

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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: Audit Census: 60 Sample Size: 4 On 9/4/25, the Department of Health conducted a follow-up survey regarding the Attorney General's audit that was conducted on 8/1/24. 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 351	8:43F-4.2(d) Participant Rights The telephone numbers in N.J.A.C. 8:43F-4.2(b) and (c), shall be conspicuously posted in the facility at every public telephone and on all bulletin boards used for posting public notices. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post the required telephone numbers at every public telephone for all participants at the facility. This deficient practice was evidenced by the following:	M 351		

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

TITLE

(X6) DATE

10/14/25

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 351	Continued From page 1 On 7/31/24, the Office of Inspector General (OIG) conducted an audit of the facility and observed that the facility had not posted the required phone numbers in the area of the public phone. On 9/4/25 at 12:10 p.m., the surveyor requested the Administrator to show the surveyor the facility's public telephone that the participants used. The surveyor observed that the public telephone did not have the required telephone numbers posted by the public telephone. The surveyor interviewed the Administrator regarding above concern and the Administrator stated that the phone numbers were posted and was unsure of why they were no longer posted.	M 351		
M 379	8:43F-5.4(c) Participant Assessment and Plan of Care 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review and interview, it was determined that the facility failed to meet the minimum required quarterly assessments for 1 of 4 participants reviewed,	M 379		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 379	Continued From page 2 Participant #1. This deficient practice was evidenced by the following: On 7/31/24, the Office of Inspector General (OIG) conducted an audit of the facility and observed that the facility had not completed quarterly [NJ Exec Order 26.4b1] assessments for 2 participants, Participant #1 and Participant #2. On 9/4/25 at 9:56 a.m., the surveyor reviewed the medical record (MR) of Participant #1 and observed that a quarterly [NJ Exec Order 26.4b1] assessment was completed on [NJ Exec Order 26.4b1]. The surveyor did not observe a quarterly assessment for [NJ Exec Order 26.4b1]. At 12:20 p.m., the surveyor interviewed the Director of Nursing (DON) and inquired about quarterly [NJ Ex Order 26.4] assessments. The DON stated that quarterly [NJ Exec Order 26.4] assessments were completed every 3 months and were in the participants MR. However, there was no documented evidence in the participant's MR that the quarterly assessment for [NJ Exec Order 26.4] was completed.	M 379		
M 407	8:43F-6.3(a) General Services The facility shall make reasonable efforts to ensure that all staff providing direct care to participants in the facility are in good health, are concerned for the safety and well-being of participants, and have not been convicted of a crime relating adversely to the person's ability to provide care to participants, except when the applicant or employee with a criminal history has demonstrated his or her rehabilitation, in accordance with the standards set forth at N.J.S.A. 2A:168A-1 et seq., and N.J.A.C.	M 407		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 407	Continued From page 3 8:43F-2.1(a)8ii, in order to qualify for employment at the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to conduct a reference and/or background checks for 1 of 3 employee, Employee #1. This deficient practice was evidenced by the following: On 7/31/24, the Inspector General's (IG) office conducted an audit of the facility and observed that the facility had not completed a reference check or background check for Employee #1. On 9/4/25 at 10:40 a.m., the surveyor reviewed the employee file for Employee #1 and observed reference checks dated for [REDACTED] and a background check documented dated [REDACTED] in the file. At 1:40 p.m., the surveyor interviewed the staff and inquired about background checks. The staff stated that she had been required to complete a background check at the start of her employment. The surveyor reviewed a facility policy dated 1/4/17 titled "Personnel Policy" which indicated " ...1. All potential employees are hired only upon reference checks as well as criminal background checks ..."	M 407		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 419	Continued From page 4	M 419		
M 419	8:43F-6.3(d) General Services The facility shall maintain written staffing schedules. Staffing schedules shall be implemented to ensure continuity of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain a written staffing schedule that ensured adequate staffing and continuity of care. This deficient practice was evidenced by the following: On 7/31/24, the Office of Inspector General (OIG) conducted an audit of the facility and observed that the facility had not maintained written staff schedules. At 9:45 a.m., the surveyor requested from the administrator staffing schedules from 7/31/24 though 11/1/24 and from 8/1/25 through 9/4/25, survey date. At 1:50 p.m., the Administrator provided the surveyor the above requested staffing schedules. However, the Administrator was unable to provide the OIG auditor the facility's staffing schedule at the time of their visit on 7/31/24. The surveyor reviewed a facility policy dated 1/4/17 titled "Personnel Policy" which indicated " ... 4. Staffing schedules are maintained and implemented to ensure continuity of care ..."	M 419		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 421	Continued From page 5	M 421		
