STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	**99 EAST MAIN STREET , MARLTON, New Jersey, 08053**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS Survey Date: 02/09/2026 Census: 64 Sample: 16 +2 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		02/24/2026
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F0645	F645 The following corrective actions have been implemented: F6454 PASRR screening for MD & ID CFR(s): 483.20(k)(1)-(3) Residents identified Resident # 8 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #8's PASRR Level I screening was reviewed and an updated	02/24/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0645 SS = D	Continued from page 1 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed accurately for a newly admitted resident. This deficient practice was	F0645	Continued from page 1 screening was completed to reflect the resident's updated diagnosis NJ Ex Order 26, 4B1. The social worker completed a revised PASRR level 1 form. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents requiring PASRR have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Director of social services in-serviced social workers regarding obtaining and reviewing the PASRR prior to admission and with significant changes. 4. How the facility will monitor its' corrective actions to ensure that the deficient practice is	02/24/2026

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F0645 SS = D	Continued from page 2 identified for 1 of 2 residents reviewed for PASRR (Resident #8), and was evidenced by the following: On 02/04/2026 at 9:57AM, during the initial tour of the facility, Resident #8 was observed out of bed in their room. A review of the Admission Record face sheet (an admission summary) revealed that the resident was admitted to the facility with the following but not limited to diagnosis of NJ Ex Order 26, 4B1. A review of Resident #8's Electronic Medical Record (EMR) revealed a PASRR level 1 dated NJ Ex Order 26, 4B1. A review of the PASRR screening, section two titled NJ Ex Order 26, 4B1 Screen" was marked "No" for the resident having a diagnosis or NJ Ex Order 26, 4B1 A review of the Minimal Data Set (MDS), an assessment tool completed on NJ Ex Order 26, 4B1 Status score of NJ Ex Order 26, 4B1 meaning the resident had NJ Ex Order 26, 4B1 review of section "I" in the MDS revealed that Resident # 8 had a diagnosis of NJ Ex Order 26, 4B1 A review of the resident's individualized comprehensive care plan included a focus area dated NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1 related to history of NJ Ex Order 26, 4B1 During an interview on 02/04/2026 12:55 PM with the surveyor, the U. S. FOIA (b) (2) said that if residents are coming from the hospital the PASRR is completed prior to admission from the hospital, if they are coming from home, it is our responsibility to fill them out. The U. S. FO said that she did not usually review PASRR from the hospital because she assumed they were correct. During an interview on 02/06/2026 1:24 PM with the surveyor, the U. S. FOIA (b) (2) said that it is the U. S. FOIA (b) (2) responsible for making sure they are accurate, and the team discusses it in morning meeting. It is important to make sure we assure the residents are placed correctly. A review of a facility's " PASRR Level 1 Assessments" with an effective date of 2/2011, revealed, "all residents prior to admission to HCC will be screened for MI/MR by social services and that information will be completed on the PASRR Level 1 form. " NJAC 8:39-27.1 (a)	F0645	Continued from page 2 being corrected and will not recur. Social service will audit all new admissions and residents with significant change monthly for three months and then and then quarterly. Social services will report the results to the QAA committee. The QAA committee meets quarterly and will review audits quarterly. This will be ongoing. The Director of Social Services/QAA committee will determine when the problem is resolved or if more training is required.	02/24/2026

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656	F 0656 The following corrective actions have been implemented: F0656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21 (b)(1)(3) Residents identified Resident # 37 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #37's care plan was updated to include [redacted] monitoring, including potential side effects and required interventions per [redacted] stewardship guidelines. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All resident's prescribed antibiotics have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic	02/24/2026

