STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20A014	A. BUILDING: _____ B. WING _____	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF SUMMIT	26 RIVER ROAD SUMMIT, NJ 07901

(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: Standard with Complaint Complaint #: NJ 00188961 Census: 84 Sample Size: 9 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 12/18/25

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined that the facility's administrator failed to enforce the facility's policy and procedure titled, "Medication Oversight Program" regarding storage of medication for 2 of 10 residents reviewed, Resident #s 1 and 10. This deficient practice was evidenced by the following:

On 10/27/25 at 10:44 a.m., the surveyor observed that the locked door to the Medication Room that was being held partially opened by a door stop. The Medication Room was located within the Wellness Office. The surveyor observed a medication cart with an opened box of NJ Exec Order 26.4b [redacted] on top of the cart, that contained NJ Exec Order 26.4b1. The surveyor observed that under the box was a small clear plastic bag with a prescription label on it, that indicated Resident #1's name on the medication, name of the medication, dosage of the medication, and the frequency in which the medication was to be administered. The surveyor observed the medication cart in the presence of the Resident Care Director (RCD).

The surveyor also observed that the medication cart was unlocked, and a medication bottle with multiple small pills was in the top right drawer. The prescription label indicated that the medication was NJ Exec Order 26.4b1 [redacted] with Resident #10's name on the medication, and the frequency in which the medication was to be

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A 310	Continued From page 2 administered. At 10:50 a.m., the surveyor interviewed the RCD regarding the Medication Room door being propped opened, the medication cart was unlocked, the NJ Exec Order 26.4b1 on top of the medication cart, and the NJ Exec Order 26.4b1 that was in an unlocked drawer of the medication cart. The RCD stated that the door was propped opened as the nursing staff were frequently in the Medication Room for supplies. The RCD stated that the NJ Exec Order 26.4b1 on top of the cart were to be destroyed, but she denied any knowledge regarding the NJ Exec Order 26.4b1 On 10/28/25 at 1:00 p.m., the surveyor reviewed the April 2023 facility policy and procedure titled, "Medication Oversight Program" which revealed "....B. Management of Controlled Substances ... 1. Storage ... Controlled substances are stored in a double locked cabinet(locked box within a locked cabinet or medication cart)." The policy also revealed, "... D. Medication Storage ... 1. Prescription and over-the-counter medications are stored as follows: ... All medications are secured in a locked medication cart or other container/area that is locked ... Controlled medications are double-locked...". At 2:40 p.m., the surveyor interviewed the Executive Director (ED) regarding the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 medications found unlocked in the Medication Room. The ED stated that the RCD had reported the incident to her and they both destroyed the NJ Exec Order 26.4b1 per the facility's policy.	A 310		
A 749	8:36-7.3(a) General and Health Service Plans	A 749		

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A 749	Continued From page 3 (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00188961 Based on interview and record review, it was determined that the facility failed to ensure that the General Service Plan (GSP) was reviewed and revised semi-annually and as needed for 2 of 10 residents reviewed, Residents #3 and #4. This deficient practice was evidenced by the following: On 10/27/25 at 10:30 a.m., the surveyor interviewed the Resident Care Director (RCD) and inquired about the GSP and the Health Service Plans (HSP). The RCD stated that resident GSP and HSP needs were documented on one Service Plan (SP) which were located in the Electronic Medical Record (EMR). The surveyor inquired how often the Service Plans were updated and the RCD stated every six (6) months, or if there was a change in the resident. Additionally, the RCD explained that there were weekly Interdisciplinary Team meetings and that changes in resident health service needs were discussed at the meetings.	A 749		

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A 749	Continued From page 4	A 749		

1. At 11:00 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that the resident moved into the facility in NJ Exec Order 26.4 of NJ Exec Orde with diagnoses of a NJ Exec Order 26.4b1 [redacted]. Review of the MR also indicated that Resident #2 had NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 [redacted] related to the NJ Exec Order 2[redacted].