M 421	8:43F-6.3(e)(1)(i) General Services (e) The facility shall develop and implement a staff orientation plan and a staff training and education plan, including plans for each service and designation of person(s) responsible for ongoing training. 1. All staff shall receive orientation at the time of employment and ongoing in-service training regarding, at a minimum, emergency plans and procedures, the infection prevention and control services, participant rights, and elder abuse. i. The facility shall document ongoing in-service training of all staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to implement a staff orientation and training record for 3 of 4 employees, Employee #'s 1, 2 and 3. This deficient practice is evidenced by the following: On 7/31/24, the Office of Inspector General (OIG) conducted an audit of the facility and observed that the facility did not have orientation records available for 4 of the employees reviewed by the auditor.	M 421		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 421	Continued From page 6 On 9/4/25 at 10:40 a.m., the surveyor reviewed the employee file for Employee #1 and observed an employee training record; however the record was dated [REDACTED] , which was after the OIG audit. At 11:00 a.m., the surveyor reviewed the employee file for Employee #2, the Administrator and observed that there was no documented evidence of employee orientation record. On 9/4/25 at 10:50 a.m., the surveyor reviewed the employee file for Employee #3 and did not observe documented evidence that the employee received orientation upon employment. At 12:30 p.m., the surveyor interviewed the Assistant Administrator (AA) and inquired about orientation for the four above employees. The AA stated that the employees received orientation but could not locate the records. The surveyor reviewed a facility policy titled, "Personnel Policy," dated 1/4/17, which indicated, " ... As part of Quality Improvement, all employees are given orientation and education at the time of employment ... training is documented and filed ..."	M 421		
M 767	8:43F-16.2(a)(1-4) Infection Control, Santation, Housekeeping (a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications, incorporated herein by	M 767		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 767	Continued From page 7 reference: 1. Guideline for Hand Hygiene in Health-Care Settings, PB85-923404, as amended or supplemented; 2. OSHA Standards 29 CFR--1910.1030, Bloodborne pathogens, as amended and supplemented; 3. Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly, and contained in MMWR 39(RR-10), as amended or supplemented; and 4. Prevention of Nosocomial Pneumonia, PB95-176970, January 3, 1997, 46(RR-1), as amended or supplemented. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to review, at least annually, their written policies and procedures regarding infection prevention and control. This deficient practice was evidenced by the following: On 7/31/24, the Office of Inspector General (OIG) conducted an audit of the facility and observed that the facility had not reviewed the facility's Policies and Procedures (PP) for infection	M 767		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 767	Continued From page 8 prevention and control since 2021. On 9/4/25 at 10:50 a.m., the surveyor reviewed the PP manual and observed that the annual review of the PP manual was updated on 12/20/22, 12/18/23 and 12/28/24. At 12:55 p.m., the surveyor interviewed the Administrator and inquired the last time the PP manual for the infection prevention and control was updated and was observed by OIG. The Administrator stated that it was last reviewed and updated on 12/20/21 since there was no new updates. The Administrator explained that she then reviewed and signed the manual for 2022 and 2023 after the OIG visit on 7/31/24.	M 767		
M 805	8:43F-16.5(a)(b)(c) Infection Control, Santation, Housekeeping (a) The facility shall provide and maintain a sanitary and safe environment for participants. (b) The facility shall provide housekeeping and pest control services. (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.	M 805		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 805	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a sanitary and safe environment for all participants. This deficient practice was evidenced by the following: On 7/31/24, the Office of Inspector General (OIG) conducted an audit of the facility and observed extension cords and wires on floor without protection, multiple water damage on ceiling tiles and exposed electrical receptacle without cover. On 9/2/25 at 9:38 a.m., the surveyor toured the facility and did not observe extension cords without protection or exposed electrical receptacles. However, the surveyor observed two ceiling tiles with brown stains. One large brown stain in the ceiling tile in the kitchen and two brown stains outside of the kitchen hallway. At 12:55 p.m., the surveyor interviewed the Administrator and inquired about the brown stains on the ceiling. The Administrator stated that the building maintenance was provided by the building management company and would contact them.	M 805		
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;	M 813		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 10 2. Nonskid wax shall be used on all waxed floors; 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	M 813		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 11 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; 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	M 813		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 12 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 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.	M 813		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT DAYCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873		
(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 13 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the safety of its participants by not having rugs in the facility and chemicals stored in unlocked kitchen cabinets. This deficient practice was evidenced by: On 7/31/24, the Office of Inspector General (OIG) conducted an audit of the facility and observed that the facility had scatter rugs near the front entrance of the facility and NJ Exec Order 26, 4B1 materials in the kitchen. On 9/3/25 at 9:00 a.m., the surveyor observed two rugs on the floor of the front entrance upon entering the facility. At 12:03 p.m., during a tour of the facility with the Administrator, the surveyor observed chemicals under the sink next to the dishwasher in the kitchen At 12:55 p.m., the surveyor interviewed the administrator and inquired about the rugs at the front entrance of the facility and the Administrator stated that the rugs were there for wet feet on rainy days. The surveyor reviewed a facility policy titled, "Housekeeping Building Maintenance Policy" "... Throw rugs or scatter rugs shall not be used in the facility ... All poisonous and toxic materials will be identified, labeled and stored in a locked cabinet or room ..."	M 813		

