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
	AL25284	A. BUILDING: ______ B. WING ______	C 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF FRANKLIN LAKES	728 FRANKLIN AVENUE FRANKLIN LAKES, NJ 07417

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A 000	Initial Comments Initial Comments: COMPLAINT #: NJ 00189117 and NJ 00167568 CENSUS: 90 SAMPLE SIZE: 6 TYPE OF SURVEY: Standard and Complaint Survey of 88 residential units The facility is not in substantial compliance with all 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 751	8:36-7.3(b) Resident Assessments and Care Plans (b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and 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: Based on facility policy review, record review, and interview, the facility failed to ensure a health	A 751		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE 01/15/26

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A 751	Continued From page 1 service plan was reviewed quarterly for 1 (Resident #4) of 5 residents reviewed for service plan requirements. Findings included: A facility policy titled, "Individualized Service Plan," revised 05/15/2025, revealed the "Procedure" included, "3. The ISP [Individualized Service Plan] is reviewed and updated," which included, "a. Every six (6) months or per state/province regulations." A "Move In Record" indicated the facility admitted Resident #4 on NJ Exec Order 26.4b1. According to the Move In Record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 of NJ Exec O and NJ Exec Order 26.4b and NJ Exec Order 26.4b1 Resident #4's "Service Plan Report" included a focus area initiated NJ Exec Order 26.4b1 titled, 'NJ Exec Order Interventions initiated NJ Exec Order 26.4b1 staff to keep the resident's NJ Exec Order 26.4b1, NJ Exec Order 26.4 the NJ Exec O with NJ Exec Ord if indicated, and to observe for and report any change in the resident's NJ Exec Ord The Service Plan Report included a focus area initiated NJ Exec Order 26.4b1 titled, "Coordination of Care." Interventions initiated NJ Exec Order 26.4b1 indicated that the resident needed NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 observe the resident closely for signs of NJ Exec Ord administer NJ Exec O medication as ordered; and notification was to be made if there was any NJ Exec Order 26.4b1. The Service Plan Report revealed the most recent review was completed on NJ Exec Order 26.4b1. During an interview on 11/13/2025 at 11:18 AM, the Resident Care Director (RCD) stated that the	A 751		

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A 751	Continued From page 2 health service plan should be completed quarterly. During a follow-up interview on 11/14/2025 at 1:41 PM, the RCD stated that she expected health service plans to be reviewed quarterly. The RCD stated Resident #4's health service plan was last revised on NJ Exec Order 26.4b1 when an evaluation had been completed and acknowledged the health service plan was not reviewed quarterly. The RCD stated that it was important to update the health service plan quarterly to identify changes in care or care levels. During an interview on 11/13/2025 at 11:15 AM, the Executive Director (ED) stated that Resident #4's health service plan was to be reviewed quarterly. During a follow-up interview on 11/14/2025 at 2:22 PM, the ED stated that he expected the health service plans to be reviewed or revised quarterly. The ED stated Resident #4's health service plan was last reviewed on NJ Exec Order 26.4b1 and had not been updated quarterly.had not been updated quarterly.	A 751		
A 775	8:36-7.5(a) Resident Assessments and Care Plans (a) The facility or program shall arrange for health care services to be provided to residents as needed, in accordance with assessments and with the health service plan. The administrator shall develop a system to identify the residents receiving health care services.	A 775		

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A 775	Continued From page 3	A 775		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00189117

Based on facility policy review, record review, facility document review, surveillance video review, and interview, the facility failed to ensure staff implemented residents' service plans, which affected 1 (Resident #1) of 3 residents reviewed for NJ Exec Ord Specifically, Resident #1's service plan directed staff to NJ Exec Order on the resident at NJ Exec Order 26.4b1 ." The resident NJ Exec on NJ Exec Order 26.4b1 at 10:06 PM and staff did not check on the resident unti NJ Exec Order 26.4b1 at 7:20 AM, when the resident was found on the floor. The failure resulted in delayed treatment for Resident #1, who suffered NJ Exec Order 26.4b1 and required hospitalization.

It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause, serious injury, serious harm, serious impairment, or death to residents.