At 11:15 a.m., the surveyor interviewed Resident #2 in the resident's apartment. Although the surveyor observed that Resident #2 had NJ Exec Order 26.4b1, the resident was NJ Exec Orde [redacted]. Resident #2 stated that he/she received NJ Exec Order 26.4b1 [redacted] and was also NJ Exec Order 26.4b1 with his/her care.

The surveyor reviewed Resident #2's Service Plan (SP) dated NJ Exec Order 26.[redacted] and updated NJ Exec Order 26.4b1. However, there were no other documentation after NJ Exec Order 26[redacted] to reflect that Resident #2's GSP was reviewed semi-annually or quarterly to reflect the resident's NJ Exec Order 26.[redacted] services until NJ Exec Order 26.4b1.

2. On 10/27/25 at 10:00 a.m., the surveyor reviewed Resident #4's medical record (MR) which revealed that Resident #4 moved into the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order [redacted]. Surveyor review of the MR also revealed that Resident #4 had a history of NJ Exec Order 26.4b1 and was received NJ Exec Order 26.4 care since NJ Exec Order 26.4[redacted].

The surveyor reviewed the physician "Order Summary Report" for Resident #4 which revealed an order for NJ Exec Order 26.4b1

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A 749	Continued From page 5 NJ Exec Order 26.4b1 by mouth at bedtime with a start date of NJ Exec Order 26.4. The MR indicated that Resident #4 had a history of NJ Exec Order 26.4b1 which included NJ Exec Order 26.4 and NJ Exec Order related to NJ Exec Order 26.4b1 and, that the NJ Exec Order 26.4b1 occurred when staff assisted the resident with care. Further review of the MR revealed that a NJ Exec Order 26.4b1 monitored and managed Resident #4's NJ Exec Order 26.4b1 medications. The surveyor reviewed Resident #4's Service Plan initiated on NJ Exec Order 26. and updated on NJ Exec Order 26.. There were no other dates observed after NJ Exec Order 26. to reflect that Resident #4's GSP was reviewed semi-annually or quarterly to address the resident's NJ Exec Order 26.4b1 and use of NJ Exec Order 26.4b1 medication until NJ Exec Order 26.4. The surveyor reviewed a facility with a last revision date of 5/15/25, titled, " Individualized Service Plan", which revealed, "Policy Statement: It is the policy of the community to implement a comprehensive person-centered care plan for each resident...that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs...1. The Resident Care Director (RCD)/ Licensed Nurse (LN) ensures that each resident has an Individualized Service Plan (ISP)...3. The ISP is reviewed and updated: a. Every six (6) months or per state/province regulations...Appendix:...NJAC 8:36:7.4 Health care services (c) Written policies and procedures shall be developed and implemented to ensure...1. Assessments of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed quarterly and more often on an as-needed basis..."	A 749		

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A 975	8:36-11.7(a)(1) Storage and Control of Medications (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart. 1. The storage area shall be kept locked when not in use. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the Resident Care Director (RCD) failed to provide an appropriate and safe medication storage area for 1 of 4 medication carts reviewed, Cart #4. This deficient practice was evidenced by the following: On 10/27/25 at 10:44 a.m., the surveyor observed a locked door to the Medication Room held partially opened by a door stop. The Medication Room was located within the Wellness Office. The surveyor observed a medication cart with an opened box of NJ Exec Order 26.4b1	A 975		

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A 975	Continued From page 7 NJ Exec Order 26.4b1 upon having entered the Medication Room, in the presence of the RCD. The surveyor observed NJ Exec Order 26.4b1 in the box. Underneath the box was a small clear plastic bag with a prescription label with Resident #1's name, name of the medication, dosage of the medication, and the frequency of having administered the medication. In addition, the surveyor observed that the medication cart was unlocked and contained a medication bottle with multiple small pills, for Resident #10. The surveyor observed the label on the bottle indicated the medicine was NJ Exec Order 26.4b1 At 10:50 a.m., the surveyor interviewed the Resident Care Director (RCD) regarding the opened door and the unlocked medication cart in the Medication Room. The RCD stated that she had propped opened the door to the Medication Room with the door stop as she entered and exited the room frequently to obtain supplies. The RCD also stated that the NJ Exec Order 26.4b1 were to be destroyed but denied any knowledge about the NJ Exec Order 26.4b1 On 10/28/25 at 1:00 p.m., the surveyor reviewed the facility policy and procedure titled, "Medication Oversight Program", dated April 2023, that revealed "Medication Oversight ... B. Management of Controlled Substances ...1. Storage ... Controlled substances are stored in a double locked cabinet (locked box within a locked cabinet or medication cart ...D. Medication Storage ... 1. Prescription and Over-the-Counter Medications ... All medications are secured in a locked medication cart or other container/area that is locked ...".	A 975		