Acceptable POC #3
Rec'd 10/29/25

NEW LIFE ADULT DAYCARE
727 FRANKLING BLVD SUITE #6
SOMERSET, NJ 08873
732-253-5658

RESPONSE

NJ DEPARTMENT OF HEALTH
Follow up Survey from the Attorney's General Audit – 9/4/25
POC Submitted – 10/15/2025
POC Re-Submitted – 10/xx/2025
POC Re-Submitted – 10/29/2025

TAG# M351 8:43F-4.2 (d): Participant Right's. Telephone numbers shall be posted in the facility at every public telephone and on all bulletin boards.

NJ Exec Order 26

10/29/25
Accepted

CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:

The Facility will meet this standard for all clients by:

- The Facility corrected this on: 9/5/2025 currently all public telephones and any bulletin boards used for posting any public notices now contain a list of the required telephone numbers for all participants in the Facility to view. This audit was done as a QAPI Audit on standard Facility QAPI Form

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all clients currently in the Program:

- The Facility will ensure all public telephones have the required telephone numbers posted as a reference for all client's to use.

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility Administrator immediately audited all public telephones and bulletin boards, on: 9/5/2025 used for posting public notices and ensured that the required listing of phone numbers was posted.
- The Facility Administrator In-Serviced all necessary staff on this requirement, completed on: 9/9/2025. All In-Service's are completed on standard Facility In-Service Forms including Signed Attendance Sheet.

MONITORING PROCEDURE:

Facility will ensure that this deficiency is monitored by implementing the following measures:

- The Facility will monitor overall compliance of this requirement by implementing a Monthly QAPI Audit to be done by the Dir of Social Services on assuring all public telephones and bulletin boards have the required phone numbers posted, this first Monthly QAPI Audit was completed on: 9/29/2025, on Facility Standard QAPI Audit Form. All Facility Audits are written, submitted for the Quarterly QAPI Meetings and filed in the Facility QAPI Binder.
- The Monthly/Quarterly QAPI Audit on posting of telephone numbers will be reviewed Monthly, this was done on 9/30/2025, with the Facility Administrator for overall compliance. Any issues will be immediately addressed and resolved.
- All audits will be presented by the Facility Administrator at the program's Q QAPI Meetings, next Quarterly QAPI Meeting will take place on: 10/30/2025. All QAPI Audits are filed in the Facility QAPI Binder.

TIME FRAME/COMPLETION DATE: CORRECTED

Completion date of: 10/1/2025

1. In-Servicing completed on 9/9/25
2. Monthly QAPI Audits on posting of telephone numbers began, September 2025.

INDIVIDUALS RESPONSIBLE:

- 1- Ownership,
- 2- Facility Administrator,
- 3- Dir. Of Social Services

TAG# M379 8:43F-5.4 (c): Medical Records: Participant Assessment and Plan of Care**CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:**

The Facility will meet this standard for the participant #1 : initials: [redacted] by: [redacted] Dietician

- The Facility will ensure all clients have a Quarterly Diet Assessment completed in a timely manner.

