N.J.S.A. 26:2H-12.16 et seq., a new assisted living residence or comprehensive personal care home licensed on or after September 1, 2001, shall attain a level of occupancy by Medicaid-eligible persons of at least 10 percent of its total bed complement within three years of licensure and shall maintain this level of Medicaid occupancy thereafter.</p>	A 475		

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

TITLE

(X6) DATE

09/12/25

New Jersey Department of Health

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A 475	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to attain a level of occupancy by Medicaid-eligible persons of at least ten percent (10%) of its total bed complement within three years of licensure as required. This deficient practice was evidenced by the following:</p> <p>On 7/30/25 at 9:15 a.m., the surveyor interviewed the "Special Project Administrator" (SPA) who informed the surveyor that the current census of residents was 99. The surveyor inquired about the number of current Medicaid-recipient residents. The SPA stated that the facility's Medicaid provider application was not yet approved by the Medicaid Program, and therefore the facility did not currently have Medicaid-recipient residents.</p> <p>Additionally, the surveyor inquired about whether there were residents who were currently eligible or had applied to become Medicaid-recipients. The SPA stated she thought there were several residents, and that she would provide the surveyor with more information. During the interview, the SPA confirmed that the facility had been open since April of 2022.</p> <p>At 9:45 a.m., during a follow up interview with the SPA, she stated that there were Medicaid-eligible residents as follows: Four (4) residents were in the process of "NJ Exec Order 26.4b1" by "NJ Exec Order 26.4b1". One (1) resident was "NJ Exec Order 26.4b1" by "NJ Exec Order 26.4b1". One (1) resident had already "NJ Exec Order 26.4b1" and one (1) resident had "NJ Exec Order 26.4b1"</p>	A 475		
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NAME OF PROVIDER OR SUPPLIER  <b>VILLAS OF HOLMDEL, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 COMMONS WAY HOLMDEL, NJ 07733</b>
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A 475	<p>Continued From page 2</p> <p>pending.</p> <p>At 1:45 p.m., the surveyor reviewed the facility's Medicaid Disclosure Statement provided by the Assistant Administrator which revealed that the facility participated in the Managed Long-Term Services and Supports (MLTSS) Medicaid program. Further review of the Medicaid Disclosure Statement revealed a "Spend-down" requirement as follows: "An individual must be a "private pay" resident of the (facility) for a continuous period of at least two years in order to qualify for placement in a bed designated by the (facility)" for Medicaid-recipients, and "when such a bed becomes available."</p> <p>The Assistant Administrator provided documentation of the facility Medicaid Provider application which was submitted by the facility. The surveyor reviewed the document which was titled, "Assisted Living Waiver New Jersey Medicaid Provider Application," and observed the document was dated 8/20/2024 and signed by the facility Executive Director.</p> <p>On 8/1/25, post survey, the surveyor emailed the Assistant Administrator to verify if the Medicaid application dated 8/20/24 was the first application submitted by the facility.</p> <p>On 8/5/25, the surveyor reviewed the Assistant Administrator's email response which confirmed that the application submitted on 8/20/2024, was the first Assisted Living Waiver New Jersey Medicaid Provider Application, submitted by the facility.</p> <p>At 12:10 p.m., the surveyor interviewed the SPA via telephone and inquired whether the pending Medicaid-eligible residents had started the</p>	A 475		

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A 475	Continued From page 3  application process. She informed the surveyor that one (1) resident was approved for Medicaid, however since the other five (5) residents had not completed their financial "spend down", those residents had not started the application process yet, nor were they approved for Medicaid benefits.	A 475		

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 13A022	MULTIPLE CONSTRUCTION A. Building _____ B. Wing _____	DATE OF REVISIT 9/16/2025
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NAME OF FACILITY VILLAS OF HOLMDEL, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 COMMONS WAY HOLMDEL, NJ 07733
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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 A0475	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:36-5.1(h)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	08/27/2025	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/30/2025		<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		