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F0656 SS = D	Continued from page 4 Based on interview and record review, it was determined that the facility failed to develop and implement a comprehensive care plan that included required monitoring for a resident receiving NJ Ex Order 26.4(b)(1) The deficient practice was identified for 1 of 5 residents (Resident # 37) reviewed for Unnecessary Medications. The deficient practice was evidenced by the following: A review of Resident # 37's physician orders located under "Orders" in the Electronic Medical Record (EMR) revealed 3 orders to administer NJ Ex Order 26, 4B1 [redacted] appointment. The start dates for each of the orders were NJ Ex Order 26, 4B1 [redacted]. A review of Resident # 37's care plan located in the EMR revealed the facility failed to include a focus, goal, or intervention regarding the use of the NJ Ex Order 26.4(or the monitoring required for potential side effects, such as NJ Ex Order 26.4(b)(1) [redacted] On 02/06/2026 at 1:25 PM during an interview with the surveyor, the U. S. FOIA (b) (2)) was informed about Resident # 37 not having a care plan for NJ Ex Order 26, 4B use. On 02/09/2026, the U. S. FOIA provided the surveyor a document that showed a care plan for NJ Ex Order 26, 4B1 Use" was initiated in Resident # 37's care plan on NJ Ex Order 26.4(b)(1) [redacted], the day after the surveyor brought the missing care plan to the U. S. FOIA (b) attention. A review of the facility-provided policy titled "Care Area Assessment Protocols (CAAs), Care Plan Reviews and Quarterly Assessments" revealed under "Policy" that "Care Area Assessment Protocols (CAAs) are used as an Integral Part of the Resident Assessment and Care Planning Process. Combined these tools are used to: ...3. Identify potential problems that could be prevented or reversed, and/or reduce the risk factors;". N.J.A.C. 8:39-11.2(e)	F0656	Continued from page 4 changes made to ensure that the deficient practice would not recur. Education was provided to all members of the Interdisciplinary Care Team (IDCT) regarding interdisciplinary care planning specific to antibiotics and antibiotic stewardship including prophylaxis. Antibiotic use will be discussed in the IDCT morning meeting. 4. How the facility will monitor its' corrective actions to ensure that the deficient practice is being corrected and will not recur. Infection preventionist will audit all orders for antibiotics to determine if order meets criteria for antibiotic usage per policy. Infection practitioner will report the results to the Director of Nursing (DON)/ QAA committee monthly. The DON will review audits monthly for three months and then quarterly. The QAA committee meets quarterly and will review	02/24/2026

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F0656 SS = D		F0656	Continued from page 5 quarterly. This will be ongoing. The DON/QAA committee will determine when the problem is resolved or if more training is required.	02/24/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a	F0690	F0690 The following corrective actions have been implemented: F0690 Bowel/Bowel Incontinence, Catheter, UTI CFR(s): 483.25(3)(1)-(3) Residents identified Resident # 83 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #83's NJ Ex Order 26, 4B1 was NJ Ex Order 26, 4B1 [redacted] 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with indwelling catheters have the	02/24/2026

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F0690 SS = D	Continued from page 6 resident received appropriate care and sufficient services based upon current standards of practice for a NJ Ex Order 26, 4B1 The deficient practice was identified for 1 of 1 resident (Resident # 83) reviewed for NJ Ex Order 26, 4B1 investigation. This deficient practice was evidenced by the following: On 02/06/2026 at 9:55 AM, the surveyor observed Resident # 83 in bed in their room. At that time, the surveyor observed the NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1. The NJ Ex Order 26, 4B1 plastic hook was not NJ Ex Order 26, 4B1 A review of the Electronic Medical Record (EMR) revealed that Resident #83 had a diagnosis of but not limited to NJ Ex Order 26, 4B1 A review of the resident's individualized comprehensive Care Plan included a focus area dated NJ Ex Order 26, 4B1, for a NJ Ex Order 26, 4B. Goals included, "the resident will be/remain free from NJ Ex Order 26, 4B1 and "the resident will show no signs or symptoms of NJ Ex Order 26, 4B1 On 02/06/2026 at 10:33 AM, during an interview with Licensed Practical Nurse (LPN) #1, the nurse stated that the NJ Ex Order 26, 4B1 should not be in NJ Ex Order 26, 4B1 should be secured in the correct position on the resident's NJ Ex Order 2 The nurse replied, "can cause NJ Ex Order 26, 4 after the surveyor asked why it was necessary to ensure that the NJ Ex Order 26, 4B did not NJ Ex Order 26, 4B1 A review of the facility policy titled "Care of NJ Ex Orde NJ Ex Order 26, 4B1 Routine" dated NJ Ex Order 26, 4B1 revealed that "Daily care is required for NJ Ex Order 26, 4B1." The provided policy does not include guidance on the placement of NJ Ex Order 26, 4B1 . NJAC 8:39-27.1 (a)	F0690	Continued from page 6 potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff were in serviced by the staff educator regarding proper catheter drainage bag securement and placement for residents with indwelling catheters. 4. How the facility will monitor its' corrective actions to ensure that the deficient practice is being corrected and will not recur. The staff educator will perform monthly audits to ensure proper securement and placement of indwelling foley catheter drainage bags. Audits will be reported monthly by the staff educator to the DON and the QAA committee. The DON will review monthly for three months and then quarterly. The QAA committee meets quarterly	02/24/2026