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard for all clients by:

- The Facility immediately corrected this deficiency, beginning with all ongoing scheduled Quarterly Diet Assessments from September 2025 forward. This was completed on 9/30/2025.
- All participants will have a Quarterly Diet Assessment completed by the Dietitian. This is done Monthly when the Consulting Dietitian Visits the Facility. For the Month of September, the Dietitian was in: 09/19/2025

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility Administrator In-Serviced all clinical staff on 9/9/2025 on the requirement for completing Quarterly Reviews, specifically the Dietitian. This In-Service is documented on standard Facility In-Service Forms including Signed Attendance Sheet.
- Facility DON made sure that all clients in the Facility are listed on the Quarterly IDC Review List that goes out monthly by the first of each month, 9/1/2025, 10/1/2025 etc., by Facility DON. This list was audited and documented as a QAPI Audit, for accuracy by the DON on 9/30/2025 to ensure all clients in the program are scheduled for a Quarterly Review. This Audit was documented and reviewed by the DON. It will become part of the Facility QAPI Audits.

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility DON is responsible for keeping the Monthly IDC Quarterly Review List current, accurate and distributed to all clinical staff monthly. It is distributed on the 1st of each month. Send it via email each month.
- The Facility Dietitian will ensure a Monthly QAPI Diet Audit is completed by the last day of each month, 9/30/2025, 10/31/2025 etc. to affirm all clients listed for review that month have a Quarterly Diet Review. This audit will be submitted to Administration on the last day of each month, 9/30/2025, 10/31/2025, etc. on a Monthly basis for review. This is done on standard QAPI Audit Form.
- The Facilities Medical Record Consultant also audits a random % of Medical Records on a Quarterly basis date to be determines most recent audit completed on 10/2/2025 to ensure all clinical Quarterly IDC Reviews are completed. This report is submitted Quarterly on date of actual visit/audit most recent is from 10/2/2025 to Administration for review and follow up on any discrepancies as well. Quarterly Medical Record Reports are done on paper, submitted and become part of the Facility QAPI Audits they are filed in the QAPI Binder. The Monthly/Quarterly QAPI Audits on Quarterly Dietary Reviews completed by the last day of each month will be presented by the Facility Administrator at the Facilities Q QAPI Meetings. Next Quarterly scheduled QAPI Meeting is: 10/30/2025. All QAPI Audits are compiled in the Facility QAPI Binder

TIME FRAME/COMPLETION DATE:

Completion date of: 10/2/25

1. All necessary staff were In-Serviced by the Facility Administrator, on: 9/9/25
2. Monthly QAPI Diet Audits for the Quarterly Diet Reviews began in September 2025
3. Quarterly QAPI Medical Record Audits effective 10/8/25

INDIVIDUALS RESPONSIBLE:

1. Facility Ownership,
2. Facility Administrator,
3. Facility DON
4. Facility Consulting Dietitian
5. Facility Medical Record Consultant

TAG# M407 8:43F-6.3 (a): General Services. All employees will be required to have a reference and or background check completed prior to employment and become part of the employee's personnel file.

N.J. Exec Order 26, 40
10/20/25
Received.

CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:

The Facility will meet this standard for all clients by:

- The Facility immediately corrected this deficiency completed by 10/1/2025., written QAPI Audit. The Facility will ensure all current and future employees have a reference and or background check done prior to employment, proof of this will be maintained in the employee's personnel file.

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS, WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard for all clients by:

- The Facility will ensure all current employees have a copy of their background/reference check done prior to employment in their employee personnel file
- The Facility will ensure all future employees have a copy of their background/reference check done prior to employment in their employee personnel file

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility Administrator performed a written QAPI audit on 10/1/2025 of all employee personnel files to ensure a copy of the employee's reference/background check was done prior to employment is in their personnel file
- Any employee personnel file found not to have a copy of their reference/background check in their personnel file was immediately requested to complete the required reference/background check. Once completed a copy of this was put in the employee's personnel file. No additional issues found in the employee files, completed on 10/1/2025
- Currently all employees have a current reference/background check completed and proof of this is in the employee's personnel file
- The Facility Administrator will ensure all future employees have a reference/background check done prior to employment and posted in their personnel file as well. Ongoing, will be done on day of hire, currently no new employees have been hired.