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A 975	Continued From page 8 At 1:15 p.m., the surveyor interviewed the RCD again regarding the Fentanyl and Lorazepam medications in the Medication Room. The RCD stated that the Fentanyl patches were discontinued previously and destroyed on 10/27/25 per the facility policy, in the presence of the Executive Director. She also stated that she did not know why the Lorazepam was in the unlocked medication cart.	A 975		
A1045	8:36-14.3(c) Drills and Tests (c) The facility shall test at least one manual pull alarm each month of the year and maintain documentation of test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure at least one manual pull alarm was tested each month of the year and maintained documentation of test dates, location of each manual pull alarm tested, person testing the alarm and its condition in accordance with N.J.A.C. 8:36-14.3 (c). This deficient practice was evidenced by the following: On 10/27/25 surveyor review of the facilities drills, inspection, test and maintenance documents provided by the Executive Director (ED), and the Area Facility Manager (AFM)revealed that there was no documentation that manual pull alarms were tested and inspected each month with	A1045		

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A1045	Continued From page 9 written record for the last 12 months. On 10/28/2025 at 2:10 p.m., the surveyor informed the ED and the AFM of the above manual pull alarms concerns.	A1045		
A1095	8:36-16.5(b) Automatic Fire Detection System (b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101.. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure smoke detector sensitivity testing was performed on its smoke detection devices in accordance with N.J.A.C. 8:36-16.5 (b). This deficient practice had the potential to affect all residents and was evidenced by the following: On 10/27/25, surveyor record review of the facility's fire alarm system inspection, test and maintenance reports revealed that there was no	A1095		

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A1095	Continued From page 10 documentation that sensitivity testing was conducted on the 202 smoke detector devices. On 10/28/25 at 2:10 p.m., the surveyor informed the Executive Director and the Area Facility Manager of the above smoke detector sensitivity testing.	A1095		
A1097	8:36-16.6 Fire Suppression Systems All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure; the 5 year internal pipe inspections on the wet and dry sprinkler systems and backflow preventer, 5 year Fire Department Connection (FDC) hydrostatic testing and 5 year gauge replacement or calibration were performed in accordance with N.J.A.C. 8:36-16.6. This deficient practice was evidenced by the following:	A1097		

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A1097	Continued From page 11 Surveyor record review on 10/27/2025 of the facility's sprinkler system inspection, test and maintenance reports revealed the following: 1. The quarterly sprinkler system inspection report dated 01/03/2025 had the following stated under "Recommendations": 5 year inspections listed below will be due May of 2025; 5 year internal pipe inspection (wet and dry systems). 5 year FDC hydrostatic testing. 5 year Backflow internal inspection. 5 year standpipe flow test. 5 year inspections should be scheduled to remain in compliance. 2. The annual sprinkler system inspection report dated 04/23/2025 had the aforementioned 5 year inspections (except standpipe flow test) listed as required under "General Deficiencies" and added the statement, 10 total water gauges are dated 2019 and must be replaced. There was no documentation of the standpipe flow test reviewed. This report further stated that the wet and dry systems were installed 05/05/2020, which would be 5 years on May 5th of 2025 and 5 months and 22 days past due at the time of survey. 3. The quarterly sprinkler system inspection report dated 07/08/2025 had the aforementioned 5 year inspections (except standpipe flow test) and replacing 10 water gauges listed as required under "General Deficiencies". 4. The semi-annual sprinkler system inspection report dated 10/08/2025 had the aforementioned 5 year inspections (except standpipe flow test) and had 11 total water gauges all listed as	A1097		