On 11/14/2025 at 3:43 PM, the facility's Executive Director (ED) was verbally informed of the immediacy of the situation involving the NJ Exec with NJ Exec Order 26.4b1 and the lack of resident NJ Exec Order 26.4b1 that caused Resident #1 to be without help for several hours after they NJ Exec

Findings included:

A facility policy titled, "Assessing and Evaluating Residents," revised 05/15/2025, the "Procedure" included, "4. The interdisciplinary team (IDT) and the Resident Care Director (RCD) collaborate to gather data to complete the comprehensive assessment or evaluation." The policy revealed, "d. Team members shall provide and/or

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A 775	Continued From page 4 coordinate personal care and services to residents, based on assessment or evaluation and ISP [individual services plan]." A "Move In Record" indicated the facility admitted Resident #1 on NJ Exec Order 26.4b1 According to the Move In Record, the resident had a medical history that included a diagnosis of NJ Exec Order 26.4b1 Resident #1's "Service Plan Report" revealed a focus area initiated on NJ Exec Order 26.4b1, that indicated the resident had NJ Exec Order 26.4b1 an NJ Exec Order 26.4b1. Interventions initiated NJ Exec Order 26.4b1 directed staff to NJ Exec Order on the resident at 'NJ Exec Order 26.4b1" to see if the residents needed any assistance and to offer the resident reassurance. An undated facility document titled, "Update To: Reportable Event" specified that on NJ Exec Order 26.4b1, Resident #1 was NJ Exec Order 26.4b1 on the NJ Exec O of their apartment between 7:30 AM and 8:00 AM. The document indicated that the resident was NJ Exec Order 2 and NJ Exec Order 26.4b1 but reported that they NJ Exe and NJ Exe their NJ Exec Ord and had NJ Exec O in the NJ Exec Order 26 and NJ Exec Orde The Update To: Reportable Event indicated the facility was notified by the hospital that the resident was admitted for NJ Exec Order 26.4b of the NJ Exec Ord on NJ Exec Order 26.4b1 at 1:30 PM. Per the document, after the resident's family reviewed surveillance footage from a camera in the apartment, it was determined Resident #1 NJ Exe on NJ Exec Order 26.4b1 at 10:06 PM 'NJ Exec Order 26.4b1. The Update To: Reportable Event indicated the evening care manager (CM), CM #5, reported that he last checked on Resident #1 at approximately 10:00 PM on NJ Exec Order 26.4b1 when he completed his final rounds for the shift. Per the document, CM #5 reported that the resident was in bed at the time of the last check. The document indicated that the overnight CM (CM	A 775		

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A 775	Continued From page 5 #2) indicated that he did not check on the resident because historically, the resident became NJ Exec Order 26.4b1 when they were NJ Exec Order 26.4b1 on the overnight shift. Per the document, Resident #1's day shift CM (CM #1) NJ Exec Order 26.4b1 the resident on NJ Exec Order 26.4b1 at approximately 7:20 AM. The Update To: Reportable Event revealed the "Conclusion" specified that based on the video shared by Resident #1's family, Resident #1 Resident #1 was NJ Exec Order 26.4b1 while attempting to NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, NJ Exec Order their NJ Exec Orde on a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on the NJ Exec O until they were NJ Exec Order 26.4b1 by staff the following morning. The document indicated that the overnight caregiver did not check on the resident because the resident is a "NJ Exec Order 26.4b1" and became NJ Exec Orde when NJ Exec Order 26.4b1 during the night. Video footage captured by a family supplied video surveillance device located in Resident #1's room, dated NJ Exec Order 26.4b1 beginning a 10:04:45 PM, revealed Resident #1 sitting on the edge of their bed in their NJ Exec Order 26.4b with a NJ Exec and NJ Exec Order 26.4 in place without the room lights on. Resident #1 reached for a NJ Exec Order 26.4b1, which were near the bed, and began to attempt to put the shoes on their feet. At 10:05:32 PM, Resident #1 began to rise to a NJ Exec Order 26.4b1 on the left side of the bed. After Resident #1 reached an NJ Exec Order 26.4b1 at 10:05:41 PM, Resident #1 reached for an NJ Exec Order 26.4b1 to the left side of the bed while turning their body in multiple directions looking around the room. Resident #1 then released the NJ Exec Order 26.4b1 at 10:06:15 PM and began to adjust the covers on the resident's bed while NJ Exec Order 26.4b1. Resident #1 then turned towards their left side and began to NJ Exec Order 26.4b1 towards two doors located in the direction of the foot of the resident's bed at	A 775		