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility Administrator will monitor overall compliance with this requirement by performing a written Monthly QAPI Audit on all new employee hires, beginning 10/1/2025 *** no new employees hired thus far. This audit will ensure that the pre-employment required background/reference check is done prior to the employee's first day of employment.

- The Monthly QAPI Audit on all new employees and their required background/reference checks will be presented by the Facility Administrator at the Facilities Q QAPI Meetings. Next Quarterly QAPI Meeting is 10/30/2025. All QAPI Audits are filed in the Facility QAPI Binder.

TIME FRAME/COMPLETION DATE: COMPLETED

Completion date of: 10/1/25

1. Audit of all employee personnel files completed 10/1/25
2. Monthly QAPI Audits on new hires personnel file, effective October 2025

INDIVIDUALS RESPONSIBLE:

1. Facility Ownership.
2. Facility Administrator

TAG# M419 8:43F-6.3 (d): General Services. Facility shall maintain written staffing schedules.

NJ Exec Order 26, 4B

10/29/25
Accepted

CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:

The Facility will meet this standard for all clients by:

- The Facility immediately corrected this deficiency. The Facility Administrator assured, the written staff schedules are completed monthly, updated as needed, posted and available for review/reference if requested. Completed 9/9/2025 for 10/2025 Staff Schedules and completed 9/9/2025 for 9/2025 Staff Schedules ** already posted but audited for compliance.

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS, WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard for all clients by:

- The Facility written staff schedules will be completed Monthly, updated as needed, posted and available for review/reference if requested. Staff Schedules are done 30 days in advance any changes etc. will be done and updated on the schedule on an as needed basis. Current schedules are posted and updated if needed for 10/2025. All staffing schedules will be maintained for 7 years filed electronically.

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility Administrator is responsible for making sure the Monthly Staff Schedules are:
 - Completed Monthly *** 30 days in advance
 - Meet required staffing hours
 - Updated as needed based on any callouts etc., this is ongoing
 - Posted as required for reference, posted by the 1st of each month
 - Available for review and reference if requested by any regulatory agency
 - Additionally, all Staff Schedules are saved in the Facilities electronic Employee Personnel File as well

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility Administrator implemented a written Monthly QAPI Audit completed on 9/30/2025 on Staffing Schedules to ensure they are accurate and posted in the Facility for reference and or review.
- The Monthly QAPI Audit, on Staffing Schedules. will be presented by the Facility Administrator to Ownership as well for review and approval. This was done on 10/1/2025, meeting is documented via Facility Meeting Attendance Sheet.

- The Monthly QAPI Audit, on Staffing Schedules. will be presented by the Facility Administrator at the Facilities QAPI Meetings. Next Quarterly QAPI Meeting will be 10/30/2025. All QAPI Audits are filed in the Facility QAPI Binder.

TIME FRAME/COMPLETION DATE:

Completion date of: 10/1/25

1. Audit of Facility to ensure Staffing Schedules are posted and available for review completed on 9/9/25
2. Monthly QAPI Audit of Staffing Schedules began in September 2025.
3. Monthly meeting with Ownership to ensure Staffing Schedules meet requirements and are posted began in October 2025

INDIVIDUALS RESPONSIBLE:

1. Facility Ownership
2. Facility Administrator

TAG# M421 8:43F-6.3 (e): General Services. The Facility should document initial and ongoing in-servicing and training for all employees.

NJ Exec Order 26, 4B

10/24/25 Accepted

CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:

The Facility will meet this standard for all clients by:

- The Facility corrected this deficiency. The Facility will ensure that all employee personnel files show proof that the employee has initial in-service completed on orientation and receives ongoing in-servicing on an annual basis. Proof of this will be in each employee's personnel file. Completed 9/25/2025

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS, WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard for all clients by:

- The Facility will ensure all current employees as well as any future employee's personnel files show the initial orientation that was completed as well as all annual in-service service they receive. All staff In-Servicing will be completed per the Facility Annual In-Service Calendar. Last In-Service for 2025 is scheduled for 12/23/2025. All In-Services are documented on Facility In-Service Form including Signed Attendance Sheet as well.