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A1097	Continued From page 12 required under "General Deficiencies". In summary at the time of survey the following inspections tests and maintenance were identified by the service vendor as deficient and no documentation that they were conducted were provided: a. 5 year internal pipe inspection wet sprinkler system. b. 5 year internal pipe inspection dry sprinkler system. c. 5 year FDC hydrostatic testing. d. 5 year Backflow preventer internal inspection. e. 5 year standpipe flow test. f. 5 year all gauges replacement or calibration. During the interview on 10/28/2025 at 2:10 p.m., the surveyor informed the Area Facility Manager and the Executive Director of the above concerns.	A1097		
A1169	8:36-16.15(a) Fire Extinguisher Specifications (a) Fire extinguishers shall comply with National Fire Protection Association (NFPA) 10, Standards For Portable Fire Extinguishers, 2002 edition, incorporated herein by reference, as amended and supplemented, available from: NFPA, One Batterymarch Park, Quincy, MA, 02169- 7471, http://www.nfpa.org, 1-800-344-3555. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was	A1169		

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A1169	Continued From page 13 determined the facility failed to ensure class K fire extinguishers have a placard placed near the extinguisher that states to actuate the fire protection system prior to using the fire extinguisher in accordance with N.J.A.C. 8:36-16.15 (a), 5:70 and NFPA 10. This deficient practice was evidenced by the following: On 10/27/28 at 12:20 p.m., the surveyor toured the kitchen and observed that the class K fire extinguisher located on a column by the cooking line had no instructional placard conspicuously placed near the extinguisher or anywhere in the kitchen that stated to actuate the fire protection system prior to using the portable fire extinguisher. 10/28/25 at 2:10 p.m., the surveyor informed the Executive Director and the Area Facility Manager of the the K fire extinguisher placard concern.	A1169		
A1179	8:36-17.1(a) Provision of Services (a) The facility shall provide and maintain a sanitary and safe environment for residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure fire door assemblies in exit stairwell enclosures had legible fire rating labels for 4 of 6 doors observed in accordance with N.J.A.C. 8:36-17.1 (a), 5:23 and 5:70. This deficient practice was evidenced by the	A1179		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF SUMMIT	26 RIVER ROAD SUMMIT, NJ 07901

(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
A1179	Continued From page 14 following: On 10/27/28 at 10:05 a.m., the surveyor toured the facility and observed fire doors in the following stairwells had no label or the label was painted over: Stairwell #1, first, second and third floor doors and; Stairwell #2, first floor door. On 10/28/25 at 2:10 p.m., the surveyor informed the Executive Director and the Area Facility Manager of the Stairwell concerns.	A1179		

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Sunrise Senior Living

Plan of Correction

Name of Facility: Sunrise Of Summit
Address of Facility: 26 River Rd, Summit NJ 07901
License number: 20A014
Inspection date(s): 10/28/2025
Name and Title of Legal Entity Representative Signing the Plan of Correction: NJ Exec Order 26.4b1

Signature of Sunrise Representative: NJ Exec Order 26.4b1
Date of Submission: 12/18/25

A310 8:36-3.4(a)(1) Administrator's Responsibilities

Completion Date: 12/18/2025

1. On 10/28/2025 NJ Exec Order 26.4b1 or Resident #1 and NJ Exec Order 26.4b1 for Resident #10 have been destroyed and disposed in the presence of Executive Director and Resident Care Director. The destruction was completed with the use of a Drug Buster disposal system on 10/29/2025. On 10/28/2025, the medication room located in the Wellness office was locked. Resident #1 moved out of the community on NJ Exec Order 26.4b1 Resident # 10 still resides in the community.

2. All residents have the potential to be affected by this deficient practice.

3. On 10/29/2025, the Executive Director in-serviced medication care managers, Licensed Practical Nurses, and Registered Nurses on the "Controlled Drug Security and Reconciliation Policy," effective 5/8/2023, and the "Medication Oversight Program," including proper storage of controlled substances.