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F0690 SS = D		F0690	Continued from page 7 and will review audits quarterly. This will be ongoing. The DON/QAA committee will determine when the problem is resolved or if more training is required.	02/24/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that medications were stored in a safe and sanitary manner by failing to maintain medications in their original containers and keeping medication storage drawers free of loose, unidentified tablets. The deficient practice was identified for 1 of 3 medications carts reviewed for medication storage. The deficient practice was evidenced by the following:	F0761	F0761 The following corrective actions have been implemented: F0761 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) Residents Identified Residents on nursing medication cart 2 on the Health Care Unit How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Loose medications found in the medication cart were removed and disposed of according to NJ state regulations. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	02/24/2026

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F0761 SS = D	Continued from page 8 On 02/06/2026 at 10:51 AM, in the presence of Registered Nurse (RN) # 1, the surveyor observed [NJ E] various [NJ Ex Order 26, 4B1] scattered within the second and third drawers from the top of the Team 2 Healthcare medication cart. At that time, the [N] tablets were observed to be of different colors, shapes, and sizes, were not in any packaging or containers, and were not labeled. At that time, during an interview with the surveyor, RN # 1 confirmed the presence of the loose tablets and stated that the drawers are cleaned weekly. RN # 1 told the surveyor she would crush the tablets up, mix in water, and dispose of them. She told the surveyor that there is no drug-dissolving solution inside of the medication cart. On 02/06/2026 at 1:25 PM during an interview with the surveyor, the [U. S. FOIA (b) (2)] was informed about the loose tablets in the medication cart. At that time, the [U. S. FOIA] said the loose tablets should have been disposed of in the medication storage room where the drug-dissolving solution is located. A review of the facility policy titled "Storage of Medications" with an effective date of 4/10/2025 revealed, "2. Medications will be stored on cart per State and Federal regulations." N.J.A.C. 8:39-29.4(a)	F0761	Continued from page 8 All residents receiving medications have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nursing staff were in serviced by the staff educator regarding compliance with medication storage requirement policy and proper disposal protocol. Daily medication cart inspection has been implemented. 4. How the facility will monitor its' corrective actions to ensure that the deficient practice is being corrected and will not recur. All medication carts will be checked daily by the team nurses for compliance with medication storage requirements as per facility policy. Staff educator will audit three out of the five medication carts monthly. Audits results will	02/24/2026

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F0761 SS = D		F0761	Continued from page 9 be reported monthly to the DON and QAA committee. The DON will review audits monthly for 3 months and then quarterly. The QAA committee meets quarterly and will review audits quarterly. This will be ongoing. The DON/QAA committee will determine when the problem is resolved or if more training is required.	02/24/2026
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to implement its NJ Ex Order 26.4 stewardship program by failing to ensure that NJ Ex Order 26.4(b)(1) for NJ Ex Order 2 procedures was based on a documented clinical indication or current professional standards. This deficient practice was identified for 1 of 5 (Resident # 37) residents reviewed for Unnecessary Medications. This deficient practice was evidenced by the following: A review of the NJ Ex Order 26, 4B1	F0881	F0881 The following corrective actions have been implemented: F0881 Antibiotic Stewardship Program CFR(s): 483.80(a)(3) Residents Identified Resident # 37 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 37's NJ Ex Order 26, 4B1 order was reviewed with physician NJ Ex Order 26, 4B1 was	02/24/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0881 SS = D	Continued from page 10 clinical recommendations for NJ Ex Order 26, 4B1 revealed that NJ Ex Order 26, 4B1 are not recommended for patients with NJ Ex Order 26, 4B1 implants to prevent NJ Ex Order 26, 4B1 during NJ Ex Order procedures. A review of Resident # 37's physician orders located under "Orders" in the Electronic Medical Record (EMR) revealed 3 orders to administer NJ Ex capsules of the NJ Ex Order 26, 4B1 appointment. The start dates for each of the orders were NJ Ex Order 26, 4B1 No other specific information was contained in the order as an indication or reason to prescribe the NJ Ex Order 26, 4B. A review of the U. S. FOIA (b) (2) NJ Ex Order 26, 4B Tracking sheet confirmed that Resident # 37 was receiving NJ Ex Order 26, 4B1 Under the section indicating if it met criteria, the document revealed, "yes" written on the sheet. On 02/05/2026 at 12:40 PM during an interview with the Surveyor, the facility's U. S. FOIA (b) (2) said the NJ Ex Order 26, 4B1 order does not meet McGeer Criteria (a set of standardized definitions used to identify and track infections in long-term care residents) and confirmed NJ Ex Order 26, 4B1 are not included in the facility's NJ Ex Order 26, 4B Stewardship Policy. 02/05/2026 12:54 PM during an interview with the surveyor, Resident # 37 confirmed he/she was on an NJ Ex Order 26, 4B because of a NJ Ex Orde being pulled last year. Further, he/she stated they had no NJ Ex Order 26, 4B1 devices in his/her heart however, the resident mentioned he/she does have NJ Ex Order 26, 4B1 devices in his/her NJ Ex Order 26, 4B1 A review of the facility-provided document titled, "Antibiotic Stewardship Program" with an effective date of 5/2020 revealed under "Policy" that "It is the policy of [Facility Name] to implement an Antibiotic Stewardship Program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of infections, and at the same time reducing the adverse events associated with antibiotic use." Further, the policy revealed under "Action" that, "The antibiotic stewardship protocol will address: ...ii. Focuses improvement response aimed at altering outmoded prescribing habits." N.J.A.C. 8:39-19.4	F0881	Continued from page 10 clarified and documented. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving prophylactic antibiotics have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Education was provided to staff regarding updated policy on prophylactic antibiotic use. All nursing staff were in serviced by the infection preventionist regarding antibiotic stewardship and clinical indication of prophylactic antibiotic use and current standards. 4. How the facility will monitor its' corrective actions to ensure that the deficient practice is being corrected and will not recur.	02/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	**99 EAST MAIN STREET , MARLTON, New Jersey, 08053**

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F0881 SS = D		F0881	Continued from page 11 Infection preventionist will review all orders for prophylactic antibiotics to determine if order meets criteria for prophylactic antibiotic usage. Audits results will be reported monthly to the DON and QAA committee. The DON will review audits monthly for three months and then quarterly. The QAA committee meets quarterly and will review audits quarterly. This will be ongoing. The DON/QAA committee will determine when the problem is resolved or if more training is required.	02/24/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030307	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

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S0000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S0000		02/24/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	**99 EAST MAIN STREET , MARLTON, New Jersey, 08053**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 04/02/2026 in relation to the 02/09/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 2/4/26, 2/5/26, and 2/6/26, Wiley Mission was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Wiley Mission is a two (2) story, Type II (222) unprotected construction that was built in the 60's. The health care building is divided into 6 smoke zones. The facility has two (2) exterior 350 KW diesel generators that provide power to approximately 80% of the building as per the [redacted]. The healthcare facility is attached to 2 residential units identified as Aldersgate and Hackett, both with 2-hour separation from the healthcare building. The healthcare facility is licensed for 86 long term care beds and is currently occupying 64.	K0000		02/27/2026
K0281 SS = F Bldg. 01	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 2/5/26 in the presence of the [redacted] it was determined that the facility failed to ensure that illumination of the means of egress was	K0281	K0281 – Illumination of Means of Egress - The following corrective actions have been implemented: Correction for Residents Specifically Affected: No residents were specifically identified as being affected by this deficient practice. Exterior light fixtures at exit doors #624, #625, and #626 will be replaced with compliant dual-lamp emergency fixtures. Illumination will be tested and verified under both normal electrical power and emergency generator power. This will be completed on March 6, 2026. Identification of Other Residents Potentially Affected: All residents were considered potentially affected. A facility-wide inspection of all exit discharge lighting	03/06/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

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K0281 SS = F Bldg. 01	Continued from page 1 provided at exits, exit doors and exit discharges in accordance with NFPA 101:2012 Edition, Sections 7.8.1.4 and 19.2.8. This deficient practice had the potential to affect all residents and was evidenced by the following: 1). Observations at 11:42 AM, revealed outside the exit/egress fire door # 624 that the light fixture above the door was observed to only have a single bulb fixture. 2). Observations at 11:57 AM, revealed outside the exit/egress fire door # 625 [redacted]) that the light fixture above the door was observed to only have a single bulb fixture. 3). Observations at 12:10 PM, revealed outside the exit/egress fire door # 626 that the light fixture above the door was observed to only have a single bulb fixture. In interviews at the time, the [redacted] confirmed the observations. Th [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 2/6/26 at 1:30 PM. N.J.A.C 8:39-31.2(e)	K0281	Continued from page 1 fixtures was conducted to verify compliance. No additional deficiencies were identified. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The Preventive Maintenance schedule has been revised to include quarterly inspection and documentation of all egress lighting fixtures. Education was provided by the Plant Operations Director to Maintenance staff. Education included NFPA 101 emergency lighting requirements, inspection procedures, and documentation expectations. Evidence of corrective actions maintained for attachment includes work invoice for fixture replacement. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Quarterly Life Safety lighting audits will be conducted by the Plant Operations Director for 12 months. Any identified variance will be corrected immediately and documented. Results will be reported to QAPI quarterly.	03/06/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K0324	K0324 – Cooking Facilities - The following corrective actions have been implemented: Correction for Residents Specifically Affected: No residents were specifically identified. The Rehabilitation Kitchen electric range has been unplugged and lock out tag applied on the breaker. All Rehabilitation staff have been educated not to use the range until the safety device is installed in accordance with Life Safety Code requirements and facility cooking supervision policy. Identification of Other Residents Potentially Affected: All residents were considered potentially affected. All cooking appliances were inspected to verify compliance with applicable Life Safety Code requirements. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.	03/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

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K0324 SS = F Bldg. 01	Continued from page 2 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 2/4/26 in the presence of the U. S. FOIA (b) (2)), it was determined that the facility failed to protect small kitchens in accordance with the requirements NFPA 101, 2012 Edition, Section 9.2.3, 19.3.2.5.1 through 19.3.2.5.5 and NFPA 96, 2011 Edition Section 10.5.1. The deficient practice could affect all residents and was determined by the following: An observation at approximately 11:32 AM revealed in the Rehabilitation Kitchen, that the plugged in electric range did not have a switch deactivating the cooktop or range after 120 minutes whenever the kitchen is not under staff supervision. An interview was conducted during the observation with the U. S. FOIA and he confirmed the observation and indicated he was unaware of this requirement. Th U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference on 2/6/26 at 1:30 PM. N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 96	K0324	Continued from page 2 The Rehabilitation Kitchen Safety Policy will be updated to include automatic shutoff requirements. Maintenance staff turned breaker off and placed lockout tag. The automatic shutoff device will be installed by March 31, 2026. Education was provided by the Plant Operations Director to Rehabilitation and Maintenance staff. Education included safe cooking practices, supervision requirements, prohibition on use of the range until the safety device is installed. An annual Life Safety kitchen equipment compliance audit has been implemented. Evidence of corrective actions maintained for attachment includes lockout/tagout documentation, and photo of lockout tag. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Quarterly inspections will be conducted by the Plant Operations Director. Inspections will include verification of automatic shutoff device functionality, compliance with cooking supervision policy, and proper use of cooking equipment. Any identified variance will be corrected immediately and documented. Results will be reviewed during QAPI quarterly.	03/31/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and interviews on 2/6/26 in the presence of the U. S. FOIA (b) (2)	K0345	K0345 – Fire Alarm System Testing - The following corrective actions have been implemented: Correction for Residents Specifically Affected: No residents were specifically identified. The contracted fire alarm vendor completed smoke detector sensitivity testing in accordance with NFPA 72 requirements. Documentation was reviewed and placed in the Life Safety compliance file. Identification of Other Residents Potentially Affected: All residents were considered potentially affected. All fire alarm inspection, testing, and maintenance documentation was reviewed to verify required testing was completed and properly documented.	02/10/2026

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K0345 SS = F Bldg. 01	Continued from page 3 it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance (ITM) of the fire sprinkler system was conducted in accordance with NFPA 101:2012 Edition, Section 9.6.1.5, NFPA 70 and NFPA 72:2010 Edition, Section 14.4.5.3.1. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review at 10:30 AM revealed that the testing of the smoke detectors was not found in the documentation that was provided by the facility for review. The fire alarm inspection reports dated: 10/22/25 and 4/2/25 did not reveal when the last smoke detector sensitivity test was conducted. In an interview at the time, the [U. S. FOIA] confirmed the record review and revealed he was unsure when the last smoke detector sensitivity test was conducted. The [U. S. FOIA (b) (2)] were informed of the deficient practice at the Life Safety Code exit conference on 2/6/26 at 1:30 PM. N.J.A.C 8:39-31.2 (e) NFPA 70, 72	K0345	Continued from page 3 What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. A recurring work order was created to track all required inspection, testing, and maintenance activities. Vendor contract requirements were clarified to ensure compliance with NFPA 72. A documentation tracking log has been implemented. Education was provided by the Plant Operations Director to Maintenance staff and administrative leadership. Education included NFPA 72 inspection, testing, and maintenance requirements, documentation expectations, and vendor oversight responsibilities. Evidence of corrective actions maintained for attachment includes fire alarm vendor reports. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Quarterly documentation audits will be conducted by the Plant Operations Director for 12 months. Any identified variance will be addressed immediately and documented. Audit findings will be reported to QAPI quarterly.	02/10/2026
K0901 SS = F Bldg. 01	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on document review and interview on 2//4/26, 2//5/26 and 2/6/26 in the presence of the [U. S. FOIA (b) (2)]), it was determined that the facility did not conduct, and document defined risk assessment fundamentals for the building system categories in accordance with the requirements of NFPA 99, 2012 Edition. The deficient practice could effect all residents. And was evidenced by the following: Document review on 2/6/26 at approximately 9:40	K0901	Correction for Residents Specifically Affected: No residents were identified as being specifically affected by this deficient practice. The facility has completed a comprehensive NFPA 99 Building System Risk Assessment in accordance with NFPA 99 (2012 Edition), Chapter 4 requirements. The assessment evaluates all applicable building systems and assigns categories (Category 1–4) based on the risk to residents in the event of system failure. The assessment was completed by the Director of Plant Operations and reviewed and approved by the CEO/Administrator & Chief Operation Officer. The completed NFPA 99 Risk Assessment, including system categorization, policy statement, and audit/review log, is maintained in the Life Safety Compliance Binder and is readily accessible. Identification of Other Residents Potentially Affected: Because this deficiency involved a facility-wide regulatory requirement, all residents were considered potentially affected. Completion and implementation	03/25/2026

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K0901 SS = F Bldg. 01	Continued from page 4 AM, revealed that the 'Generator set document folder' was reviewed and there was no documented risk assessment for the building system categories. An interview was conducted at approximately 9:55 AM with the [redacted], who stated that the NFPA 99 Risk Assessment for the building system categories had not been completed. The [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 2/6/26 at 1:30 PM. NJAC 8:39-31.2(e) NFPA 99, 2012 edition categories 1 through 4.	K0901	Continued from page 4 of the NFPA 99 Risk Assessment ensures that all building systems have been formally evaluated and categorized in accordance with code requirements, thereby supporting resident safety across the facility. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur: The facility has implemented the following systemic changes: The Director of Plant Operations has been formally designated as responsible for NFPA 99 compliance and documentation oversight. A formal NFPA 99 Policy has been implemented requiring annual review and updates with any significant changes. Facility contracted with vendor to annually Electrical Safety and Preventative Maintenance Contract. The NFPA 99 Risk Assessment has been incorporated into the Facility Assessment (F838). A Life Safety Compliance Calendar has been established. Education was provided by the Administrator to [redacted] Evidence of compliance includes the completed NFPA 99 Risk Assessment, Vendor Agreement, and policy statement. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The facility will monitor compliance through the following: Annual review of the NFPA 99 Risk Assessment by the Director of Plant Operations. Annual Administrator and CEO review and sign-off. Quarterly Life Safety documentation audits. Maintenance of an Audit Log / Review Tracking Sheet. Reporting of results to the QAPI Committee quarterly.	03/25/2026

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K0902 SS = F Bldg. 01	Gas and Vacuum Piped Systems - Other CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Other List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review and interview on 2/6/26 in the presence of U. S. FOIA (b) (2) it was determined that the facility failed to install a mechanical exhaust inlet in the Manifold room in accordance with NFPA 99. This deficient practice had the potential to affect all residents and was evidenced by the following: Record review at 10:10 AM, revealed that the annual piped in medical gas inspection report from the facility vendor dated: 1/6/26 indicated that in the 1st floor manifold room "it was recommended that the facility install a mechanical exhaust inlet within 1' of the floor" as per NFPA 99 (2012 edition) 9.3.7.5.3,2 & 9.3.7.5.3.3. An interview was conducted with the U. S. FOIA during record review where he confirmed the findings from the facility vendor inspection report. The U. S. FOIA (b) (2) were informed of the deficient practice at the life safety code exit conference on 2/6/26 at 1:30 PM. NJAC 8:39-31.2(e) NFPA 99	K0902	K0902 – Medical Gas Manifold Exhaust - The following corrective actions have been implemented: Correction for Residents Specifically Affected: No residents were specifically identified. A mechanical exhaust inlet will be installed in the manifold room in accordance with NFPA 99 requirements by March 24, 2026. Airflow will be tested and verified by March 24, 2026. Documentation will be retained. Identification of Other Residents Potentially Affected: All residents were considered potentially affected. The entire medical gas system was reviewed with the contracted vendor to ensure compliance. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. A Vendor Deficiency Tracking Log was implemented requiring correction of identified issues within 30 days. Oversight procedures were clarified to ensure timely follow-up and documentation. Education was provided by the Plant Operations Director to Maintenance staff and administrative leadership. Education included NFPA 99 medical gas system requirements and monitoring expectations. Evidence of corrective action video of installed exhaust system functioning. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Quarterly review of vendor inspection findings will be conducted by the Plant Operations Director for 12 months. Any identified variance will be corrected immediately and documented. Findings will be reported to QAPI quarterly.	03/24/2026
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection	K0353	K0353 – Sprinkler Maintenance - The following corrective actions have been implemented: Correction for Residents Specifically Affected: No residents were specifically identified. Sprinkler heads in the laundry area were cleaned and inspected to ensure no obstruction and to verify required clearance standards were maintained. Identification of Other Residents Potentially	03/02/2026

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K0353 SS = E Bldg. 01	Continued from page 6 and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 2/5/26 in the presence of the[redacted] it was determined that the facility failed to maintain fire sprinkler heads free from loading, dust, debris and paint in accordance with NFPA 25: 2011. This deficient practice was observed for for 2 of 50 fire sprinkler heads, had the potential to affect all residents, and was evidenced by the following: An observation at 11:48 AM revealed 2 of 4 sprinkler heads in the laundry room commercial dryer section were loaded with a heavy coating of lint/dust in the front and back of the 2-dryers. In an interview at the time of observation, the[redacted] confirmed the findings. The[redacted] were informed of the deficient practice at the Life Safety Code exit conference on 2/6/26 at 1:30 PM. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K0353	Continued from page 6 Affected: All residents were considered potentially affected. A facility-wide sprinkler inspection was conducted to verify proper condition and 18-inch clearance compliance throughout the building. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Weekly laundry sprinkler inspections were added to the Preventive Maintenance schedule. Education was provided by the Plant Operations Director to Maintenance staff. Education included sprinkler obstruction prevention, 18-inch clearance requirements, and inspection procedures. Evidence of corrective actions maintained for attachment includes sprinkler inspection ongoing work order and photograph. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Monthly sprinkler inspections will be conducted by Maintenance staff under the supervision of the Plant Operations Director. Inspections will include verification of proper clearance and absence of obstructions. Any identified obstruction or variance will be corrected immediately and documented. Findings will be reported to QAPI quarterly.	03/02/2026
K0374 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid	K0374	K0374 – Smoke Barrier Doors - The following corrective actions have been implemented: Correction for Residents Specifically Affected: No residents were specifically identified. Smoke barrier doors were adjusted to ensure full closure, proper latching, and functioning automatic closing devices. Doors were tested and verified not to be wedged or otherwise impeded.	03/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	99 EAST MAIN STREET , MARLTON, New Jersey, 08053

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K0374 SS = E Bldg. 01	Continued from page 7 bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 2/4/26 in the presence of the U. S. FOIA (b) (2)), it was determined that the facility failed to ensure that smoke barrier doors were in accordance with NFPA 101:2012 Edition, Sections 19.3.7.6, 19.3.7.8 and 19.3.7.9. This deficient practice had the potential to affect all residents in that smoke zone and was evidenced by the following: An observation at 1:00 PM, revealed that the smoke barrier doors to the piano lounge when closed from the electro-magnetic hold open device. The doors did not fully close due to the door hitting the top of the frame. During an interview, the U. S. FOIA confirmed the observation. The U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference on 2/6/26 at 1:30 PM. N.J.A.C 8:39-31.1(c), 31.2 (e)	K0374	Continued from page 7 Identification of Other Residents Potentially Affected: All residents were considered potentially affected. All smoke barrier doors were inspected facility-wide to verify proper working condition and compliance. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Semi-annual smoke barrier door inspections have been implemented. Education was provided by the Plant Operations Director to Maintenance staff. Education included smoke barrier door closure requirements, latching integrity, and obstruction prevention. Education attendance was documented. Evidence of corrective actions maintained for attachment includes door inspection logs and repair documentation. Also attached video of doors closing properly. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Semi-annual smoke barrier door inspections will be conducted by the Plant Operations Director. Inspections will include verification of door closure, latching, and proper operation. Any identified variance will be corrected immediately and documented. Results will be reported to QAPI quarterly.	03/02/2026
K0293 SS = D Bldg. 01	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K0293	K0293 – Exit Signage - The following corrective actions have been implemented: Correction for Residents Specifically Affected: No residents were specifically identified. The non-illuminated exit sign outside the main kitchen will be replaced and tested to verify continuous illumination under both normal and emergency power by March 6, 2026. Identification of Other Residents Potentially Affected: All residents were considered potentially affected. All exit signs were tested facility-wide to ensure proper illumination and compliance with Life Safety Code	03/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILEY MISSION	99 EAST MAIN STREET , MARLTON, New Jersey, 08053

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K0293 SS = D Bldg. 01	Continued from page 8 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 2/4/26 in the presence of the [redacted], it was determined that the facility failed to ensure that illuminated exit signs were installed above doors through which the egress path leads in accordance with NFPA 101:2012 Edition, Section 7.10.1.2.2 and 7.10.2.1. This deficient practice had the potential to affect 15 of 64 residents and was evidenced by the following: An observation at 12:38 PM revealed that the exit sign outside the main kitchen was not provided with any illumination in the exit/egress corridor. In an interview at the time of observation the [redacted] confirmed the finding. The [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 2/6/26 at 1:30 PM. N.J.A.C 8:39-31.2 (e)	K0293	Continued from page 8 requirements. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Quarterly 30-second exit sign testing has been added to the Preventive Maintenance program, with documentation logs implemented. Annual 90-minute testing will be conducted per NFPA requirements. Education was provided by the Plant Operations Director to Maintenance staff. Education included exit sign illumination requirements, testing procedures, and documentation expectations. Evidence of corrective actions maintained for attachment includes the work order invoice for exit sign. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Quarterly testing will be conducted by Maintenance staff under the supervision of the Plant Operations Director. Any identified variance will be corrected immediately and documented. Results will be reported to QAPI quarterly.	03/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

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E0000	Initial Comments An emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 2/4/26, 2/5/26 and 2/6/26. The facility was found to be in non-compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		02/27/2026
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan.	E0004	E0004 – Emergency Preparedness (Transfer Agreements) The following corrective actions have been implemented: Correction for Residents Specifically Affected: No residents were specifically identified. The transfer agreements were executed and current; however, during internal audit it was identified that one Emergency Preparedness binder did not contain the most recently executed copies at the time of review. The binder was immediately corrected and verified to ensure it contained the current, fully executed agreements. Identification of Other Residents Potentially Affected: All residents were considered potentially affected. All Emergency Preparedness binders and electronic files were audited for consistency and verified to contain current executed transfer agreements. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. A Master Emergency Preparedness Document Control Log was implemented. The Plant Operations Director and Administrator have been designated responsible for updating all binders and electronic files upon execution of agreements. An annual January Emergency Preparedness audit with secondary verification has been added. Education was provided by the Administrator to the [redacted], Administrative Team, and Nursing Leadership. Education included Emergency Preparedness requirements related to transfer	03/02/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

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E0004 SS = F	Continued from page 1 The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Based on review of facility documents and interview on 2/6/26 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined the facility failed to establish and maintain the facility transfer contracts and agreements at least annually in accordance with Appendix Z, §483.73(a): Emergency Plan. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility documents at 10:05 AM, revealed that facility contracts and transfer agreements were not updated at least annually. The following contracts and transfer agreements were not annually updated: 1. Transfer agreement: NJ Ex Order 26, 4B1 [redacted] dated: 1/29/24. 2. Transfer agreement: NJ Ex Order 26, 4B1 signed: 1/13/20 and 1/17/20 effective 2/28/20 and 2/28/23. 3. Transfer agreement: NJ Ex Order 26, 4B1 dated: 6/20/19. 4. Transfer agreement: NJ Ex Order 26, 4B1 [redacted]: signed 4/5/24 and 4/8/24 In an interview at the time of document review, the U. S. FOIA (b) (2) indicated the above documents were not updated as of this survey. The U. S. FOIA (b) (2) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 2/6/26 at 1:30 PM. NJAC 8:39-31.2(e), 31.6(i)	E0004	Continued from page 1 agreements. Evidence of corrective actions maintained for attachment includes updated Emergency Preparedness binder contents, current executed transfer agreements, the Emergency Preparedness Document Control Log. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Plant Operations Director will conduct the annual Emergency Preparedness audit each January. The Administrator will review the Document Control Log quarterly to ensure all binders reflect current agreements. Emergency Preparedness compliance, including transfer agreements, will be reviewed at QAPI meetings conducted quarterly. Any identified discrepancy will be corrected immediately and documented.	03/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/02/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 04/02/2026 in relation to the 02/09/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 04/02/2026 in relation to the 02/09/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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