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility Administrator is responsible for compliance with all employee personnel files
- The Facility Administrator performed a written audit on 9/25/2025 on all current employee files to ensure they have proof of initial orientation training as well as the required annual In-Servicing training. If any employee file was missing proof of this the Administrator met with the individual employee to ensure they completed the required training and signed off on this as well. The Facility is compliant with this requirement, effective 10/1/2025.
- The Facility Administrator made sure the current Policy and Procedure on Staff Training was reviewed. This was completed on 10/1/2025.
- The Facility Administrator also devised/revised the 2 Forms on 10/1/2025, for compliance with staff training:
 - Initial Orientation Check-off for new hires
 - Annual In-Service Check-off for all current employees
- The Facility Administrator also performed an In-Service on 10/3/2025, with all employees on this Policy/requirement as well reviewing the Orientation Check-Off Form, Annual Facility In-Service Calendar and

the Annual In-Service Check-off Form as well. This In-Service is documented on standard Facility In-Service Form including Signed Attendance Sheets.

- The Facility Administrator is responsible for assuring all new hires receive an initial orientation prior to employment in the Facility. Proof of this is shown via the initial orientation check-off form that all employees sign once they have completed their initial orientation. This is kept in the employee personnel file.
- The Facility Administrator is responsible for assuring all current employees receive/participate in the required Annual, Facility In-Service's based on the Facility In-Service Calendar. Proof of this is shown via the annual In-Service Form that all employees must sign once they complete each of the required Facility In-Services per the calendar. This is kept in the employee's personnel file as well.

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility will implement a written Monthly QAPI Audit to begin in 10/25 and be completed for October by 10/31/2025 and to be done for all new hires *** ongoing to ensure they have completed all orientation training as well as signing off on the initial orientation check-off form. This will be done by the Facility Administrator. No new hires for October 2025.
- The Facility will implement a written Annual QAPI Audit to be done for all employees to ensure they have completed all required training as well as signing off on the Annual In-Service check-off form. This will be done by the Facility Administrator. This will be done and completed 12/30/2025
- Both employee training audits will be presented by the Facility Administrator, at the Facilities Q QAPI Meetings. Next Quarterly QAPI Meeting is scheduled for 10/30/2025. All QAPI Audits once submitted become part of the Facility QAPI Binder.

TIME FRAME/COMPLETION DATE: COMPLETED

Completion date of: 10/1/25

1. The Facility Administrator audited all employee personnel files for compliance with required training effective 9/25/25
2. The Facility Administrator revised the current Policy on employee training including the implementation of the 2 forms effective 10/1/25
3. The Facility Administrator In-Serviced all staff on employee training effective 10/3/25
4. The Facility Administrator began the Monthly and or Annual QAPI Audits on staff required training effective 10/1/25

INDIVIDUALS RESPONSIBLE:

1. Facility Ownership
2. Facility Administrator

TAG# M0767 8:43F-16.2 (a): Infection Control, Sanitation and Housekeeping. The Facility is required to develop, implement and review at least annually written policies and procedures regarding infection prevention and control. These must be consistent with CDC publications.

NJ Exec Order 26

10/24/25 Accepted

CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:

The Facility will meet this standard for all clients by:

- The Facility immediately corrected this deficiency. By reviewing their current policies and procedures regarding infection prevention/control. This was completed on 10/1/2025. The policies were reviewed and or revised to be compliant with CDC publications including:
 - Guideline for Hand Hygiene in Health Care Settings
 - OSHA Standards Bloodborne pathogens
 - Prevention and Control of TB in Facilities providing services to elderly
 - Prevention of Nosocomial Pneumonia
- The Policies were reviewed, revised and signed off on a devised Annual Policy Review Form, as required by Facility staff: Administration and the DON. Completed by 10/1/2025

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS, WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard for all clients by:

- The Facility Policies and Procedures on Infection Prevention/Control were and will be reviewed, revised if needed and signed off on the Annual Policy Review Form, on an annual basis. This is scheduled to be done every January, completed by 1/31 each year and revised as needed throughout the year based on Facility needs.

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility Administrator met with the DON to ensure the current Policy and Procedures on Infection Prevention/Control were reviewed, revised and signed off. Completed on 10/1/2025
- The Facility Administrator/DON perform annual In-Servicing on Infection Control with all employees/clients as well. Completed on 10/13/2025. This was done on standard Facility In-Service Form including Signed Attendance Sheet.

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility Administrator implemented a written Annual QAPI Audit on Infection Prevention/Control, this will be completed by 10/30/2025. This audit will ensure all Facility Policies and Procedures pertaining to Infection Control are reviewed, updated if needed, compliant with regulatory requirements and signed off by the Facility Administrator and DON on an annual basis. This audit will be completed by DON by 10/30/2025
- On an annual basis the Facility Administrator and DON will meet to review this audit for compliance and to address any issues of non-compliance. This is to be scheduled for every January and completed by 1/31 annually. It will be documented on the standard Meeting Format Form.
- This Annual QAPI Audit on Infection Control will be presented by the Facility Administrator at the Facilities Q QAPI Meetings. Next Quarterly scheduled QAPI Meeting is 10/30/2025. All QAPI Audits are filed in the Facility QAPI Binder.

TIME FRAME/COMPLETION DATE:

Completion date of: 10/13/25

1. Review of current Facility Policies and Procedures on Infection Control completed by the DON on 10/1/25
2. In-Services done with employees and clients completed by 10/13/25
3. Annual QAPI Audit began effective month of October 2025

INDIVIDUALS RESPONSIBLE:

1. Facility Ownership
2. Facility Administrator
3. Facility DON

TAG# M805 8:43F-16.5 (a) (b) (c): Infection Control, Sanitation and Housekeeping.
The Facility is required to maintain a sanitary and safe environment for all participants.

NJ Exec Order 26,4

10/29/25 Accepted.

CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:

The Facility will meet this standard for all clients by:

- The Facility immediately corrected this deficiency. By assuring the following areas were addressed:
 - Extension cords are to have protection all electrical cords were audited on 9/5/2025 to ensure they have protection,
 - Any electrical receptacle cannot be exposed and needs to be covered these were all audited on 9/5/2025 and all were covered
 - Ceiling tiles should not have any type of damage on them such as water stains etc. The entire building was audited physically and included a written QAPI Building Audit as well, and ceiling tiles were checked to ensure they have no type of damage including water damage etc. Audit took place on 9/5/2025.

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS, WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard by 9/5/2025, for all clients by:

- The areas cited to be deficient in the building were assessed and fixed, completion date of
- The entire building was assessed for any violations including use of extension cords, electrical receptacles and ceiling tiles.

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility Administrator contacted the Building Management company to come and assess the issues identified during these inspections. Building Management responded by coming and doing a building audit Administration reviewed previous written Building Audit as well on 9/25/2025 and all areas found deficient were assessed and fixed by 9/30/2025.
- The Facility Administrator also performed an In-Service Infection Control, Housekeeping and Sanitation on 9/26/2025 this is documented on standard Facility In-Service Form including Signed Attendance Sheet as well, with all employees on Building Safety to review the issues noted and to educate staff to be alert to any possible future issues the building may exhibit. All Facility In-Services are filed in the Facility In-Service Binder

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility Administrator implemented a written Monthly QAPI Audit effective 9/2025 completed by 9/30/2025 on Infection Control, Sanitation and Housekeeping. This includes a building audit to assess the building for safety including but not limited to use of extension cords, electrical receptacles and ceiling tiles. This will be done by Facility Administrator Monthly moving forward and completed by the last day of each month.
- The written Monthly QAPI Audit on: Infection Control, Sanitation and Housekeeping will be reviewed and addressed monthly with: Ownership and Building Management as well to address any possible ongoing issues found. This was done with Ownership on 10/1/2025. Moving forward it will be scheduled for the 1st of each month. This meeting will be documented on Facility Meeting Form
- The Monthly QAPI Audit on: Infection Control, Sanitation and Housekeeping. will be presented by the Facility Administrator at the Facilities Q QAPI Meetings. Next Quarterly QAPI Meeting is scheduled for 10/30/2025. All Facility QAPI Audits are filed in the Facility QAPI Binder.

TIME FRAME/COMPLETION DATE:

Completion date of: 10/1/25

1. Building Management tour to address deficient building issues completed on 9/25/25
2. In-Services done with employees on 9/26/25
3. QAPI Audits began effective month of September 2025

INDIVIDUALS RESPONSIBLE:

1. Facility Ownership
2. Facility Administrator
3. Facility Employees
4. Building Management

TAG# M813 8:43F-16.7 (a): Infection Control, Sanitation and Housekeeping. The Facility is required to maintain a sanitary and safe environment for all participants. Including no use of rugs in the building and all chemicals must be stored in a secure locked location.

NJ Exec Order 26.2

10/29/25 Accepted

CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:

The Facility will meet this standard for all clients by:

- The Facility immediately corrected this deficiency. By assuring the following areas were addressed:
 - Scatter rugs were removed from throughout the building completed on 9/25/2025
 - All chemicals utilized in the building are kept in a secure locked location, for dishwasher soap and rinsing agent The cabinet was installed with lock next to dishwasher. Others are stored in locked utility closet completed on 9/25/2025

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS, WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard for all clients by:

- The areas cited to be deficient included use of scatter rugs which were removed and storage of chemicals which require they be kept in a secure locked location. Completed by 9/25/2025

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility Administrator immediately audited the building on 9/25/2025 for scattered rugs *** all were removed and any chemical being utilized in the Facility was stored in a secure locked location.
- The Facility Administrator performed an In-Service on 9/25/2025 with all personnel on Infection Control, Sanitation and Housekeeping, including the importance of not using any type of rug in the facility and the proper storage of chemicals. All In-Services are documented on Facility In-Service Form including Signed Attendance Sheet.

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility Administrator implemented a written Monthly QAPI Audit effective 9/2025 and completed on 9/30/2025 on Infection Control, Sanitation and Housekeeping. This includes no rugs to be used in the building and the secure locked storage of all chemicals. This will be done by Facility Administrator monthly moving forward and completed by the last day of each month.
- Additionally, the written Monthly QAPI Audit will be reviewed with ownership as well for overall compliance. This was completed on 10/1/2025 and moving forward will be scheduled for to be held on the 1st of each month. Proof of this meeting will be documented on Facility Meeting Form.
- The Monthly Report on: Infection Control, Sanitation and Housekeeping. will be presented by the Facility Administrator at the Facilities Q QAPI Meetings. Next Quarterly QAPI Meeting scheduled for 10/30/2025. All QAPI Reports are compiled and filed in the Facility QAPI Binder.

TIME FRAME/COMPLETION DATE:

Completion date of: 9/25/25

1. Audit of building for compliance effective 9/25/25
2. In-Service completed with employees on 9/25/25

3. QAPI Audits began effective month of September 2025

INDIVIDUALS RESPONSIBLE:

1. Facility Ownership
2. Facility Administrator
3. Facility Employees

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 18112	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/29/2025
NAME OF FACILITY NEW LIFE ADULT DAYCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 727 FRANKLIN BOULEVARD, SUITE # 6 SOMERSET, NJ 08873	

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 M0351	Correction	ID Prefix M0379	Correction	ID Prefix M0407	Correction
Reg. # 8:43F-4.2(d)	Completed	Reg. # 8:43F-5.4(c)	Completed	Reg. # 8:43F-6.3(a)	Completed
LSC	10/01/2025	LSC	10/02/2025	LSC	10/01/2025
ID Prefix M0419	Correction	ID Prefix M0421	Correction	ID Prefix M0767	Correction
Reg. # 8:43F-6.3(d)	Completed	Reg. # 8:43F-6.3(e)(1)(i)	Completed	Reg. # 8:43F-16.2(a)(1-4)	Completed
LSC	10/01/2025	LSC	10/01/2025	LSC	10/13/2025
ID Prefix M0805	Correction	ID Prefix M0813	Correction	ID Prefix	Correction
Reg. # 8:43F-16.5(a)(b)(c)	Completed	Reg. # 8:43F-16.7(a)(1-23)	Completed	Reg. #	Completed
LSC	10/01/2025	LSC	09/25/2025	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 ☐	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			