4. Starting on 12/18/2025 and for 2 months, the Resident Care Director will hold meetings with the medication care managers, Licensed Practical Nurses, and Registered Nurses to review "Storage of Medication" policy. Plan of Correction to ensure compliance of the "Storage of Medication" policy will be reviewed and evaluated quarterly for two quarters by the Executive Director at Quality Assurance Performance Improvement (QAPI) meeting to verify compliance with policy and procedure of medication storage. If not compliant, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. QAPI meeting scheduled for 1/15/2026 by the Executive Director with the coordinators.

5. Completion Date: 12/18/2025

accepted 12/18/25

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A749 8:36-7.3(a) General and Health Service Plans

Target Completion Date: 1/22/2026

1. Residents # 2 and # 4 still reside in the community. The service plan for Resident #2 was updated on 10/15/2025 by the Resident Care Director to reflect current services the resident is receiving. Service plan for Resident #4 was updated on 10/15/2025 by the Resident Care Director to reflect current services the resident is receiving.

2. All residents have the potential to be affected by this deficient practice. Resident Care Director completed an audit on 10/30/2025 to ensure residents with Health Service Plans were identified through weekly update from outside service providers and documented in the Resident's service plans.

3. The Executive Director re-educated the Resident Care Director, Assisted Living Coordinator, and Reminiscence Coordinator on 10/29/2025 on the current "Individualized Service Plan" policy. This policy includes updating service plans to reflect current services provided to residents.

4. Residents receiving outside services including physical therapy, occupational therapy and speech therapy will be reviewed by Resident Care Director, Assisted Living and Reminiscence Coordinators at weekly Interdisciplinary Team meetings x 6 meetings beginning 12/18/2025 and ending 1/22/2026 to ensure the Care Plans are updated. The "Individualized Service Plan" policy will be discussed quarterly at Quality Assurance Performance Improvement x 2 meetings initiated on 1/15/2026. This Plan of Correction to ensure compliance of General and Health Service Plans will be discussed and evaluated quarterly for two quarters by the Executive Director and Resident Care Director at Quality Assurance Performance Improvement meeting to verify accuracy. If General Service Plans and Health Care Plans have not been reviewed or updated timely, this Plan of Correction will be amended, and a new Plan of Correction and training will be implemented and monitored to verify the violation does not occur again. Quality Assurance Performance Improvement meeting will be initiated on 1/15/2026 by the Executive Director with the coordinators.

5. Target Completion Date: 1/22/2026

Accepted 12/18/25

A 975 8:36-11.7(a)(1) Medication Storage

Completion Date: 12/18/2025

1. On 10/29/2025, [redacted] for Resident #1 and [redacted] for Resident #10 have been destroyed and disposed in the presence of Executive Director and Resident Care Director using the Drug Buster disposal system. Resident #1 moved out of the community on [redacted] Resident # 10 still resides in the community.

2. All residents have the potential to be affected by this deficient practice. Medication cart audits were completed by Resident Care Director on 10/30/2025 to ensure no other narcotics were unsecured.

3. On 10/29/2025, the Resident Care Director in-serviced medication care managers, Licensed Practical Nurses, and Registered Nurses on the "Controlled Drug Security and Reconciliation Policy," effective 5/8/2023, and the "Medication Oversight Program," including proper storage of controlled substances. The Resident Care Director will conduct monthly medication cart audits for 2 months to ensure narcotics are properly stored. Next scheduled audit is 12/18/2025.

4. This Plan of Correction to ensure compliance of proper Medication Storage will be discussed and evaluated quarterly for two quarters, or monthly for 6 months, by the Executive Director and Resident Care Director at Quality Assurance Performance Improvement meeting to verify monthly medication cart checks are completed and compliant. If Medication Storage is non-compliant, this Plan of Correction will be amended, and a new Plan of Correction and training will be implemented and monitored to verify the violation does not occur again. Quality Assurance Performance Improvement meeting initiated on 1/15/2026 by the Executive Director with the coordinators.