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A 775	Continued From page 6 10:06:28 PM. Resident #1 took approximately NJ Exec O [redacted] at 10:06:34 PM, causing the resident to NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b towards a six-drawer dresser on the residents left side. Resident #1 NJ Exec Order 26.4b1 items on the dresser when NJ Exec Order 26.4b1 the dresser during the NJ Exec until the resident NJ Exec Order 26 on the NJ Exec O with their NJ Exec Ord in the direction of the head of the bed near the video surveillance camera. Audio in the video revealed Resident #1 NJ Exec Order 26.4b1 before the video surveillance clip ended at 10:06:45 PM. A second clip of video footage captured by the family supplied video surveillance device located in Resident #1's room, dated NJ Exec Order 26.4b1 beginning at 7:20:14 AM, revealed the interior of the room with a NJ Exec Order 26.4b1 chair sitting in an angled position in front of the entrance door with the seat cushion in the floor in front of the dresser. Resident #1 was not visible on the screen. A female staff member (CM #1) entered the resident's room and NJ Exec Order 26.4b1 when she saw Resident #1 NJ Exec Order 26.4b1 went to the resident's side and asked, NJ Exec Order 26.4b1 [redacted] then ran out of the resident's room at 7:20:25 AM, leaving the door open and the resident NJ Exec Order 26.4b1. CM #1 returned to Resident #1's room at 7:20:46 AM, followed by a second female staff member at 7:20:58 AM. A third female staff member entered the room with vital sign equipment on a NJ Exec Order 26.4b1 at 7:21:10 AM. During the video clip, Resident #1 is heard audibly speaking when staff members instructed the resident that they were NJ Exec Order 26.4b1 the resident and that they were going to contact emergency medical services (EMS). NJ Exec Order is visible on the residents' sheets when one staff member began removing the residents' bed linens from the bed before the clip ended at	A 775		

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A 775	Continued From page 7 7:22:16, prior to EMS arrival. Resident #1's "Progress Notes" revealed a "NJ Exec O Progress Note," dated NJ Exec Order 26.4b1 at 12:46 PM, that indicated Resident #1 had an unwitnessed NJ Exec in the resident's room on NJ Exec Order 26.4b1 at 8:05 AM (in contrast with the surveillance footage). The NJ Exec O Progress Note revealed Resident #1 NJ Exec Order 26.4b1 a NJ Exec Order 26.4b1 from the NJ Exec did not know how the NJ Exec occurred, and the resident reported NJ Exec O in the NJ Exec Order 26 and NJ Exec Orde Per the note, Resident #1 stated NJ Exec Order 26.4b1 . The note indicated that the resident had visible NJ Exec Orde in their NJ Exec Order 26 The note indicated the EMS was called, and the resident was transferred to the hospital with a NJ Exec Order 26.4b1 in place. A hospital "Emergency Department Note," dated NJ Exec Order 26.4b1 at 9:41 AM, revealed Resident #1 was brought to the hospital after an NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 to the NJ Exec Ord of their NJ Exec Ord and NJ Exec Order 26.4b1 in the resident's NJ Exec Order 26 The Emergency Department Note indicated that the resident was on the NJ Exec O for an unknown NJ Exec Order 26.4b with an NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 , which required NJ Exec Order 26.4b1 , had an NJ Exec Order 26.4b1 , and was admitted to the hospital after NJ Exec Order 26.4b1 revealed NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) on the NJ Exec O A hospital "NJ Exec Order 26.4b1 " that included an addendum, dated NJ Exec Order 26.4b1 , indicated that Resident #1 had a prior NJ Exec in NJ Exec Order 26.4b1 that resulted in an NJ Exec Orde to the resident's NJ Exec Order The NJ Exec Order 26.4b1 &	A 775		

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A 775	Continued From page 8 NJ Exec Order 26.4b1 indicated the resident's family NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 and stated that at the time of the resident's NJ Exec Order 26.4b1, the resident was looking for their NJ Exec Order 2 when they NJ Exec Order 26.4b1, which caused the resident to NJ Exec Order 26.4b1. According to the NJ Exec Order 26.4b1, Resident #1 NJ Exec Order 26.4 their way to bed while NJ Exec Order 26.4b1 for NJ Exec O but eventually NJ Exec Order 26.4b1 " approximately two hours later and NJ Exec O by staff the following morning on the NJ Exec O with NJ Exec Order 26.4b1. Resident #1's hospital "Discharge Summary," dated NJ Exec Order 26.4b1, indicated NJ Exec Order 26.4b1 revealed a NJ Exec Order 26.4b1 over the NJ Exec Order 26.4b1 A facility document titled, "Privileged and Confidential Statement of Event," dated NJ Exec Order 26.4b1 revealed, a handwritten statement by CM #5 that indicated that he worked from 2:00 PM to 10:00 PM on NJ Exec Order 26.4b1 and assisted Resident #1 to prepare for bed by placing the resident's NJ Exec Order 26.4b on around 5:00 PM. The statement indicated that CM #5 checked on Resident #1 after 6:30 PM and again at 10:05 PM (in contrast with the surveillance footage). A facility document titled, "Privileged and Confidential Statement of Event," dated NJ Exec Order 26.4b1 revealed a handwritten statement by CM #2 that indicated that on the evening of NJ Exec Order 26.4b1, CM #2 worked the overnight shift and NJ Exe Resident #1 NJ Exec Order given their NJ Exec Order 26.4b in the past. The statement indicated that, in the past, Resident #1 found it NJ Exec Order 26.4b1 of their NJ Exec Order 26.4b1, and given the residents past NJ Exec Order 26.4b1 he allowed Resident #1 to NJ Exec Orde	A 775		

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A 775	Continued From page 9 NJ Exec Order 26.4b1. A facility document titled, "Privileged and Confidential Statement of Event," dated NJ Exec Order 26.4b1 revealed, a handwritten statement by Medication Care Manager (MCM) #7 that indicated that on the morning of NJ Exec Order 26.4b1 she and MCM #6 were on duty providing care to residents on two other units who had NJ Exec Orde at around 7:15 AM. The statement revealed that Resident #1 was NJ Exec Orde on the NJ Exec O by a CM and when MCM #7 arrived at the resident's room, the resident was on the NJ Exec O with their NJ Exec Ord between the NJ Exec O and the NJ Exec Order 26.4b1 and Resident #1 was NJ Exec Order 26.4b1. The statement indicated that there was NJ Exec Order 26.4b1 in the resident's NJ Exec Order 26 The statement indicated that EMS was called. A facility document titled, "Privileged and Confidential Statement of Event," dated NJ Exec Order 26.4b1, revealed a handwritten statement by CM #1 that indicated that on the morning of NJ Exec Order 26.4b1 she entered Resident #1's room to NJ Exec Order 26.4b1. The statement indicated that Resident #1 was NJ Exec Or on the NJ Exec O with their NJ Exec Ord by the NJ Exec Order 26.4 and had NJ Exec Order 26.4b1. Per the statement, CM #1 immediately notified a nurse who came to assess the resident and then contacted EMS for transportation. During an interview on 11/12/2025 at 9:41 AM, CM #1 stated on the morning of NJ Exec Order 26.4b1 she entered Resident #1's room and NJ Exec Orde the resident on the NJ Exec O with NJ Exec Order 26.4b1 in and NJ Exec Order 26.4b1. During an interview on 11/13/2025 at 9:39 AM, the NJ Exec Order 26.4b1)	A 775		

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A 775	Continued From page 10 stated that she expected safety checks to be completed at least at the start of the shift, once during the shift, and at the end of the shift. During an interview on 11/12/2025 at 1:45 PM, the RCD stated that the care manager (CM #2) was interviewed and admitted that he did not check Resident #1 during the night of the resident's NJ Exec on NJ Exec Order 26.4b1. The RCD stated that she expected every resident to be checked. During an interview on 11/13/2025 at 1:14 PM, the Executive Director (ED) stated that resident checks depended on the resident's service plan because the facility was their home, and the checks could be disruptive. The ED stated that he expected staff to complete rounds in the NJ Exec Order 26.4b unit. He stated that the night shift staff had been conditioned that Resident #1 got NJ Exec Order 26.4b at night with the checks. He stated that ideally, the resident should have been checked on, but staff knew how the resident was and did not want the resident to get NJ Exec Order 26.4b. The ED stated that staff not checking on the resident at all was not according to the resident's service plan.	A 775		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.	A 891		

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A 891	Continued From page 11	A 891		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, the New Jersey Administrative Code (NJAC) 8:24, "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines," review of the Food and Drug Administration (FDA) Food Code, and facility policy review, the facility failed to maintain the kitchen in a safe, clean, and sanitary manner. Specifically, dishwashing staff and a server were observed without hair restraints in the kitchen. Additionally, staff failed to ensure opened food items were labeled and dated. The deficient practice had the potential to affect all residents who received nourishments from the facility's kitchen.

Findings included:

1. Reference: NJAC 8:24-2.4(a)(c)1 revealed, "(c) The following requirements shall apply to hair restraints: 1. Except as provided in (c)2 below, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens; and unwrapped single-service and single-use articles."

A facility policy titled, "Uniforms and Personal Hygiene for Food Service," revised 08/07/2025, revealed the section titled, "1. Uniform Requirements," "b. Dishwashers" specified, "vii. Approved hair restraint." The policy further revealed the section titled, "2. Hygiene" specified,

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
	AL25284	A. BUILDING: ______ B. WING ______	C 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF FRANKLIN LAKES	728 FRANKLIN AVENUE FRANKLIN LAKES, NJ 07417

(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 891	Continued From page 12 "g. Hair is neat and clean, and worn pulled away from the face. An approved hair restraint is worn at all times while preparing or plating food." During an observation of the kitchen on 11/11/2025 at 9:16 AM, Dishwasher (DW) #3 began plating a breakfast tray. DW #3 was observed to have a full head of hair that was not secured with a hair restraint. During an observation and concurrent interview on 11/11/2025 at 9:27 AM, DW #3 washed dishes without a hair restraint. DW #3 stated that when he was hired, he received a hat that was part of his uniform and used to keep his hair restrained; however, he lost the hat. He stated that he was supposed to keep his hair secured so that it did not get into the food. During an observation and concurrent interview on 11/11/2025 at 9:42 AM, Server #4 prepared a plate of food in the kitchen. Server #4 had a hair restraint placed on the top of her head with NJ Exec Ord extending to her NJ Exec Orde not covered by the hair restraint. Server #4 stated that she was trained to have her hair covered when working in the kitchen. She stated that she had difficulty covering her NJ Exec Order 2 because they were NJ Exec Order 26.4. She stated she was educated that her hair was supposed to be covered for food safety. During an interview on 11/11/2025 at 9:46 AM, the Dining Services Coordinator (DSC) stated that the staff knew they were supposed to keep their hair covered and that hair restraints were available at the kitchen entrance. During an interview on 11/14/2025 at 2:16 PM, the Resident Care Manager (RCD) stated that every time a person entered the kitchen, they	A 891		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL25284	A. BUILDING: ______ B. WING ______	C 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 891	Continued From page 13	A 891		

should have a hair restraint on. She stated that she expected hair restraints to be utilized when in the kitchen.

During an interview on 11/14/2025 at 3:43 PM, the Executive Director (ED) stated that hair restraints were utilized by anyone preparing or serving food. He stated that the facility utilized restaurant-style dining, so he did not expect servers to utilize hair restraints when serving meals to residents if they were not behind the line preparing food. The ED stated that if staff were plating food, they would need a hair restraint.

2. Reference: NJAC 8:24-3.3 (z) specified, "(z) Food shall be protected from contamination that may result from a factor or source not specified above."

A facility policy titled, "Food Storage, Preparation and Service," revised 08/07/2025, revealed the section titled, "1. General Food Handling" specified, "d. All food items are labeled, dated and rotated to maintain a system of First In, First Out (FIFO)."

During an observation of the kitchen and a concurrent interview with the Dining Services Coordinator (DSC) on 11/11/2025 at 9:24 AM, the facility's walk-in refrigerator contained a metal container with a large wedge of white meat covered in clear plastic wrap; a cylindrical, sausage shaped package of pink meat with one end cut off covered in clear plastic wrap; a half of a pie covered with clear plastic wrap; a block of cheese with one end cut off and covered with clear plastic wrap; and a cylindrical, sausage shaped package of brown colored meat cut off on one end and covered with clear plastic wrap. All items were unlabeled and undated. A walk-in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL25284	A. BUILDING: ______ B. WING ______	C 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF FRANKLIN LAKES	728 FRANKLIN AVENUE FRANKLIN LAKES, NJ 07417

(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 891	Continued From page 14 freezer revealed a medium sized cardboard box with beige colored items, loose in the bottom of the box. The items were unlabeled and undated. The DSC identified that the white wedges of meat were turkey, the pink meat was ham, the half of pie was pumpkin pie, the brown meat was liverwurst, and the beige items in the box in the freezer were manicotti. The DSC stated that he was off during the weekend, and that was how they left the place when he was not there. He stated that they were also short-staffed in the kitchen but were trained not to leave items unlabeled or undated. During an interview on 11/14/2025 at 2:16 PM, the Resident Care Manager (RCD) stated that food should be dated. She stated that she expected food to be labeled and dated as soon as it was opened. During an interview on 11/14/2025 at 3:43 PM, the Executive Director (ED) stated that leftovers were discarded after two days, and all food should be labeled and dated to include opened items.	A 891		
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:	A1179		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL25284	A. BUILDING: ______ B. WING ______	C 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF FRANKLIN LAKES	**728 FRANKLIN AVENUE FRANKLIN LAKES, NJ 07417**

(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 15 Based on observation, interview and record review, it was determined that the facility failed to maintain a safe environment for residents which has the potential to affect all 90 residents residing at the facility. This deficient practice was evidenced by the following: On 11/13/25 at 12:39 p.m., the surveyor reviewed the quarterly fire marshal records provided by the Director of Maintenance (DOM) which revealed that the facility failed to provide 3 of 4 quarterly fire marshal inspections. At 12:45 p.m. the surveyor interviewed the DOM regarding the missing fire marshal inspections. The DOM stated that the local Fire Department outsources the Fire Marshal Inspections to another local Fire Department. The DOM also stated that the other Fire Marshal was unavailable at the beginning of the year and could not conduct the local fire marshal inspections.	A1179		

POC #3 received 1/25/26
Accepted 1/26/26

Sunrise Senior Living Plan of Correction

Name of Facility:	Sunrise Senior Living of Franklin Lakes
Address of Facility:	728 Franklin Avenue, Franklin Lakes, NJ 07417
License number:	AL25284
Inspection date(s):	November 14, 2025
Name and Title of Legal Entity	Sunrise of Franklin Lakes OPCO, LLC
Representative Signing the Plan of Correction:	NJ Exec Order 26.4b1 CALA
Signature of Sunrise Representative:	NJ Exec Order 26.4b1
Date of Submission: 1/25/2026	

A751 - 8:36-7.3(b) – Resident Assessments and Care Plans

1. Resident #4 continues to reside in the community. Resident's Health Service Plan (HSP) was reviewed and documented on NJ Exec Order 26.4b1 by the Registered Nurse (RN) to reflect current services.

2. Residents with Health Service Plans have the potential to be affected by the deficient practice. On 1/8/2025, the Executive Director (ED) and RN initiated a review of all residents with Health Service Plans. The review was completed on 1/12/2025. The audit focused on the accuracy and timeliness of Health Service Plan documentation which is required to be updated quarterly, and as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. Notable findings during the audit were reviewed and updated to reflect current needs for the residents.

3. On 1/6/2026, the ED and RN completed a review of the facility's policies, including *'Assessing and Evaluating Residents'* and *'Individual Service Plans and Health Service Plans'*. The re-training session for RN's focused on the following policies, *'Assessing and Evaluating Residents'* and *'Individual Service Plans and Health Service'*. The RN will review HSP's as needed based upon resident's response to care provided or quarterly.

4. Starting 1/19/2026 and for four weeks, the ED or designee, along with RN, will conduct weekly reviews of residents identified as having a Health Service Plans during Interdisciplinary Team (IDT) meetings to ensure that residents receive timely documentation aligned with resident's needs. For two quarters this will be discussed at the Quality Assurance Performance Improvement (QAPI) meeting. The Executive Director (ED) and QAPI committee will identify outcomes and trends with plan of correction performance and monitor effectiveness of changes or adjustments. QAPI meeting scheduled for 1/14/2026.

5. Deficiency Corrected by Date: 1/16/2026. NJ Exec Order 26.4

approved 1/26/26

A775 - 8:36-7.5 (a) – Resident Assessments and Care Plans

1. Resident #1 continues to reside in the facility, in the NJ Exec Order 26.4b1 unit. The resident sustained a NJ Exec on NJ Exec Order 26.4b1 and was transferred to the hospital on NJ Exec Order 26.4b1 for further evaluation and treatment. The resident returned to the facility on NJ Exec Order 26.4b1 following the hospitalization. Upon resident's return, the RN completed a comprehensive re-assessment on NJ Exec Order 26.4b1 to evaluate the resident's condition and ensure appropriate interventions in collaboration with his Primary Care Physician and family. Updates to resident's care plan were made to reflect current needs based on the re-assessment.

2. All residents have the potential to be affected by the deficient practice. On 1/8/2026 the Executive Director (ED), Registered Nurse (RN), Assisted Living Coordinator (ALC) and Reminiscence Coordinator (RC) initiated a review of residents identified with falls and/or risk factors for falls. The purpose of the review is to ensure that Individualized Care Plans include accurate interventions and corresponding documentation based on resident's needs and/or preferences. Notable findings during the audit were reviewed and updated to reflect current needs for the residents. Updates to the care plans were completed on 1/8/2026.

3. On 1/6/2026, the ED and RN completed a review of the facility's policies, including *'Assessing and Evaluating Residents'*, *'Falls Management Program'* and *'Individual Service Plans and Health Service Plans'*. The ED and RN also initiated a re-training session for Registered Nurses (RNs), Licensed Practical Nurses (LPN), Care Coordinators (Assisted Living Coordinator (ALC) and Reminiscence Coordinator (RC) on the following policies *'Assessing and Evaluating Residents'*, *'Falls Management Program'* and *'Individual Service Plans and Health Service Plans'*. The training will be completed by 1/16/2026.

4. Starting 1/19/2026 and for four weeks, the ED or designee, along with RN and Care Coordinators, will conduct weekly reviews of residents identified falls and/or risk factors to falls during Interdisciplinary Team (IDT) meetings to ensure that the residents' Individualized Care Plans include accurate interventions and corresponding documentation based on resident's needs and/or preferences. For two quarters this will be discussed at the Quality Assurance Performance Improvement (QAPI) meeting. The Executive Director (ED) and QAPI committee will identify outcomes and trends with plan of correction performance and monitor effectiveness of changes or adjustments. QAPI meeting scheduled for 1/14/2026.

5. Deficiency Corrected by Date: 1/16/2026. NJ Exec Order 26.4 approved 1/26/26

A891 - 8:36-0.5 (a) – Dining Services

1. Following an observation on 11/11/2025, where it was noted, the dishwasher began plating a breakfast tray without a hair restraint, washing dishes without a hair restraint and a server prepared a plate of food in the kitchen with proper hair restraint covering the NJ Exec Order 26.4b1.
   Both team members were given hair nets and black baseball style caps were ordered and arrived 11/18/25. Two hair net stations were installed: one just inside the entrance to the main kitchen and one outside the Dining Services Coordinators' (DSC) office.

   On 11/11/2025 it was noted the refrigerator contained a metal container with a large wedge of white

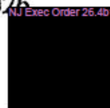
meat covered in plastic wrap; half a pie covered in plastic wrap, a block of cheese and a block of meat cut off at one end. All items were unlabeled and undated. In addition, a box in the freezer revealed a medium sized cardboard box with beige colored items, loose in the bottom of the box. The items were unlabeled and undated.
All unlabeled and undated food items were disposed of by the end of the day on 11/11/2025. The DSC initiated a re-training session the same day for the dietary team members. The re-training sessions covered the following policies, '*Uniforms and Personal Hygiene for Food Service*' and '*Food Storage, Preparation and Service*'.

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

3. On 11/14/2025 the DSC initiated a "*Food Labeling*" and "*Personal Hygiene*" audit tool to be conducted daily for one week, beginning 11/18/2025, then weekly for four weeks beginning 11/25/2025, and then monthly beginning January 2026 for three months. Target completion date for monitoring is March 2026.
The Executive Director (ED) initiated a re-training for '*Uniforms and Personal Hygiene for Food Service*' and '*Food Storage, Preparation and Service*' for chefs, dishwashers and servers starting on 1/6/2026 and target completion date is 1/20/2026.

4. Results of the '*Food Labeling*' *and* '*Personal Hygiene*' audits will be discussed at the Quality Assurance Performance Improvement (QAPI) meetings for 2 quarters. The ED and QAPI committee will identify outcomes and trends with plan of correction performance and monitor effectiveness of changes or adjustments. QAPI meeting will be scheduled for 1/14/2026.

5. Deficiency Corrected by Date: 1/20/2026



approved 1/26/26

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

1. Following the incident on 11/14/2025, the Maintenance Coordinator (MC) reached out to the local fire inspector on 11/15/25 to initiate a fire safety inspection. The borough of Franklin Lakes did conduct a fire code inspection on 12/29/2025. On 1/9/2026, the facility received a report from Fire Official declaring the community in full compliance with the NJ of the International Fire Code and NJ Uniform Fire Code.

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

3. The Executive Director (ED) initiated re-training for the Maintenance Coordinator (MC) for '*Test and Inspection Policy*' on January 8, 2026. Moving forward the MC will reach out to the local fire inspector quarterly to initiate a fire safety inspection. If there is any delay in the local Fire Marshal's response to the inspection request, the matter will be escalated from the MC to the ED to ensure the appropriate authorities are notified and timely response to the required fire inspections is achieved.

4. The ED or designee, along with MC will ensure the local quarterly fire inspections are completed. If this is not completed quarterly the local fire marshal will be notified. Any

concerns involving fire safety will go through the local change of command until resolved. Results will be discussed at the Quality Assurance Performance Improvement (QAPI) meetings for 2 quarters. The ED and QAPI committee will identify outcomes and trends with plan of correction performance and monitor effectiveness of changes or adjustments. QAPI meeting will be scheduled for 1/14/2026.

5. Deficiency Corrected by Date: 1/16/26.

approved 1/26/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
AL25284 Y1	Y2	1/26/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF FRANKLIN LAKES	728 FRANKLIN AVENUE FRANKLIN LAKES, NJ 07417

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 A0751 Reg. # 8:36-7.3(b) LSC	Correction Completed 01/16/2026	ID Prefix A0775 Reg. # 8:36-7.5(a) LSC	Correction Completed 01/16/2026	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 01/20/2026
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	ID Prefix Reg. # LSC	Correction Completed
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	
11/14/2025	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
AL25284	A. Building B. Wing	1/26/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF FRANKLIN LAKES	728 FRANKLIN AVENUE FRANKLIN LAKES, NJ 07417

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0751 Reg. # 8:36-7.3(b) LSC	Correction Completed 01/16/2026	ID Prefix A0775 Reg. # 8:36-7.5(a) LSC	Correction Completed 01/16/2026	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 01/20/2026
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	ID Prefix Reg. # LSC	Correction Completed
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 11/14/2025	☐ 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
AL25284 Y1	A. Building B. Wing Y2	1/26/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF FRANKLIN LAKES	728 FRANKLIN AVENUE FRANKLIN LAKES, NJ 07417

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1179 Reg. # 8:36-17.1(a) LSC	Correction Completed 01/16/2026	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/14/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			