New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25262	A. BUILDING: _____ B. WING _____	C 10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA AT CINNAMINSON	605 ROUTE 130 CINNAMINSON, NJ 08077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00184128 CENSUS: 73 SAMPLE SIZE: 3 SURVEY DATE: 10/10/2025 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 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;	A 401		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/14/25

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A 401	Continued From page 1	A 401		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00184128

Based on interview, and closed record review, it was determined that the facility failed to provide a safe environment for a resident who previously NJ Ex Order 26.4(b)(1) while a resident at the facility and who required NJ Ex Order 26.4(b)(1) after hospitalization, as the resident was an NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for NJ Exec Order 26.4b1 following NJ Ex Order 26.4(b)(1) and was evidenced by the following:

A review of a Facility Reportable Event (FRE) that occurred on NJ Ex Order 26.4 at 2:50 PM, and was reported to the New Jersey Department of Health (NJDOH) on NJ Ex Order 26 at 3:32 p.m., revealed that the facility received a message from Resident #1's Power of Attorney (POA) who reported that they had concerns for the resident's NJ Ex Order 26.4(. Upon receipt of the message, the facility staff ran to the resident's room and found that the NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1). The resident was seen NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) next to them with NJ Ex Order 26.4(b)(1) . In addition there were NJ Ex Order 26 the resident and NJ Ex Order 26.4(b)(1). The resident NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1). The facility called NJ Exec Or immediately and NJ Ex Order 26.4(b)(1) and EMS (Emergency Medical Services) who arrived within minutes and NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1) and provided emergency care

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A 401	Continued From page 2 and the resident was taken to the hospital. On 10/10/25 at 9:50 AM, the surveyor reviewed the Electronic Health Record (EHR) of Resident #1. A review of the Emergency Data Summary (an admission summary) revealed that Resident #1 was admitted to the facility with diagnoses which included but were not limited to; [NJ Ex Order 2 redacted], and NJ Ex Order 26.4(b)(1) [redacted]. A review of a "Assessment/Evaluation Service Planning" that was completed by the facility Health and Wellness Director (HWD)/Registered Nurse on [NJ Ex Order 26.4(b) redacted] revealed that the resident did not receive [NJ Ex Order 26.4(b) redacted] care services and was able to NJ Exec Order 26.4b1 [NJ Ex Order 26.4 redacted] Further review of the assessment indicated that the resident had no current [NJ Ex Order 26.4(redacted]) and had a current diagnosis of [NJ Ex Order 26.4 redacted] and NJ Ex Order 26.4(b)(1) A review of the facility Care Plan entry dated [NJ Ex Order 26.4(redacted] revealed "Resident had a [NJ Ex Order 26.4(b)(redacted] Upon returning from the hospital a NJ Ex Order 26.4(b)(1) was required....Services/Interventions included; [NJ Ex Or redacted] put in place. Discipline: Outside provider." A review of an Advanced Practice Nurse (APN) assessment dated [NJ Ex Order 26.4(redacted] at 9:58 a.m., revealed "Chief Complaint: f/u (follow-up) s/p (status post) hospitalization after NJ Ex Order 26.4(b)(1) ...Patient seen and examined sitting up in w/c (wheelchair). Resident had NJ Ex Order 26.4(b)(1) [redacted]. Resident reports [NJ Exec Orde redacted] as "[NJ Ex Ord redacted] "...In order to return to the facility, it was required that the resident have [NJ Ex Order 26.4(b)(1 redacted] for	A 401		

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A 401	Continued From page 3 NJ Exec Order 2 NJ Ex O noted at the resident's side. The resident reported NJ Ex Order 26.4(b)(1) at this time and 'NJ Ex Order 26.4(b)(1)."... NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1). Resident reported NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) but reports no NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) A review of a Progress Note (PN) dated NJ Ex Order 26.4(at 12:49 PM, revealed the Resident Associate (RA, a Medication Technician/Certified Nursing Assistant) #2 documented "Resident returned back to our community this morning from the hospital (name redacted)....The resident was made aware that they would be NJ Ex Order 26.4(b)(1) a day..." Further review of the PN revealed a Type of Incident: NJ Exec Order 26.4b1 Incident dated NJ Ex Order 26.4(at 11:02 PM, that indicated that the Licensed Practical Nurse (LPN) #1 documented that "the Resident stated the NJ Ex Order 26.4(b)(1) who was to NJ Ex Order 26.4(b)(the resident NJ Ex Order 26.4(b)(1) and was NJ Ex Ord and the resident NJ Ex Order 26.4(b)(1) in the room. The resident stated that they NJ Ex Order 26.4(b)(1) to get NJ Ex Order 26.4(b)(1) of their apartment....the resident was informed that by NJ Ex Order 26.4(b)(1) the resident had NJ Ex and would have to return to the hospital. The resident NJ Ex Order 26.4(b)(1) showing where they previously NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 them and said, NJ Ex Order 26.4(b)(1) ...I NJ Ex Order 26.4(b)(1) to send the resident back to the hospital. I also had staff sit with the resident until NJ Exec Orde arrived." Further review of a PN dated NJ Ex Order 26.4(at 10:14 AM, revealed that the RA #2 documented in a PN that the resident arrived back to NJ Ex Order 26.4(b)(1) from the hospital and was in their apartment with their NJ Ex Order 26.4(b)(1)	A 401		

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A 401	Continued From page 4 Further review of a PN dated [NJ Ex Order 26.4(b)] at 5:12 p.m., revealed that LPN #1 documented that the resident sent their [NJ Ex Order 26.4(b)(1)] to get their medication at 5:02 PM, which was due at 5:00 p.m., and stated to the [NJ Ex Order 26.4(b)(1)] that she should not [NJ Ex Order 26.4(b)(1)] by no means...Resident was reminded to use the pendant (call bell) and they were not to [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] the room... Further review of the PN revealed a "Type of Incident: [NJ Exec Order 26.4b] Incident" dated [NJ Ex Order 26.4(b)(1)] 4:21 p.m., which indicated that the HWD documented the following in a Resident Report: Resident stated they were having [NJ Ex Order 26.4(b)(1)] [redacted].What was seen and heard: It was reported from [NJ Ex Order 26.4(b)] that resident went to the store with the aide and purchased [NJ Ex Order 26.4(b)(1)] [redacted]). Nursing staff unaware [NJ Ex Order 26.4(b)(1)] stated the resident NJ Ex Order 26.4(b)(1) [redacted] in one sitting and then the [NJ Ex Ord] reported to staff once the NJ Ex Order 26.4(b)(1). The resident stated that they had [NJ Ex Order 26.4(b)(1)] and that [NJ Ex Order 26.4(b)(1)] them. The resident was seen by [NJ Ex Order 2] [redacted] immediately and it was recommended that resident had [NJ Ex Order 26.4(b)(1)] and be sent to NJ Ex Order 26.4(b)(1) . On 10/10/25 at 10:39 AM, during an interview with the Health and Wellness Director (HWD) she stated that Resident #1 NJ Ex Order 26.4(b)(1) and that the "system [hospital] failed them afterwards." The HWD stated that the home office stated that the resident could not return to to the facility without [NJ Ex Order]. The HWD stated that there was an instance where facility staff rounded and found that the NJ Ex Order 26.4(b)(1) [redacted] and the resident was [NJ Ex Order 26.4(b)(1)] in their	A 401		

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A 401	Continued From page 5 NJ Ex Order 26.4(b)(1) with their NJ Ex Order 26.4(b)(1). When the surveyor asked where the incident was documented, the HWD stated that the incident was not documented as the facility staff reported the incident directly to the HWD. At that time, the Memory Care Manager (MCM) who was also present stated that another agency's NJ Exec let the resident NJ Exec Order 26.4b1 (name redacted) and let the resident 'NJ Ex Order 26.4(b)(1) [redacted]." The MCM further stated that the aide then allowed the resident to be in the NJ Ex Order 26.4(b)(1) The NJ Ex C reported to the oncoming aide that she saw the NJ Ex Order 26.4(b)(1) [redacted] was in the trash can afterward and the oncoming aide immediately reported the incident to us. At that time, the HWD stated that she called the doctor immediately and had NJ Ex Order 26.4(b)(1) evaluate the resident. The HWD further stated that the resident was then sent to the hospital where they were admitted and never returned. The HWD stated the resident was 'NJ Exec Order 26.4b1." When the surveyor asked how the facility educated the NJ Ex Order 26.4(b)(1) regarding the facility expectations for resident safety, the HWD stated the agency educated their staff. The HWD further stated that when facility staff reported that the NJ Ex C staff was also NJ Ex Order 26.4(b)(1) in the resident's room, they got a new aide. The HWD further stated that a different aide let the resident go into the NJ Ex Order 26.4(b)(1), before the NJ Ex Order 26 [redacted] was NJ Ex Order 26.4(b)(1) by the resident. The HWD stated that the facility staff checked on the resident in addition to the NJ Ex Or service provided. At that time, the surveyor asked the HWD for documented evidence that the facility staff	A 401		

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A 401	Continued From page 6	A 401		

performed routine wellness checks every shift on the resident while NJ Ex Order 26.4(b)(1) of the agency NJ Ex Order 26.4(b)(1). The HWD was unable to provide the surveyor with documented evidence that the wellness checks were routinely performed every shift as described. The HWD was also unable to provide the surveyor with documented evidence when requested that the agency NJ Ex Order 26.4(b) and the facility staff were provided with education, training, and expectations to safeguard the resident from NJ Ex Order 26.4(b)(1) while on NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4

On 10/10/25 at 1:04 p.m., the surveyor interviewed RA #2 who stated that the resident's NJ Ex Orde were told that the resident required NJ Ex Order 26.4(b and the resident should not have been NJ Ex Order 26.4(b)(1) even when the resident was NJ Ex Order 26.4 as the resident must be accompanied with NJ Ex Order 26.4(b)(1). RA #2 stated that she had recalled seeing a NJ Ex O coming out of the resident's room to request medication for the resident. RA #2 stated that the residents could NJ Ex Order 26.4(b)(1) with the NJ Ex Order 26.4(b)(1) but the NJ Ex Order 26.4(b)(1) were employed by an outside agency and they may not communicate with us.

At that time, the surveyor asked RA #2 if the facility provided any education or training to the facility staff after the resident's NJ Ex Order 26.4(b)(1) to assure resident safety. RA #2 stated that she was one of the staff who found the resident immediately after the NJ Ex Order 26.4(b)(1). RA #2 stated that it was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) was provided, but she was unsure if any education was provided.

On 10/10/25 at 3:25 p.m., the facility failed to

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A 401	Continued From page 7 provide the surveyor with a policy that addressed an acute change in resident condition to assure resident safety when requested.	A 401		
H 000	Initials Comments TYPE OF SURVEY: Complaint COMPLAINT #: NJ00184128 CENSUS: 73 SAMPLE SIZE: 3 SURVEY DATE: 10/10/2025 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.	H 000		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record.	H5790		

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H5790	Continued From page 8	H5790		

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Complaint #: NJ00184128

Based on interview, and record review, it was determined that the facility failed to ensure that a Universal Transfer Form (a mandatory form used by New Jersey's licensed healthcare facilities to communicate essential patient care information during a transfer to another facility) was completed prior to hospital transfer and evidence of completion was retained within the resident's closed medical record.

This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for safety precautions following NJ Ex Order 26.4(b)(1) and was evidenced by the following:

On 10/10/25 at 9:50 AM, the surveyor reviewed the Electronic Health Record (EHR) of Resident #1.

A review of the Emergency Data Summary (an admission summary) revealed that Resident #1 was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 2 [redacted], and NJ Ex Order 26.4(b)(1) [redacted]

A review of the Progress Notes (PN) revealed a "Type of Incident: NJ Exec Order 26.4b1 of Resident

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H5790	Continued From page 9 Condition (with or without 911), Incident" dated [redacted] at 2:45 PM, which revealed: Location: NJ Ex Order 26.4(b)(1) Resident Report: resident NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). What Was Seen and Heard: resident [redacted] in ed with [redacted] and NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) What Did You Do? Checked for [redacted] and [redacted] NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) [redacted], [redacted] called immediately... Further review of the EHR revealed a Progress Note (PN) dated [redacted] at 10:50 PM, which indicated "Resident was sent out to the hospital (name redacted) after not wanting NJ Ex Order 26.4(b)(1) [redacted]..." Further review of a PN dated [redacted] at 4:58 PM, revealed, "It was reported from [redacted] that the resident (name redacted) went to the store with aide and purchased NJ Ex Order 26.4(b)(1). Nursing staff unaware. The [redacted] stated the resident NJ Ex Order 26.4(b)(1) [redacted] in one sitting and then the aide reported to staff once [redacted]. The resident stated that they had [redacted] and it NJ Ex Order 26.4(b)(1)....The resident agreed to [redacted] go to the ER (emergency room) for [redacted] eval and possibly get admitted into NJ Ex Order 26.4(b)(1). [redacted] called and resident was taken to the hospital (name redacted) via [redacted] No s/s (signs and symptoms) of [redacted] when leaving the building..." On 10/10/25 at 1:25 PM, the Health and Wellness Director (HWD) confirmed the timeline of the resident's hospitalizations which occurred on	H5790		

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H5790	Continued From page 10 NJ Ex Order 26, when the resident as hospitalized for NJ NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(, when the resident returned from the hospital and NJ Ex Order 26.4(b)(1) and was sent back out to the hospital, and lastly on NJ Ex Order 26.4(, and that was the resident's final send out to the hospital due to the NJ Ex Order 26.4(b)(1) . During a later interview with the HWD on 10/10/25 at 2:45 PM, the surveyor reviewed both the resident's EHR and the hybrid paper based medical record both of which failed to contain documented evidence that a Universal Transfer Form was completed and sent to the hospital with the resident for each hospital transfer that occurred on NJ Ex Order 26 , NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b) At that time, the HWD stated that if the Universal Transfer Form was not in the chart, then a copy was not made and placed in the chart. The HWD stated that the facility was required to keep a copy and it was to be maintained in the resident's medical record. When the surveyor asked how the facility could ensure that the Universal Transfer Form was completed prior to hospital transfer the HWD stated, "If it was not documented, it was not done." A policy for the completion of the Universal Transfer Form was not provided when requested.	H5790		

POC#3 received 11/20/25
Accepted 11/20/25

AZALEA
AT CINNAMINSON

Azalea at Cinnaminson
Plan of Corrections for Survey conducted on 10/10/2025.
*License 25262

To whom it may concern:

Here is the response to the NJ Department of Health after they found my initial plan of corrections unacceptable.

Tag# A401
8:36-4.1 (a)(22) Resident Rights

Element #1 — Corrective action taken for Resident #1

1. Resident #1 Status: Resident #1 was discharged on NJ Ex Order 26.4(b)(1) He/She was safely discharged to NJ Ex Order 26.4(b)(1) qualified to meet his/her needs.

2. If Resident #1 no longer resides at the facility, the DON confirmed that the final service plan documentation is complete and accurate. Completed 2/13/2025.

Element #2 — Identification of other residents and protective actions

1. The DON completed a facility-wide audit on 1 1 /3/2025 to identify all residents with:
- A diagnosis of depression
- A history of suicidal ideations
- Recent psychological or behavioral health risk indicators
2. Supportive Services: Residents identified were referred or re-referred for:
- Behavioral health evaluations - Psychiatry and counseling services
- Social work support
- 1:1 supervision needs assessment
3. This took place on 11/3/2025 and 11/4/2025. We had a sign-in sheet for residents who were identified. This deficient practice was corrected on 11/4/2025.

4. Updated GSPs and HSPs include:

- Specific interventions for depression
- Protocols for suicidal ideation risk
- Notification procedures
- Safety checks as required

This update was completed and verified on 11/3/2025. This deficient practice was corrected on 11/3/2025.

AZALEA
AT CINNAMINSON

Element #3 — Systemic measures to prevent recurrence

A. Completion of audit. An audit was completed to identify any resident with depression or suicidal ideation risk.

Documentation was updated for all identified residents. This happened on 11/3/2025 and 11/4/2025.

B. Care Planning Interventions

1. For any resident with suicidal ideation history, the facility will implement:

- Mandatory psychiatric evaluation
- Behavior monitoring documentation
- Immediate risk-escalation protocols

As of 11/3/2025, no residents had a diagnoses or suicidal ideation history. This deficient practice was corrected on 11/3/2025.

2. The DON will supervise the creation, updating, and ongoing review of all GSPs and HSPs.

Ongoing updates at:

- Change of condition
- Quarterly review
- Post-incident review

This was reviewed on 11/3/2025 and will be an ongoing project, monitored by the DON. The current residents and the deficient practice will be completed and corrected by 12/15/2025.

C. Staff & Agency Education

1. Education Topics:

- Resident rights and safety obligations under N.J.A.C. 8:36-4.1
- Supervision requirements for residents with psychiatric risks
- How to recognize and report suicidal ideation
- Expectations for 1:1 supervision
- Immediate steps if a resident is at risk
- Protocol if a private duty companion is found sleeping or unable to perform duties

2. Who Will Conduct Training:

- DON
- Administrator
- Licensed mental health professional, when needed.

3. Who Will Be Trained:

- All facility staff (nursing, caregivers, housekeeping, activities, dietary) - All agency/temporary staff
- All private duty aides providing 1:1 supervision

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4. Meetings will be held quarterly for staff and residents and there will be a log-in sheet to keep track of all attendees.

The first training took place on 2/6/2025. We have, since then, consistently performed in-services, covering all of the above topics. Also, a counseling support group now comes in weekly, every Thursday. D. Private Duty Companion Protocol

If a companion assigned to 1 :1 supervision is found sleeping or unable to perform duties for any reason:

- They will be immediately removed from assignment.
- Facility staff will assume 1 :1 supervision until safe replacement is secured.
- Incidents will be documented and reported to the agency.
- Administrator will review agency compliance.

Element #4 — Monitoring; Ongoing Evaluation Monitoring Plan

1. The DON will conduct weekly audits for 12 weeks, then monthly audits for 12 months, reviewing:
   - GSP/HSP accuracy
   - Whether interventions for residents with depression/suicidal ideation are followed
   - Documentation of 1:1 supervision
   - Staff adherence to safety protocols

This began on 11/3/2025 and will continue weekly. This deficient practice was corrected on 11/3/2025.

2. Regular Meetings:
   - QAPI meetings will take place monthly, chaired by the Administrator.
   - Attendees: Administrator, DON, Social Worker, Unit Managers, QAPI Nurse.
   - Meetings will review audit results, care plan accuracy, and incident trends. 3. Audit findings will be documented, and corrective actions will be taken the same day if deficiencies are found.

First meeting took place on 11/10/2025, 2nd meeting is scheduled for 12/15/2025 and will continue monthly.

This deficient practice was corrected on 11/10/2025. [redacted] approved 11/20/25

Tag# HOOO and H5790

8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM

Complaint # #: NJ00184128

1. Enforcement of Licensure Regulations

AOOO referenced the items below and these deficient practices will be corrected by:

For any resident identified without a Universal Transfer Form on file, staff completed the required Universal Transfer Form based on available documentation (nurse notes, MAR, assessments) and filed it in the resident's medical record to ensure the chart is complete.

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The hospital and/or receiving facility contacted, if necessary, to verify that the required transfer information was provided at the time of transfer. This took place on 11/3/2025.

Status of Resident #1: Resident #1 was discharged or NJ Ex Order 26.4(b)(1) He/She was safely discharged to NJ Ex Order 26.4(b)(1) qualified to meet his/her needs.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

Monitoring for Effectiveness

- Goal: 100% of all resident transfers to the hospital have a completed and filed UTF.
- Timeframe: Within 90 days of implementation.
- Evaluation: Audit results demonstrate Sustained compliance

Audit was completed 11/7. All residents have completed and filed UTF. This practice will continue and be ongoing. This deficient practice was corrected on 11/7/2025.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur:

Documentation Checklist:

- Add a "Transfer to Hospital" checklist to the nurse's station or EMR workflow including a checkbox:
    1. Universal Transfer Form completed
    2. Copy filed in chart
    3. Packet sent with EMS o The nurse must initial the checklist before signing off.

This was completed on 11/3/2025. The DON will remain on top of this going forward. This deficient practice was corrected on 11/3/2025.

Ongoing Monitoring:

- The Nurse Manager or Designee will perform weekly audits for 4 weeks, then monthly for 3 months, reviewing all transfers for Universal Transfer Form presence in the chart. This began on 11/3/2025 and will continue. Reinforcement and Accountability:
- Staff not following the procedure will receive coaching or progressive discipline per facility policy. This deficient practice was corrected on 11/3/2025.

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4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes,

1 . Audit and Verification:
   - The Charge Nurse or designee will immediately audit all hospital transfers from the past 30 days to ensure a Universal Transfer Form copy is in each resident's chart.
   - If any are missing, staff will complete and file the form retroactively as feasible. This was completed on 11/3/2025 and will be ongoing. This deficient practice was corrected on 11/3/2025.

2. Staff Re-Education:
   o All nursing staff will receive immediate re-education on the facility's Transfer and Discharge Policy, emphasizing that the Universal Transfer Form must be:
   a. Completed in full before the resident leaves the facility.
   b. A copy made for the chart before EMS departure.

   All nursing staff received this re-education on 11/3/2025.

3. Accountability Reminder:
   - A memo or visual reminder will be posted at the nurses' station near the 911 phone and fax/copier.

   This was posted on 11/3/2025. This deficient practice was corrected on 11/3/2025.

4. Documentation Checklist:
   O Add a "Transfer to Hospital" checklist to the nurse's station or EMR workflow including a checkbox:
      1. Universal Transfer Form completed
      2. Copy filed in chart
      3. Packet sent with EMS o The nurse must initial the checklist before signing off.

   As noted above, this was added on 11/3/2025. This deficient practice was corrected on 11/3/2025.

5. Ongoing Monitoring:
   - The Nurse Manager or Designee will perform weekly audits for 4 weeks, then monthly for 3 months, reviewing all transfers for Universal Transfer Form presence in the chart. As noted above, this was started on 11/3/2025 and will continue. This deficient practice was corrected on 11/3/2025.

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6. Reinforcement and Accountability:
    - Staff not following the procedure will receive coaching or progressive discipline per facility policy.
7. This began as of 11/3/2025 and will remain ongoing. **This deficient practice was corrected on 11/3/2025.**

approved
11/20/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
25262 Y1	A. Building B. Wing Y2	11/20/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA AT CINNAMINSON	605 ROUTE 130 CINNAMINSON, NJ 08077

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 A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 11/10/2025	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	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	
10/10/2025	☐ 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
25262 Y1	A. Building B. Wing Y2	11/20/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA AT CINNAMINSON	605 ROUTE 130 CINNAMINSON, NJ 08077

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H5790 Reg. # 8:43E-13.4(d) LSC	Correction Completed 11/03/2025	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
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