5. Completion Date: 12/18/2025

Accepted 12/18/25

A1045 8:36-14.3(c) Drills and Tests

all LS tags renewed by LS F.P.

Completion Date: 12/16/2025

1. A fire drill was completed on 11/25/2025 at 3:20pm by the Area Facility Manager to staff. This drill included pull station location, name of employee who initiated pull station, time pulled, date and condition of alarm. On 11/25/2025 at 3:20pm the manual pull alarm was tested by the Area Facility Manager and in working order.

2. All residents have the potential to be affected by this deficient practice.

3. On 10/29/2025, Area Facility Manager was re-educated on Drills and Tests by Executive Director. Maintenance Assistant was educated on the same by Area Facility Manager during onboarding on 11/10/2025. On 11/25/2025 at 3:20pm the manual pull alarm was tested by the Area Facility Manager and in working order. Monthly fire drills conducted by Area Facility Manager to staff will include checking manual pull alarms and documenting appropriately. Next fire drill is scheduled for 12/16/2025.

4. This Plan of Correction to ensure compliance of Drills and Tests will be discussed and evaluated quarterly for two quarters by the Executive Director and Area Facility Manager at Quality Assurance Performance Improvement meeting to verify its completion. If it is not complete, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify the violation does not occur again. Quality Assurance Performance Improvement meeting initiated on 1/15/2026 by the ED with the coordinators.

5. Completion Date: 12/16/2025

Accepted 1/2/26

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A1095 8:36-16.5(b) Automatic Fire Detection System

Completion Date: 12/16/2025

1. The Area Facility Manager and the outside licensed vendor conducted the smoke sensitivity test on 12/10/2025 and this test was compliant.

2. All residents at the facility have the potential to be affected by this deficient practice.

3. On 10/29/2025, Area Facility Manager was re-educated on Automatic Fire Detection System by Executive Director. On 11/10/2025, Area Facility Manager educated Maintenance Assistance on same during onboarding. A smoke sensitivity test was completed at the community by the outside licensed vendor between 12/9/20/25 – 12/10/2025 and all are within required regulations. A biannual work order for sensitivity testing will be placed in the community's electronic monitoring maintenance system on 12/16/25 by the Executive Director. This will ensure that our Area Facility Manager conducts these tests as required in accordance with NFPA 72 national Fire Alarm and signaling code Section 14.4.5.3.2.

4. The Area Facility Manager will utilize our electronic monitoring maintenance program to maintain and monitor all required testing, including smoke sensitivity biannual checks. The Plan of Correction will be discussed and evaluated quarterly for two quarters by the Executive Director and the Area Facility Manager at the Quality Assurance Performance Improvement (QAPI) meeting to verify it is still effective. If it is not effective, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. QAPI meeting scheduled for 1/15/2026, by the Executive Director with the Area Facility Manager and Department Heads.

5. Completion Date: 12/16/2025

Accepted 1/2/26

A1097 8:36-16.6 Fire Suppression Systems

Target Completion Date: 1/7/2026

1. Five-year inspections to include Internal Pipe Inspection, Check Valve Inspection, Back Flow Inspection, and Hydrostatic Test and replacement of 12 outdated pressure gauges are scheduled for outside licensed vendor to be completed on 1/7/26.

2. All residents have the potential to be affected by this deficient practice.

3. Five-year inspections have been added to electronic building maintenance system by the Area Facility Manager by 12/31/2025. Document of completion will be uploaded to complete the task and stay compliant. Task will flag if there is no documentation.

4. This Plan of Correction to ensure compliance of Fire Suppression System will be discussed and evaluated quarterly for two quarters by the Executive Director and Area Facility Manager at Quality Assurance Performance Improvement meeting to verify its completion. If not complete, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. Quality Assurance Performance Improvement meeting initiated on 1/15/2026 by the Executive Director with the coordinators.

5. Target Completion Date: 1/7/2026

Accepted 1/2/26

A1169 8:36-16.5(a) Fire Extinguisher Specifications

Completion Date: 12/16/2025

1. On 10/28/2025, Area Facility Manager posted a temporary K-Class instruction sign above K-Class extinguisher and ordered the required K-Class instruction sign. Required sign arrived on 10/30/2025 and was posted above the K-class extinguisher upon arrival.

2. All residents have the potential to be affected by this deficient practice.

3. During monthly extinguisher inspections, Area Facility Manager will review posted signage to ensure visibility. Next scheduled extinguisher inspection for all extinguishers is 12/16/2025 and will be conducted by Maintenance Assistant. Check for community's K-Class extinguisher signage added to monthly extinguisher checklist on 12/9/2025. Maintenance Assistant trained on 11/10/2025 by Area Facility Manager to check signage for extinguishers during monthly extinguisher inspection. No other K-Class extinguishers identified. On 10/30/2025, required K-Class extinguisher signage was postage above K-Class extinguisher.

4. This Plan of Correction to ensure compliance of Fire Extinguisher Specifications will be discussed and evaluated quarterly for two quarters by the Executive Director and Area Facility Manager at Quality Assurance Performance Improvement meeting to verify its completion. If not complete, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. Quality assurance Performance Improvement meeting initiated on 1/15/2026 by the Executive Director with the coordinators.

5. Completion Date: 12/16/2025

Accepted 1/2/26

A1179 8:36-17.1(a) Provision of Services

Completion Date: 11/10/2025

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1. On 10/28/2025, the Area Facility Manager inspected all fire doors and removed paint from fire rating tags on all affected fire doors. As of 10/28/2025 and ongoing, fire rating tags on all extinguishers are visible.

2. All residents have the potential to be affected by this deficient practice. Area Facility Manager audited fire doors in the community on 10/28/2025 to ensure fire tag ratings were visible.

3. On 11/10/2025, the Maintenance Assistant was trained by the Area Facility Manager to check fire rating tags during monthly fire drills to ensure clear tag visibility. Area Facility Manager will inspect fire rating tags quarterly for 2 quarters to ensure proper visibility. Next scheduled quarterly inspection is 1/15/2026.

4. This Plan of Correction to ensure compliance with the Provision of Services will be discussed and evaluated quarterly for two quarters by the Executive Director and Area Facility Manager at Quality Assurance Improvement meeting to verify its completion. If not complete, it will be amended and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. Quality assurance Performance Improvement meeting initiated on 1/15/2026 by the Executive Director with the coordinators.

5. Completion Date: 11/10/2025

Accepted 1/12/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
20A014 (Y1)	A. Building B. Wing (Y2)	1/2/2026 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF SUMMIT	26 RIVER ROAD SUMMIT, NJ 07901

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 12/18/2025	ID Prefix A0749 Reg. # 8:36-7.3(a) LSC	Correction Completed 01/22/2026	ID Prefix A0975 Reg. # 8:36-11.7(a)(1) LSC	Correction Completed 12/18/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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
10/28/2025

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
20A014 Y1	A. Building B. Wing Y2	1/2/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF SUMMIT	26 RIVER ROAD SUMMIT, NJ 07901

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ID Prefix A0310	Correction	ID Prefix A0749	Correction	ID Prefix A0975	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-7.3(a)	Completed	Reg. # 8:36-11.7(a)(1)	Completed
LSC	12/18/2025	LSC	01/22/2026	LSC	12/18/2025
ID Prefix A1045	Correction	ID Prefix A1095	Correction	ID Prefix A1097	Correction
Reg. # 8:36-14.3(c)	Completed	Reg. # 8:36-16.5(b)	Completed	Reg. # 8:36-16.6	Completed
LSC	12/16/2025	LSC	12/16/2025	LSC	01/07/2026
ID Prefix A1169	Correction	ID Prefix A1179	Correction	ID Prefix	Correction
Reg. # 8:36-16.15(a)	Completed	Reg. # 8:36-17.1(a)	Completed	Reg. #	Completed
LSC	12/16/2025	LSC	11/10/2025	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	
10/28/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO