STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

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N J EASTERN STAR HOME	**111 FINDERNE AVENUE , BRIDGEWATER, New Jersey, 08807**

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F0000	INITIAL COMMENTS Complaint #s: 415364, 2708965, 2647550 Standard Survey: 1/23/2026 Census: 72 Sample Size: 18 + 3 Closed Records The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities, deficiencies were cited.	F0000		03/10/2026
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F0607	PLAN OF CORRECTION – CMS TAG F607 (SS=D) 1. Corrective Action(s) Taken for Those Found to Be Out of Compliance The facility reviewed the personnel files of Employees #1, #3, #4, #5, #8, #12, on and #13 on 1/26/26, identified by the survey, and all missing background checks, reference checks, and license verifications were completed for current employees. Employees 1, 4, 5 and 13 remained on schedule as all required hiring documentation had been completed prior to the survey. RN #3 was [NJ Exec Order 26] from the schedule prior to survey, upon audit of HR file. Employee #12 HR file shows that background check was completed prior to the date of first shift worked. This employee has [NJ Exec Order 26.4b1] by the facility since [NJ Exec Order 26] RN Employee #8 [NJ Exec Order 26.4b] date was [NJ Exec Orde] 2. How the Facility Will Identify Other Employees at Risk All residents are potentially at risk from the	03/10/2026

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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F0607 SS = D	Continued from page 1 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to a.) complete reference checks for 2 out of 52 employees (Employee #4, #5); b.) complete background checks for 3 out 58 employees (Employee #1, #12, #13); and c.) complete license checks for 2 out of 58 employees (Employee #3, #8). This deficient was identified for newly hired employees reviewed since last survey from 9/27/2024 and was evidenced as follows: 1.) A review of the employee personnel files revealed the following: For Employee #4, a U.S. FOIA (b)(6) with a start date of NJ Exec Order 26, there was no evidence of a reference check prior to the start of employment. For Employee #5, a U.S. FOIA with a start date of NJ Exec Order 2, there was no evidence of a reference check prior to the start of employment. 2.) A review of the employee personnel files revealed the following: For Employee #1, a U.S. FOIA (b)(6) with a start date of NJ Exec Orde, there was no evidence of a background check prior to the start of employment. Employee #12, U.S. FOIA (b)(6) with a start date of NJ Exec Order 26, there was no evidence of a background check prior to the start of employment. Employee #13, a U.S. FOIA (b)(6) with a start date of NJ Exec Order 26, there was no evidence of a background check prior to the start of employment. 3.) A review of the employee personnel files revealed the following: Employee #3, a U.S. FOIA (b)(6) with a start date of NJ Exec Order 26-A there was no evidence of a license	F0607	Continued from page 1 identified deficient practice. The facility conducted a 100% audit of all active employee personnel files hired since the last standard survey on 1/28/26. The audit verified completion of criminal background checks prior to start of employment, 2 documented professional reference checks, and primary source license verification. No other missing documentation was identified. 3. Measures Put in Place to Prevent Recurrence The facility revised and reinforced its Abuse Prevention Policy and Comprehensive Recruitment and Hiring Policy on 2/4/26. The Administrator re-educated all Directors on the above revised policies. A mandatory Pre-Employment Compliance Checklist requiring completion of background checks, reference checks, and license verification prior to the employee's first day of work was implemented. HR clearance, based on checklist compliance, is required prior to the first scheduled shift for all new employees. 4. Monitoring and Ongoing Compliance The monitoring and compliance plan was started on 2/6/26. Human Resources Director will conduct monthly audits of all new hire personnel files for three (3) months, followed by quarterly audits for 2 quarters. Audit results will be reported by the HR Director to the QAPI Committee quarterly for two quarters. Any identified noncompliance will be corrected immediately and addressed through re-education or disciplinary action as appropriate.	03/10/2026

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F0607 SS = D	Continued from page 2 check prior to the start of employment. Employee # 8, ar[U.S. FO] with a start date of [NJ Exec Order 23] there was no evidence of a license check prior to the start of employment. On 1/22/26 at 2:01 PM, in the presence of the survey team, the surveyor made the [U.S. FOIA (b)(6)] U.S. FOIA (b)(6) [U.S. FOIA (b)(6)]), and the [U.S. FOIA (b)(6)] U.S. FOIA (b)(6) were made aware of the concerns regarding employee background checks, reference checks and license checks prior to hire. The [U.S. FO] acknowledged that the background checks, reference checks and license checks should be completed prior to hire in accordance with their abuse policy. The [U.S. FO] further stated that human resources complete the background check. The department head will complete the two reference checks. On 1/23/26 at 11:00 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] and [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)] who stated that background checks, reference checks, and license checks should be completed prior to the employees hire. She further stated that the head of the department that the employee is hired will complete the reference checks. The human resources department will complete the background checks prior to hiring. A review of the facility's "Abuse" policy, revised 9/30/25…our facility will not knowingly hire any individual who has a history of abusing other persons. We will conduct employment background screening checks, reference checks and criminal background checks, as required, on all individuals who are offered employment within the New Jersey Eastern Star Home. Human resources (or other person as directed by the Administrator) will conduct employment background checks, 2 reference checks, and criminal conviction checks (including fingerprinting as required by law) on persons upon offer of employment…The appropriate professional licensing board will be contacted for any licensed individual who may have direct contact with residents to ensure there are no prior convictions for abuse or related offenses. A review of the facility's "Comprehensive Recruitment and Hiring Policy", revised 8/14/25… Policy: the NJESH is committed to maintaining a comprehensive set of procedures for the recruitment and hiring of new employees to ensure efficiency and fairness in the selection process…All potential new hires must follow the process below: The HR manager will review the	F0607		03/10/2026

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F0607 SS = D	Continued from page 3 application and conduct a background check. Once the background check is completed and the potential new hire is cleared, the HR manager will advise the Department Head to schedule a physical and drug test. The Department of Head must contact at least 2 references and fill out the reference form... Once the new hire passes the physical/drug test and the reference checks have been done and if the new hire accepts the offer, then they must see the HR Manager for the new hire paperwork packet. The new hire cannot start until the HR manager receives the new hire paperwork packet and it's complete. This includes the reference checks from the Department Head. NJAC 8:39-9.3(b)	F0607		03/10/2026
F0678 SS = D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is NOT MET as evidenced by: READY TO BE REVIEWED Based on observation, interview, and record review, it was determined that the facility failed to document the [redacted] for 2 of 3 residents reviewed (Resident #30 and # 73) for [redacted] This deficient practice was evidenced by the following: 1.On 1/21/26 at 9:38 AM, during the initial tour, the surveyor observed Resident #30 in bed with their eyes closed. The resident did [redacted] to the surveyor. The surveyor reviewed Resident #30's electronic medical record (EMR). A review of the resident's Admission Record Face Sheet (FS; an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]	F0678	Element 1: Corrective Action for Residents Affected - Reviewed the medical records of Resident #30 and Resident #73. - Obtained physician orders for [redacted] consistent with valid NJ [redacted] forms. - Entered [redacted] orders into the Electronic Medical Record (EMR) and updated the EMR dashboard and hybrid paper chart. - Updated care plans to reflect [redacted], and goals of care, including [redacted] and comfort-focused interventions as applicable. All of the aforementioned items were completed on 1/26/26. Element 2: Identification of Other Residents Who May Be Affected -As all residents have the potential to be affected by the deficient practice, the DON conducted a 100% audit of all current residents to verify the presence of physician orders for code status in the EMR dashboard. - Ensured care plans reflect code status and are consistent with POLST and advance directives and corrected any deficiencies identified. The aforementioned items were completed on 2/3/26. Element 3: Systemic Changes to Prevent Recurrence - Reinforced the POLST and Advance Directives policy requiring DNR/DNI/DNH orders to be entered into designated EMR fields.	03/10/2026

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F0678 SS = D	Continued from page 4 NJ Exec Order 26.4b1), NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 A review of the resident's EMR revealed the following physician orders (PO) with the start date of [redacted] Eval and treatment with [Name Redacted], Resident was evaluated and admitted to [Name Redacted]. Further review of the residents' EMR and hybrid paper chart did not reveal a PO for the resident's [redacted]. A review of the resident's hybrid paper chart revealed a New Jersey Practitioner Orders for [redacted]) form, dated [redacted]. The [redacted] documented the resident had an [redacted] that they [redacted]" and [redacted]". The form was signed by the resident and a physician. A review of the resident's Care Plan (CP) included a focus area which indicated "I [redacted] related to [redacted] secondary to my current medical condition, [redacted] for [redacted] and my enrollment to [redacted] care program. The CP had an initiation date of [redacted] 2.On 1/20/26 at 11:15 AM, during the initial tour, the surveyor observed Resident #73 sitting in their wheelchair. A review of the resident's FS revealed the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted] A review of the resident's hybrid paper chart included a N[redacted] form, dated [redacted]. The [redacted] documented the resident had [redacted] that they [redacted] The form was signed by the resident representative and a physician. A review of the residents' EMR and hybrid paper chart revealed there was no PO for the resident's [redacted]. A review of the resident's CP did not reflect a focus area to indicate resident's [redacted].	F0678	Continued from page 4 - Inservice Coordinator provided re-education to licensed nursing staff on 2/3/26 regarding the policy, physician orders for code status, care plan documentation, and importance of the EMR dashboard being updated at all times. Element 4: Monitoring to Ensure Sustained Compliance DON will conduct weekly audits for four (4) weeks, then monthly audits for 2 quarters to verify physician orders for code status, EMR dashboard display, hybrid paper chart, and care plan documentation. This monitoring plan was initiated on 2/6/26. - DON or designee will present results to the QAPI Committee on a quarterly basis for the next 2 quarters. Immediate corrective action and staff re-education provided as needed.	03/10/2026

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F0678 SS = D	Continued from page 5 On 1/22/26 at 12:13 PM, the surveyor interviewed the U.S. FOIA (b)(6) about NJ Exec O). The U.S. FOIA stated if the resident's NJ Exec Order 26.4b1 was a NJ Exec Order 26.4, there would not be any PO in the EMR. The surveyor inquired what if the resident had NJ Exec Order 26.4b1. The U.S. FOIA stated that there would be POs entered in the EMR, the NJ Exec Order 26.4b1 would be reflected in the CP, and it would display in the dashboard (where you would see basic information about the resident). The U.S. FOIA stated it was important to have a resident's NJ Exec Order 26.4b1 in the EMR so that "all the staff have same information in order to take care of the resident." In the presence of the surveyor, the U.S. FOIA reviewed the EMR for Resident #30 and Resident #73 and acknowledged there were no POs for their NJ Exec O , and their NJ Exec Order 26.4b1 was not reflected in their dashboard. The U.S. FOIA stated Resident #30 was NJ Exec Order 26.4b1 services and the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 after the resident NJ Exec Order 26 from the hospital. At that time, after reviewing Resident #73's EMR in the presence of the surveyor, the U.S. FOIA stated, "there is no NJ Exec Order 26.4b orders that means the resident is a NJ Exec Order 26 ." The U.S. FOIA then reviewed the paper chart for Resident #73 and read the NJ Exec Order 26 form and further stated that the resident's NJ Exec Ord NJ Exec Ord should be NJ Exec Order 26.4 . The U.S. FOIA further reviewed the CP for Resident #73 and acknowledged that the care plan was not updated with the NJ Exec Order 26.4b1 and should have been updated. On 1/22/26 at 2:05 PM, the survey team met with the U.S. FOIA (b)(6) U.S. FOIA (b)(6) U.S. FOIA (b)(6) and U.S. FOIA (b)(6) . The surveyor informed the administration of the above-mentioned concerns. On 1/23/26 at 9:49 AM, the U.S. FOIA (b)(6) U.S. F and U.S. FOIA U.S. FOIA (b)(6) met with the survey team. The U.S. FOIA U.S. FOIA (b) stated the NJ Exec Order 26.4b1 was reviewed for Resident #30 and Resident #73. The U.S. FOIA (b)(6) acknowledged the POs should have been entered in EMR for both residents. A review of the facility provided policy titles, "POLST" signed and dated 3/11/21 indicated under Procedure: "F. The DNI, DNR, DNH must be placed in the appropriate field in the EMR." N.J.A.C. 8:39-9.6 (a)	F0678		03/10/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F0686	Plan of Correction – F0686 (Pressure Ulcers) SS=D 1. Corrective Action(s) Taken for the Resident(s) Found to Have Been Affected	03/10/2026

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F0686 SS = D	Continued from page 6 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a [redacted] was functioning properly and accurately setup according to the resident's [redacted] in accordance with a physician's order for a resident who was previously identified to have had an [redacted]. This deficient practice was identified for 2 of 2 residents (Resident #15 and Resident #38) reviewed for [redacted] and was evidenced by the following: a.) On 1/20/26 at 10:58 AM and 12:09 PM, the surveyor observed Resident #15 lying in bed, sleeping, on an [redacted]. The resident's [redacted] was observed to be set to a [redacted] of [redacted] pounds. On 1/21/26 at 9:26 AM, the surveyor observed Resident #15 lying in bed, awake, eating breakfast, the [redacted] was noted to be set to a [redacted] of [redacted]. On 1/22/26 at 9:27 AM, the surveyor observed the [redacted] set to a [redacted] of [redacted]. The resident was in bed sleeping, at that time. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which	F0686	Continued from page 6 On 01/22/2026, upon identification of the [redacted] settings not corresponding to resident [redacted], licensed nursing staff immediately adjusted the [redacted] settings for Resident #15 and Resident #38 to [redacted] with resident's most [redacted] documented [redacted], and according to manufacturer's guidelines. Both residents were assessed for any [redacted], and [redacted] were identified. Licensed nursing staff on the affected units received education on 1/26/26 regarding proper setup and verification of [redacted] settings, the importance of accurate [redacted]-based pressure redistribution, compliance with physician orders and manufacturer instructions to prevent [redacted]. 2. Identification of Other Residents Having the Potential to Be Affected The Infection Preventionist completed a facility-wide review of all residents utilizing low air loss mattresses on 1/26/26. Each resident's mattress pump setting was compared to the most recent documented resident weight and physician orders. No additional residents were found to be affected by the deficient practice. 3. Measures Implemented to Prevent Recurrence The facility implemented systemic changes to ensure proper use and monitoring of pressure-reducing mattresses, including reinforcement that all low air loss mattress settings must be adjusted to the resident's current weight, physician orders, and manufacturer instructions. A Low Air Loss Mattress Policy and Procedure was implemented and includes ensuring physician order is in place, verification of mattress placement, function, and weight setting every shift. All nursing staff were in-serviced on this policy on 2/3/26. 4. Monitoring and Ongoing Compliance The monitoring and compliance plan for this deficiency was initiated on 2/6/26. The Director of Nursing/designee will conduct weekly audits for four (4) weeks and monthly audits for 2 quarters, for residents utilizing low air loss mattresses. The audit will include verification that mattress pump settings match the resident's current documented weight, and confirmation that mattress function checks are completed each shift.	03/10/2026

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F0686 SS = D	Continued from page 7 included but were not limited to; NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted] was NJ Exec Order 26.4b1. Further review of the MDS, indicated that the resident was at NJ Exec Order 26.4b1 a NJ Exec Order 26.4b1, and on that date ha NJ Exec Order 26.4b1 [redacted]. Additional review of the MDS, revealed the [redacted] and [redacted] Treatments section included a NJ Exec Order 26.4b1 for the [redacted] and NJ Exec Order 26.4b1. The resident's [redacted] was [redacted] to be [redacted] pounds. A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated [redacted], the resident had a NJ Exec Order 26.4b1 [redacted] related to NJ Exec Order 26.4b1 secondary to the [redacted] process. Interventions included: NJ Exec Order 26.4b1 [redacted] on [redacted] and to [redacted] the resident in [redacted] in a way that [redacted] is [redacted]. Another focus area dated [redacted], revealed that the resident had [redacted] to the [redacted] related to [redacted] Interventions included: administer treatments per physician orders and monitor its effectiveness, provide the resident with preventive care. A record review revealed ongoing [redacted] assessment with recommendations by [redacted] consultants were [redacted], the [redacted] A review of the Order Summary Report included the following physician orders (PO): A PO, dated [redacted], for NJ Exec Order 26.4b1 to the [redacted] topically every shift for [redacted]. A PO, dated [redacted], for [redacted]	F0686	Continued from page 7 The DON/designee will present the audit results to the facility's Quality Assurance and Performance Improvement (QAPI) committee, quarterly for two quarters. Any identified non-compliance will result in immediate corrective action, and staff re-education.	03/10/2026

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F0686 SS = D	Continued from page 8 NJ Exec Order 26.4b1 two times a day for NJ Exec Order 26.4b1. A PO, dated NJ Exec Order 26, for a NJ Exec Order 26.4b1, check placement and functioning every shift for NJ Exec Order NJ Exec Order 2 b.) On 1/20/26 at 11:03 AM, the surveyor observed Resident #38 lying in bed, sleeping, on an NJ Ex. The resident's NJ Exec Order 26.4b1 was observed to be set to a NJ Exec Orde of NJ Exec NJ Exec Order 26.4b1 On 1/21/26 9:28 AM, the surveyor observed Resident #38 lying in bed, awake, on an NJ Exec Order 26.4b1. The resident's NJ Exec Order 26.4b1 was observed to be set to a NJ Exec Orde t o NJ Exec C NJ Exec Order 26 On 1/22/26 9:29 AM, the surveyor observed Resident #38 lying in bed, awake, on an NJ Exec Order 26.4b1. The resident's NJ Exec Order 26.4b1 was observed to be set to a NJ Exec Orde o NJ Exec C NJ Exec Order 26 A review of the Admission Record revealed the resident had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A review of the resident's most recent comprehensive MDS, an assessment tool dated NJ Exec Order 26, included the resident was NJ Exec Order 2 to NJ Exec Order 26 the interview for BIMS, indicating the resident's NJ Exec Order 26 was NJ Exec Order 26.4b1 and their NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1. Further review of the MDS, indicated that the resident was at NJ Exec Order 26.4b1 a NJ Exec Order 26.4b1 and on that date had NJ Exec NJ Exec Order 26.4b1. Additional review of the MDS, revealed that the NJ Exec O and NJ Exec Order 26.4b1 Treatments section included a NJ Exec Order 26.4b1 for the NJ Exec and NJ Exec Order 26.4b1 care. The resident's NJ Exec Orde was noted to be NJ Exec NJ Exec Order 26 A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated NJ Exec Order 26 the resident had a NJ Exec Order 26 for NJ Exec O related to NJ Exec Order 26.4b1 secondary to the diagnosis. Interventions included: NJ Exec Order 26.4b1 on the NJ Exec and to NJ Exec Order 26.4b the resident in NJ Exec in a way	F0686		03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

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F0686 SS = D	Continued from page 9 that NJ Exec Order 26.4 was NJ Exec Order 26. Another focus area dated NJ Exec Order 26., revealed that the resident had NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1. Interventions included: administer treatments per physician orders and monitor its effectiveness, and to use NJ Exec Order 26.4b1 NJ Exec Order 26. A record review revealed ongoing NJ Exec Order 26.4b1 assessment with recommendations by NJ Exec Order 26.4b1 consultants were NJ Exec Order 26.4b1, the NJ Exec Orde was NJ Exec Ord to be NJ Exec Order but in a NJ Exec Order 26.4b1. A review of the Order Summary Report included the following POs: A PO, dated NJ Exec Order 26. for NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 NJ Ex Order 26.4 every shift for NJ Exec Order 26.4b1. A PO, dated NJ Exec Order 2, for a NJ Exec Order 26.4b1, check placement and function every shift for NJ Exec Orde NJ Exec Order. A PO, dated NJ Exec Order 26.4, for NJ E NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 two times a day for Exec Orde. On 1/22/26 at 10:52 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding Resident #15's and Resident #38's NJ Exec Order 26. settings. The U.S. FOIA stated an NJ Exec Order 26.4b1 function was to NJ Exec Order 26.4b1 on their NJ Exec Order 26.4b1 and to NJ Exec Order 26.4b1 for at-risk residents. When asked about the importance of assessing whether a mattress worked properly and maintained the correct NJ Exec Order 26.4b1, the U.S. FOIA replied that the NJ Exec Order 26.4b1 goes by the resident's NJ Exec Orde because we don't want it to be too NJ Exec or too NJ Exec for the resident's NJ Exec Order 26.4b1. He stated that if it was set to the wrong setting, then it would defeat the purpose of having an NJ Exec Order 26.4b1. The U.S. FOIA further stated NJ Ex Order 2 care recommends the NJ Exec Order 26.4b1, the nurse or vendor would set the NJ Exec Order 26.4b1 up for the resident. The nurse was responsible for checking the NJ Ex Order 26.4(b)(1) setting when they complete their normal rounds every shift. At 11:01 AM, the surveyor and the U.S. FOIA went to Resident #15's room. The surveyor asked whether the NJ Exec Orde was set correctly for Resident #15's NJ Exec Order ; the U.S. FOIA stated that the resident NJ Exec Order 26.4b1 NJ Ex Order 26. or NJ Exec Order 26.4 but the NJ Exec Order 26.4b1 was NJ Exe to NJ Ex Order 26.4. The surveyor and the U.S. FOIA went to Resident #38's room. The U.S. FOIA confirmed that Resident #38's NJ Exec Orde on NJ Exec Order 26.	F0686		03/10/2026

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F0686 SS = D	Continued from page 10 was [redacted] pounds and the [redacted] was [redacted] to [redacted] pounds. The [redacted] acknowledged that it should have been set according to the residents' [redacted] and that he will check the settings for all residents on [redacted] to ensure they are on the correct [redacted]. On 1/22/26 at 2:01 PM, in the presence of the survey team, the surveyor made the [redacted], and the [redacted] aware of the concerns regarding Resident #15's and Resident #38's [redacted]. The [redacted] acknowledged that the [redacted] should be according to a resident's [redacted] to [redacted]. On 1/23/26 12:24 PM, the [redacted], stated that there were no facility policies on resident [redacted]. She further stated that moving forward the facility would implement a policy on [redacted]. A review of the manufacturers "Operation Manual" for the air mattress and pump provided to the surveyor by the facility states: Step 4.0 system package: Weight (lbs) simply press weight button to adjust patient, weight 100 lbs to 325 lbs according to patient weight… A review of the facility's "Skin Integrity Program" policy, reviewed 4/25/24, included… use pressure relieving devices such as special mattresses... NJAC 8:39-27.1(a)	F0686		03/10/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to follow physician orders (PO) for	F0689	Plan of Correction CMS Tag – F0689 (SS=D) 1) Corrective action for the resident(s) affected by the deficient practice Nursing staff placed the floor mat to the left side of the bed, per physician order. Nursing staff verified correct placement and safe use of the floor mat and monitored placement of the floor mat, during each shift, when the resident was in bed Staff were reeducated on correct placement and monitoring on 1/26/26. Care plan was updated for fall intervention. 2) Identification of other residents potentially affected and corrective action The DON/designee completed an audit of all residents with orders for floor mats on 1/26/26 to	03/10/2026

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F0689 SS = D	Continued from page 11 NJ Exec Order 26.4b1 as written on the Physician Order Summary. This deficient practice was identified for 1 of 3 residents (Resident # 2) reviewed for accidents and was evidenced by the following: On 1/21/26 at 9:56 AM, the surveyor observed Resident #2 with their eyes closed in their bed. The surveyor observed a NJ Exec Order 26.4b1 folded up, leaning against the wall under the window. On 1/21/26 at 10:13 AM, the surveyor interviewed the U.S. FOIA (b)(6)) in the presence of the Licensed Practical Nurse (LPN#1). The surveyor inquired about the NJ Exec Order 26.4 for Resident #2 and the U.S. FOIA stated, "it might be something new", and "it is for NJ Exec Order 26.4b ". The surveyor reviewed the electronic medical record for Resident #2. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) NJ Exec Order 26.4b1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4 revealed a Brief Interview for Mental Status score of NJ out of 15, which indicated that the resident had NJ Exec Order 26.4b1 Further review of the MDS indicated that Resident #2 was NJ Exec Orde as " NJ Exec " as having a NJ Exec Order 26.4b in the NJ Exec Order 26.4b1 prior to their admission. A further review of section NJ revealed that the resident had NJ Exec Order 26 related to a NJ Exe prior to admission. A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area of a NJ Exec for NJ Exec O related to NJ Exec Order 26.4b1 secondary to diagnoses of NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 NJ Ex 1. NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b Further review of the ICCP reflected a focus area of the resident had a NJ Exec Order 2 of NJ Exec Order 26 related to	F0689	Continued from page 11 ensure ordered interventions are implemented as written. No other residents were found to have orders for floor mats that were not implemented. 3) Systemic changes to prevent recurrence Inservice coordinator/designee will re-educate all nursing staff on implementing physician-ordered fall prevention interventions exactly as written. Inservice education will include the Physician Orders policy as well as the Fall Risk policy. Education will stress the purpose and correct placement of floor mats and required shift-to-shift monitoring. Nursing supervisors/designees will incorporate compliance review into routine rounds. The aforementioned items were completed on 2/3/26. 4) Monitoring to ensure compliance and sustain improvement The monitoring plan for this deficiency was initiated on 2/6/26. The DON/designee will conduct audits of residents with fall prevention physician orders weekly x 4 weeks, and quarterly for 2 quarters. DON/designee will present audit results to the QAPI committee quarterly, for two quarters Any identified non-compliance will be corrected immediately, and staff will receive re-education as needed.	03/10/2026

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F0689 SS = D	Continued from page 12 diagnosis of [redacted], initiated on [redacted] A review of the Order Summary Report (OSR) reflected an active PO dated [redacted] for [redacted] to [redacted] of bed, monitor placement every shift for prevention. On 1/22/26 at 9:35 AM, the surveyor interviewed LPN#2, who stated that Resident #2 was a [redacted] when the resident was admitted to the facility. LPN#2 also stated that the importance of the [redacted] was for [redacted] when the resident was [redacted] in the evenings. On 1/22/26 at 2:10 PM, during a meeting with the survey team, the [redacted], and [redacted] were made aware of the above mentioned concerns. No additional information was provided. A review of facility's undated "Fall Prevention Program" policy, revealed… While the falls care plan may include potentially effective interventions, it is staff compliance that will reduce fall risk. A program's success or failure can only be determined if staff actually implement the recommended interventions… Resident response must also be monitored to determine if an intervention is successful. Changes in care and alternate interventions should be decided based on continued assessment… A review of facility's "Physician Orders Policy", revised 2/10/25, revealed …Nursing supervisors or designees will audit orders periodically for accuracy, timeliness, and compliance… NJAC 8:39-27.1(a)	F0689		03/10/2026
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	F0761	PLAN OF CORRECTION (POC) –F0761 1) Corrective action for the resident(s) affected Five unlabeled Enoxaparin syringes were immediately removed and disposed of at time of discovery. Open liquid protein supplement was	03/10/2026

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F0761 SS = D	Continued from page 13 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 observations, interview, and review of facility policy, it was determined that the facility failed to appropriately label medications in accordance with professional standards of practice. The deficient practice was identified for 1 of 5 medication carts (the Subacute Rehab Side 2 medication cart) inspected during the Medication Storage task. The deficient practice was evidenced by the following: On 01/22/2026 at 9:40 AM, the surveyor inspected the Subacute Rehab side 2 medication cart with the U.S. FOIA (b)(6) on D wing. The surveyor observed five syringes of Enoxaparin 30mg/3mL (a prescription drug used to prevent and treat blood clots, especially after surgery or serious illness) were lying in the third drawer, with no resident label or date and were not in a bag. The syringes were in their original packaging. The [redacted] stated, "I'm going to be honest, they are not stock, they should be labeled". The [redacted] then disposed of the syringes in the sharps container on the right side of the cart. The [redacted] stated the pharmacy checks the carts but did not know how often. The [redacted] was unaware if nursing staff checked the carts. Further review of	F0761	Continued from page 13 removed and discarded. Medication cart contents were checked for additional unlabeled/undated items on 1/26/26. 2) Identification of other residents potentially affected All residents have the potential to be affected by the deficient practice. DON/designee audited all medication carts for resident-specific labeling, proper storage in labeled bins/boxes, dating of opened multi-use liquids/supplements, and expired/discontinued items and cleanliness on 2/3/26. Noncompliant items were removed immediately and replaced through pharmacy as needed. 3) Systemic changes to prevent recurrence Re-education of licensed nursing staff on 2/6/26 was conducted by the Pharmacy Consultant and Inservice Coordinator on labeling requirements for resident-specific medications, prohibition of loose medications in drawers, dating opened liquids/supplements, medication cart storage and cleaning expectations. Pharmacy Consultant will reinforce compliance expectations during monthly medication cart reviews. 4) Monitoring to ensure compliance The monitoring plan was initiated on 2/6/26. Nursing supervisor/designee will complete medication cart audits weekly for 4 weeks and quarterly for 2 quarters. DON/designee will report audit results to the QAPI Committee quarterly for two quarters. Noncompliance will result in immediate correction, re-education, and progressive discipline as indicated.	03/10/2026

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F0761 SS = D	Continued from page 14 the cart revealed a bottle of liquid protein supplement was present in the bottom drawer. The bottle was opened and not labeled with the open date. The [U.S. FO] stated, "they are good for 30 days". On 01/22/2026 at 2:10 PM, during a meeting with the survey team, the U.S. FOIA (b)(6) U.S. FOIA (b)(6) U.S. FOIA (b)(6), and U.S. FOIA (b)(6) were made aware of the above mentioned concerns. On 01/23/2026 at 12:40 PM, in a phone interview with the U.S. FOIA (b) (6) the [U.S. FO] stated "the [U.S. FO] makes sure the facility is compliant with medication storage and labeling. If Enoxaparin is in the cart, it should have a patient specific label on it. If it is found without a label, I would inquire with nursing, find out who the resident was and put it in the labeled box. It is not stock and should not be floating unlabeled." The [U.S. FO] also stated he did a formal medication pass observation and medication cart check a couple of weeks ago. A review of the facility policy titled "Cleaning and Disinfection of Medicine Carts", dated 03/15/2023 provided by the U.S. FOIA (b)(6) U.S. FOIA (b)(6)) revealed Policy Statement... Medication carts are considered shared medical equipment and shall be maintained in a clean, sanitary, and safe condition at all times. Scope: This policy applies to all licensed nursing staff, nursing supervisors, and the Infection Preventionist. N.J.A.C. § 8:39-29.4 (a) (h)	F0761		03/10/2026
F0868 SS = D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F0868	CMS 2567 Plan of Correction-F0860 (SS=D) Deficiency: Quality Assessment and Assurance (QAA) / QAPI Committee – Infection Preventionist Participation Element 1: Corrective Action for the Deficiency Identified The facility reviewed the QAPI meeting dated 04/07/2025 where the Infection Preventionist (IP) was not present. The IP subsequently reviewed and reported infection prevention and control data to the QAPI Committee, including infection surveillance and trends on 1/26/26. Element 2: Identification of Other Potentially Affected Areas All residents have the potential to be affected by the	03/10/2026

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F0868 SS = D	Continued from page 15 (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure the required committee members, the U.S. FOIA (b)(6) was present for one of five Quality Assurance and Performance Improvement (QAPI) meetings. This deficient practice was evidenced by the following: On 01/20/2026 at 09:34 AM, during entrance conference, the surveyor requested the QAPI sign-in sheets from the last survey date of 9/27/2024 to present. On 01/23/2026 at 10:49 AM, the surveyor reviewed the "QAPI Meeting Sign In Sheet" dated NJ Ex Order 26.4(b)(1), which revealed the U.S. F did not sign the sheet. On 01/23/2026 at 10:49 AM, during a meeting with surveyor, the U.S. FOIA (b)(6) NJ Exec Order 26.4b1, U.S. FOIA (b)(6)) reviewed the "QAPI Meeting	F0868	Continued from page 15 deficient practice. A retrospective review of all QAPI sign-in sheets and minutes from the last survey date to present was completed on 1/26/26. Verification included attendance of required members and documentation of infection control reporting. No additional deficient practice in required attendance or reporting were identified. Element 3: Systemic Changes to prevent recurrence A standardized QAPI Meeting Attendance Checklist was implemented. Department heads and QAPI committee members were re-educated by the Administrator on regulatory requirements requiring QAPI attendance on 2/6/26. Assistant administrator will reschedule meetings if possible or ensure alternate participation by a designee providing the IP report will be arranged if the IP is unavailable. Element 4: Monitoring to Ensure Sustained Compliance Monitoring plan was initiated on 2/6/26. Administrator/designee will perform quarterly audits of QAPI sign-in sheets, agendas, and minutes, confirming IP attendance and documentation of Infection Preventionist reporting. Results will be reviewed by the QAPI Committee and reported to the Governing Body annually by the Administrator/designee. Corrective action and education will occur if deficiencies are identified.	03/10/2026

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F0868 SS = D	Continued from page 16 Sign In Sheet" dated 04/07/2026 and confirmed the [redacted] did not sign the sign in sheet. The [redacted] stated in the absence of the [redacted] the [redacted] would review the [redacted] information. On 01/23/2026 at 12:32 PM, a review of the "QAPI Minutes" dated 04/07/2025 at 10:40 AM revealed under the Nursing section "skill competencies." Further review did not reveal infection control was not presented. On 01/23/2026 at 12:35 PM, in the presence of the survey team, the [redacted] acknowledged the QAPI Minutes provided were the full minutes, and there was nothing additional to add. A review of the facility's "Quality Assurance & Performance Improvement (QAPI)" policy dated 07/30/2025, revealed Purpose: New Jersey Eastern Star Home will participate in an effective, comprehensive, data driven QAPI process that focuses on systems of care, outcomes, and services for residents and staff…Facility governing body will ensure that the QAPI program is defined, implemented, and maintained, addressing identified priorities. Procedure: A. The QAPI committee is comprised of: …4) Infection Control/Preventionist. NJAC 8:39-33.1(b); 33.2(c)(7)	F0868		03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031804	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		03/10/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 12 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each	S0560	S560-Mandatory Access to Care How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice. An apparent cause analysis was performed on 1/26/26 to determine the cause of the deficient practice on the dates identified during the survey. It was determined that the facility's budgeted CNA staffing for those dates met the required ratio. However, no CNA was available or willing to take the shift, and despite contacting multiple contracted agencies, the facility was unable to secure coverage. Re-inservice of nursing supervisors regarding patient care ratios was conducted to reiterate the importance of filling call-outs for the oncoming shift. There were no negative outcomes identified. How the facility will identify other residents Having the potential to be affected by the deficient practice? All residents have the potential to be affected by the	03/10/2026

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: 031804	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	**111 FINDERNE AVENUE , BRIDGEWATER, New Jersey, 08807**

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S0560	Continued from page 1 direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The survey team requested AAS-11staffing for the 2 weeks from 01/04/2026 to 01/17/2026 prior to the 01/23/2026 survey. The facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -01/05/26 had 8.5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -01/06/26 had 8.5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -01/07/26 had 8.5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -01/08/26 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -01/09/26 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -01/10/26 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -01/11/26 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs. -01/12/26 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs. -01/13/26 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs. -01/17/26 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. On 01/20/2026 at 12:15 PM, the surveyor interviewed the Staffing Coordinator (SC), who stated she tried to meet the CNA ratios but sometimes there were late call outs, and she sometimes could not cover the shift. The SC stated she posts the shifts to the agency but sometime the agency does not pick up the shift because it was too late. A review of the facility's policy "Staffing Policy" revised 3/11/2024 revealed Procedure: A…schedules nursing personnel in accordance with resident needs	S0560	Continued from page 1 deficient practice. What measures will be put into place or systematic changes made to ensure that the deficient practice would not reoccur? Staffing Coordinator and supervisors were re-educated regarding the importance of complying with the required minimum direct care to staff ratios as mandated by the State of New Jersey. Schedule done for entire month and reviewed weekly and daily and by shift to manage any last-minute staff call-outs. Staffing agreements maintained with 9-agencies. Staffing coordinator works closely with staffing agencies to implement a "stat" turnaround to fill unexpected staff callouts/shift vacancy Staffing coordinator updated list of certified nursing assistants, per shift, willing to work overtime. Staffing coordinator updated list of nurses, per shift, willing to work as certified nursing assistants. Internal staff offered financial incentive to fill last minute vacant shifts when needed. Actively recruit LPN students doing their clinical rotation in our facility to work temporarily as CNA's while awaiting their LPN exam results. HR Director reviewed and revised open position advertisements and increased sign-on bonus to attract additional candidates. Administration created a postcard mailing to certified nursing assistants in our area to advertise our new pay and bonus offerings. The aforementioned items were completed on 2/6/26.	03/10/2026

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S0560	Continued from page 2 on each of the three nursing units…also staff's the facility to meet the New Jersey staffing rations set for each shift.	S0560	Continued from page 2 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur. The monitoring plan was initiated on 2/9/26. Daily communication between DON/designee and Staffing Coordinator/designee to review nursing schedule for projected compliance with ratios. DON/designee will perform weekly staffing audits for four (4) weeks, followed by monthly audits for 2 quarters. Results of audit will be presented to the QAPI committee for 2 quarters by DON/designee.	03/10/2026
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure newly hired employees had received health examinations by a Physician, Advanced Practice Nurse, or a Licensed Physician's Assistant prior to employment; or within thirty days of a Registered Nurse's (RN) completed initial assessment upon employment, for 4 out of 58 employees (Employee #2, #5, #10 and #11) hired since the last Department of Heath recertification survey of 9/27/2024. This deficient practice was evidenced by the following: A review of the employee personnel files revealed the following: For Employee #2, a Licensed Practical Nurse (LPN)	S1405	CMS Plan of Correction -S1405 Deficiency: Mandatory Infection Control and Sanitation – Employee Health Examinations Element 1: How the Corrective Action Will Be Accomplished for Those Found to Be Affected Upon identification of the deficient practice, the facility reviewed the personnel files of Employee #2, #5, #10, and #11. Required employee health physical examinations completed were obtained and verified. All required documentation was placed in the employee health files. The Infection Preventionist /designee and Human Resources verified infection control clearance prior to continued work assignments. The aforementioned items were completed on 1/26/26. Element 2: How the Facility will Identify Other Employees Who May Be Affected All residents have the potential to be affected by the deficient practice. Infection Preventionist conducted a 100% audit of employee health files to be completed by 2/18/26 for all staff hired since the last recertification survey. Element 3: Measures Put Into Place or Systemic Changes Made to Ensure the Deficient Practice Will not Recur The HR Director revised the Comprehensive	03/10/2026

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S1405	Continued from page 3 with a start date of [NJ Exec Order 26], there was no evidence of a health physical in their employee health file. For Employee #5, an LPN, with a start date of [NJ Exec Order], there was no evidence of a health physical in their employee health file. For Employee #10, a housekeeper, with a start date of [NJ Exec Order 26], there was no evidence of a health physical in their employee health file. For Employee #11, an activities staff, with a start date of [NJ Exec Order 26], there was no evidence of a health physical in their employee health file. On 1/22/26 at 2:01 PM, in the presence of the survey team, the surveyor made the Infection Preventionist (IP), Assistant Administrator (AA), and the Minimum Data Set Coordinator (MDS Coordinator) aware of the concerns regarding employee health physicals prior to hiring. The AA acknowledged the employees' health physical should be completed at the facility prior to date of hire. The AA acknowledged that the missing items should have been kept in the employees' files. On 1/23/26 at 11:00 AM, the surveyor interviewed the Director of Administer Services and Human Resources, who stated health physicals were completed prior to hire at the facility. A review of the facility's "Comprehensive Recruitment and Hiring Policy", revised 8/14/25… Policy: the NJESH is committed to maintaining a comprehensive set of procedures for the recruitment and hiring of new employees to ensure efficiency and fairness in the selection process…All potential new hires must follow the process below: The HR manager will review the application and conduct a background check. Once the background check is completed and the potential new hire is cleared, the HR manager will advise the Department Head to schedule a physical and drug test. The Department of Head must contact at least 2 references and fill out the reference form... Once the new hire passes the physical/drug test and the reference checks have been done and if the new hire accepts the offer, then they must see the HR Manager for the new hire paperwork packet. The new hire cannot start until the HR manager receives the new hire paperwork packet and it's complete. This includes the reference checks from the Department	S1405	Continued from page 3 Recruitment and Hiring Policy. Additionally, a standardized pre-employment health compliance checklist was implemented on 1/26/26 to ensure that no employee begins work without the proper clearances. Human Resources, Department Heads, Infection Preventionist and administrative staff were in-serviced by the Administrator on the updated Comprehensive Recruitment and Hiring Policy on 2/4/26. Element 4: How the Facility Will Monitor Its Corrective Actions to Ensure Sustained Compliance Infection Preventionist or designee will conduct monthly audits of all newly hired employee health files will be conducted for 4 weeks, followed by quarterly audits for 2 quarters and presented to the QAPI committee for 2 quarters. Audits will verify completion of health physicals, TB screening, and proper documentation as specified on the New Hire Onboarding Checklist. Immediate corrective action and staff education will occur for any identified deficiencies.	03/10/2026

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S1405	Continued from page 4 Head.	S1405		03/10/2026
S1410	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(b)(1) (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to perform a NJ Ex Order 26.4 NJ Exec Order 26.4b1 (NJ Exec 2) as required for new employees hired for NJ Exec Order 26.4b1 infection and disease screening upon hire for 5 out of 58 employees (Employee #5, #6, #7, #9 and #14) hired since the last Department of Heath recertification survey of 9/27/2024. This deficient practice was evidenced by the following: A review of the employee personnel files revealed the following: For Employee #5, a Licensed Practical Nurse (LPN) with a start date of NJ Exec Order 26 there was no evidence of a NJ Exec Order 26.4 NJ Exec Order 26.4b1 prior to the start of employment. For Employee #6, a housekeeper with a start date of NJ Exec Order 2 , there was no evidence of a NJ Exec Order 26 NJ Exec Order 26.4b1) prior to the start of employment.	S1410	CMS-2567 Plan of Correction-S1410 Deficiency: Mandatory Infection Control and Sanitation – TB Screening Licensure Requirement Element 1: Corrective Action for Employees Affected Infection Preventionist immediately reviewed the deficient employee health files for employees #5, #6, #7, #9, and #14. Required two-step Mantoux tuberculin skin testing (PPD) or approved alternative documentation was obtained and verified. Documentation was placed in employee health files. The Infection Preventionist and Human Resources verified TB clearance prior to continued work assignments. The aforementioned items were completed on 1/26/26. Element 2: Identification of Other Potentially Affected Employees All residents have the potential to be affected by the deficient practice. An audit of 100 % of the employee health files for staff hired since the last recertification survey will be completed by 2/18/26. Documentation was reviewed for two-step PPD completion or approved exemptions. Element 3: Systemic Changes to Prevent Recurrence The Administrator and Infection Preventionist in-serviced Department Heads on the Comprehensive Recruitment and Hiring Policy on 2/4/26 to prohibit employee start dates without TB screening compliance. A mandatory new hire onboarding checklist, which includes employee health requirements, was implemented on 1/26/26. HR clearance, based on checklist compliance, is required prior to the first scheduled shift for all new employees. Element 4: Monitoring to Ensure Sustained Compliance	03/10/2026

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S1410	Continued from page 5 For employee # 7, a certified nursing assistant (CNA) with a start date of [NJ Exec Order 2], there was no evidence of a [NJ Exec Order 26.4b1] prior to the start of employment. For Employee #9, a activities staff with a start date of [NJ Exec Order 26.4b1] there was no evidence of a [NJ Exec Order 26.4b1] prior to the start of employment. For employee # 14, a CNA with a start date of [NJ Exec Order 2], there was no evidence of a [NJ Exec Order 26.4b1] prior to the start of employment. On 1/22/26 at 2:01 PM, in the presence of the survey team, the surveyor made the Infection Preventionist (IP), Assistant Administrator (AA), and the Minimum Data Set Coordinator (MDS Coordinator) aware of the concerns regarding employee's two-step Mantoux tuberculin skin test prior to hiring. The AA acknowledged that the employees' [NJ Exec Order 26.4b1] test would be obtained on every newly hired employee unless they presented a recent chest [NJ Exec Order 26.4b] She stated the Mantoux (PPD) tests were completed at the facility prior to date of hire. The AA acknowledged that the missing items should have been kept in the employees' files. On 1/23/26 at 11:00 AM, the surveyor interviewed the Director of Administer Services and Human Resources, who stated a [NJ Exec Order 26.4b1] were completed prior to hire at the facility. She further stated if the employee had a positive [NJ Exec] test then a [NJ Exec Order 26.4b1] would be done. A review of the facility's "Comprehensive Recruitment and Hiring Policy", revised 8/14/25… Policy: the NJESH is committed to maintaining a comprehensive set of procedures for the recruitment and hiring of new employees to ensure efficiency and fairness in the selection process…All potential new hires must follow the process below: The HR manager will review the application and conduct a background check. Once the background check is completed and the potential new hire is cleared, the HR manager will advise the Department Head to schedule a physical and drug test. The Department of Head must contact at least 2 references and fill out the reference form... Once the new hire passes the physical/drug test and the reference checks have been done and if the new hire accepts the offer, then they must see the HR	S1410	Continued from page 5 The monitoring plan was initiated on 2/6/26. Infection Preventionist or designee will perform monthly audits of all newly hired employee health files monthly for 4 weeks, then quarterly for 2 quarters and findings will be presented to the QAPI committee based on the new hire onboarding checklist compliance. Immediate corrective action will be taken for any identified deficiencies.	03/10/2026

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S1410	Continued from page 6 Manager for the new hire paperwork packet. The new hire cannot start until the HR manager receives the new hire paperwork packet and it's complete. This includes the reference checks from the Department Head.	S1410		03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/17/2026 in relation to the 01/23/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		03/19/2026

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031804	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/17/2026 in relation to the 01/23/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		03/19/2026

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: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING **2A - NJ EASTERN...** B. WING	(X3) DATE SURVEY COMPLETED **01/23/2026**

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K0000 Bldg. 2A	INITIAL COMMENTS The NJDOH conducted a Life Safety Code survey on 01/21/26 and 01/22/26. The facility was found to be in non-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 Occupancies. NJ Eastern Star is a one-story building with basement that was built in 1957 with an addition constructed in 2015. The building is composed of Type II (111) protected construction. The facility is divided into four - smoke zones. The 2 generators service 100% of the building per the Maintenance Director.	K0000		03/10/2026
K0223 SS = F Bldg. 2A	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by:	K0223	K0223 – Doors with Self-Closing Devices (SS = F) 1. Corrective action(s) taken for those residents found to be affected by the deficient practice No residents in the facility were affected by the deficient practice. G4 is a non-residential room strictly used for storage. The facility immediately corrected the cited deficiencies repairing or adjusting the self-closing devices on the apartment G4 door. Door closer parts ordered from the supply company for the supply room crawl space door and will be installed to ensure that both doors self-close and latch properly. Stored items in apartment G4 were reviewed to ensure they did not interfere with door operation. Both doors will be tested to confirm proper self-closing, latching, and secure closure. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The facility acknowledges that all residents have the potential to be affected by the deficient practice. The Maintenance Director or designee conducted a facility-wide inspection of all doors required to be self-closing, including apartment doors, resident doors, hazardous area doors, smoke barrier doors,	03/10/2026

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.

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N J EASTERN STAR HOME	111 FINDERNE AVENUE , BRIDGEWATER, New Jersey, 08807

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K0223 SS = F Bldg. 2A	Continued from page 1 Based on observation and interview on 01/21/2026, in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that a door with a self-closing device was maintained and kept in the closed position in accordance with NFPA 101:2012 Edition, Sections 7.2.1.8 and 19.2.2.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:07 AM revealed apartment G4. The unoccupied apartment was storing resident furniture, boxes and various household items within. The apartment door was unable to self-close and latch. In an interview at the time, the U.S. FO confirmed the observation. An observation at 10:30 AM within the Supply Room, revealed a door approximately 36 inches wide x 36 inches high leading into a crawl space. The door would not self-close and latch. In an interview at the time, the U.S. FO confirmed the observation. The facility's U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference on 01/22/2026 at 2:30 PM. The U.S. FOIA (b)(6) was unavailable at the time of exit. NJAC 8:39-31.2(e)	K0223	Continued from page 1 and other protected openings, to identify any additional doors that do not self-close and latch properly. Any identified deficiencies were documented and corrected promptly. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The facility implemented a preventive maintenance process requiring routine inspections of all self-closing doors to ensure proper operation, latching, and unobstructed closure. Maintenance Director re-educated the maintenance staff on 2/10/26 on Life Safety Code requirements related to self-closing devices and the importance of maintaining doors in the closed position. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, and who will be responsible The Maintenance Director or designee will conduct and document semi-annual audits of self-closing doors throughout the facility. Findings will be presented by the Maintenance Director or designee at the QAPI Committee meeting 2 times in the next 12 months. Corrective actions will be taken as indicated to ensure ongoing compliance.	03/10/2026
K0353 SS = F Bldg. 2A	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 and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K0353	K0353 – Sprinkler System: Maintenance and Testing (SS = F) 1. Corrective action(s) taken for those residents found to be affected by the deficient practice No residents in the facility were affected by the deficient practice. The facility immediately inspected the affected sprinkler heads in Room NJ Exec Orde and throughout D & E wings. Maintenance Director scheduled company NJ Exec Order 26.4b1 to conduct cleaning of all sprinkler heads in D & E resident rooms and bathrooms, with visible foreign matter buildup to ensure proper operation. The bathroom vents were evaluated to confirm they were not discharging debris directly onto sprinkler heads.	03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING 2A - NJ EASTERN... B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0353 SS = F Bldg. 2A	Continued from page 2 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 observation, interviews, and documentation on 01/21/2026, in the presence of the U.S. FOIA (b)(6), it was determined that the facility failed to ensure that the automatic sprinkler system was inspected, tested, and maintained (ITM) quarterly in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8 and NFPA 25:2011 Edition, Chapter 5. This deficient practice had the potential to affect all residents, and was evidenced by the following: An observation at 12:27 PM, in room NJ Exec Ofc, revealed a bathroom fire sprinkler head with buildup of an unknown foreign matter. The foreign matter was covering approximately one half of the glass bulb, frame, and deflector. The sprinkler head was located approximately 8 to 9 inches from the bathroom vent which was pushing dust and debris onto the sprinkler head. In an interview at the time, the U.S. FO confirmed the observation. Observations throughout the tour of D=Wing revealed 26 of 27 resident bathroom fire sprinkler heads had the same buildup of foreign matter and were located within approximately 8-9 inches of the bathroom exhaust. In interviews after each observation, the U.S. FO confirmed them. The facility's U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference	K0353	Continued from page 2 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The facility acknowledges that all residents have the potential to be affected by the deficient practice. The Maintenance Director or designee conducted a facility-wide inspection of all resident bathroom sprinkler heads and other areas where sprinkler heads are located near vents or air movement sources. This inspection included verification that sprinkler heads were free of dust, debris, corrosion, paint, or other foreign materials that could impair activation. Any additional deficiencies identified were corrected promptly. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The facility implemented a sprinkler system inspection, testing, and maintenance (ITM) program. Quarterly visual inspections of sprinkler heads will include verification that heads are clean, unobstructed, and not adversely affected by airflow from vents. Maintenance Director re-educated Maintenance staff on 2/10/26 on requirements, including proper sprinkler head condition and environmental factors that may contribute to contamination. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, and who will be responsible The Maintenance Director or designee will conduct and document quarterly sprinkler head inspections as part of the facility's inspection, testing, and maintenance (ITM) program. Inspection findings will be presented by the Maintenance Director or designee at the QAPI committee meeting, then quarterly, for the next 2 quarters. Corrective actions will be implemented as needed to ensure continued compliance.	03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING 2A - NJ EASTERN... B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

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K0353 SS = F Bldg. 2A	Continued from page 3 on 01/22/2026 at 2:30 PM. The U.S. FOIA (b)(6) was unavailable at the time of exit. NJAC 8:39-31.2(e) - 31.1(C) NFPA 25	K0353		03/10/2026
K0355 SS = F Bldg. 2A	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 01/22/2026 in the presence of the U.S. FOIA (b)(6) it was determined the facility failed to ensure that Class K portable fire extinguishers were provided with the required instructional placard in accordance with NFPA 101:2012 Edition, Sections 9.7.4 and NFPA 10:2010 Edition, Sections 5.5.5.3, A 5.5.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:38 PM revealed a fire extinguisher within the kitchen, covered by a weather resistant protective bag. The extinguisher was located directly underneath the required K-Class fire extinguisher warning sign. When the protective bag was removed from the extinguisher, it was found to be an ABC type extinguisher. In an interview at the time, the U.S. FOI confirmed the observation. The U.S. FO was asked if there was a K-Class fire extinguisher in the kitchen, he answered no. The U.S. FO stated that he had received a replacement K-Class extinguisher, which was currently in the maintenance garage, but had not yet placed it in the kitchen. The facility's U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference	K0355	K0355 – Portable Fire Extinguishers (SS = F) 1. Corrective action(s) taken for those residents found to be affected by the deficient practice No residents in the facility were affected by the deficient practice. The facility immediately removed the improperly placed ABC fire extinguisher from the kitchen area and installed the required Class K fire extinguisher in the designated kitchen location. The Class K extinguisher was mounted properly, made readily accessible, and verified to have the required instructional labeling visible and unobstructed. The protective cover was evaluated to ensure it does not interfere with extinguisher identification or instructions. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The facility acknowledges that all residents have potential to be affected by the deficient practice. The Maintenance Director or designee conducted a facility-wide inspection of all portable fire extinguishers, with particular attention to kitchen and cooking areas, to verify that the correct extinguisher type is provided, required instructional placards are present, and extinguishers are properly installed and identifiable. No other deficiencies were identified. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The facility implemented a portable fire extinguisher management audit, which includes verification of extinguisher type by hazard area, confirmation that instructional signage and labels are present and visible, and coordination with the contracted fire protection vendor for proper selection and placement. The Maintenance Director re-educated Maintenance staff on 2/10/2026 on requirements specific to Class K extinguishers and kitchen fire hazards. 4. How the corrective action(s) will be monitored to	03/10/2026

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K0355 SS = F Bldg. 2A	Continued from page 4 on 01/22/2026 at 2:30 PM. The U.S. FOIA (b)(6) was unavailable at the time of exit. NJAC 8:39-31.2(e)	K0355	Continued from page 4 ensure the deficient practice will not recur, and who will be responsible The Maintenance Director or designee will conduct and document monthly inspections of all portable fire extinguishers, including verification of correct extinguisher type, visibility of instructions, and proper placement. Inspection results will be presented by the Maintenance Director or designee at the QAPI committee for 2 quarters. Corrective actions will be taken as needed to maintain compliance.	03/10/2026
K0362 SS = F Bldg. 2A	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 01/21/2026, in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that corridor walls were constructed to resist the passage of smoke in accordance NFPA 101: 2012 Edition, Section 19.3.6.2 and 19.3.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:28 AM, revealed an	K0362	K0362 – Corridors: Construction of Walls (SS = F) Corrective action(s) taken for those residents found to be affected by the deficient practice No residents in the facility were affected by the deficient practice. The approximately 30-inch by 32-inch grate located in the laundry room washer area discharging air into the corridor was removed on 2/27/2026. The opening was permanently sealed and restored using approved fire-rated materials providing a smoke-resistant barrier consistent with the existing wall construction to maintain corridor wall integrity. All corrective work was completed by a qualified contractor and verified by the Maintenance Director 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The facility acknowledges that all residents have the potential to be affected by the deficient practice. The Maintenance Director or designee conducted a facility-wide inspection of all corridor walls, including areas adjacent to mechanical rooms, laundry rooms, storage rooms, and other use areas, to identify any unprotected openings, grilles, penetrations, or improperly installed dampers that could allow the passage of smoke into corridors. Any additional deficiencies identified were removed, permanently sealed and restored using approved fire-rated materials providing a smoke resistant barrier consistent with the existing wall construction to maintain corridor wall integrity. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Director of Maintenance re-educated the	03/10/2026

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K0362 SS = F Bldg. 2A	Continued from page 5 approximately 30-inch-wide x 32-inch-high grate installed on the cinderblock wall of the laundry room washer area discharging air from the room into the corridor. Continued observation revealed a non-compliant fire damper with a fusible link mounted in the wall which would allow for the passage of smoke into the exit corridor. In an interview at the time, the U.S. FOI confirmed the observation. The facility's U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference on 01/22/2026 at 2:30 PM. The U.S. FOIA (b)(6) was unavailable at the time of exit. NJAC 8:39-31.2(e)	K0362	Continued from page 5 maintenance staff on 2/27/2026 on the requirements related to corridor wall construction and smoke barrier integrity. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, and who will be responsible The Maintenance Director or designee will conduct and document monthly for 6 months the inspections of the corridor wall construction and smoke barrier integrity. Findings will be presented by the Maintenance Director or designee at the QAPI committee meeting for 2 quarters. Corrective actions will be taken as indicated to maintain compliance.	03/10/2026
K0511 SS = F Bldg. 2A	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 01/21/2026, in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that electrical equipment had approved wiring and electrical outlets in accordance with NFPA 70, 2011 Edition, Section 19.5.1.1, 9.1.1 and 9.1.2. The deficient practice had the potential to affect all residents and was evidenced by the following: Observations during the Life Safety Tour form 9:30 AM to 1:05 PM, revealed the use of modified plugs on multiple patient beds. An observation at 10:50 AM in Resident room NJ Exe	K0511	K0511 – Utilities: Gas and Electric (SS = F) 1. Corrective action(s) taken for those residents found to be affected by the deficient practice No residents in the facility were affected by the deficient practice. The facility immediately ordered and received replacement power cords for the modified electric plugs identified. The affected beds in NJ Ex bed 1, A5 bed 1, NJ Exec bed 2, NJ Exec bed 2, NJ Exec bed 2, NJ Exec private bed, NJ Exec C private bed, NJ Exec C private bed will be repaired by qualified personnel or replaced to ensure manufacturer-approved wiring, intact cord jackets, and proper strain relief at the plug connection. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The facility acknowledges that all residents have the potential to be affected by the deficient practice. The Maintenance Director or designee conducted a facility-wide inspection of all patient beds and other electrical equipment to identify any modified, damaged, or non-approved plugs, cords, or wiring. Any additional non-compliant electrical equipment identified was removed from service and corrected promptly. 3. What measures will be put into place or systemic	03/10/2026

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K0511 SS = F Bldg. 2A	Continued from page 6 bed 1, revealed a modified plug. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. An observation at 11:15 AM in Resident room [redacted] bed 1, revealed a modified plug. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. An observation at 11:17 AM in Resident room [redacted] bed 2, revealed a modified plug. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. An observation at 11:23 AM in Resident room [redacted] bed 2, revealed a modified plug. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. An observation at 11:25 AM in Resident room [redacted] bed 2, revealed a modified plug. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. An observation at 11:30 AM in Resident room [redacted] private bed, revealed a modified plug. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. An observation at 11:30 AM in Resident room [redacted] private bed, revealed a modified plug. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. An observation at 12:03 PM in Resident room [redacted] private bed, revealed a modified plug. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. An observation at 12:45 PM in Resident room [redacted] private bed, revealed a modified plug. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. In an interview after each finding, the [redacted] confirmed the observation. The facility's U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference on 01/22/2026 at 2:30 PM. The [redacted] was unavailable at the time of exit.	K0511	Continued from page 6 changes made to ensure that the deficient practice will not recur The facility implemented an electrical equipment safety process requiring that all electrical repairs and replacements be performed using manufacturer-approved components and methods. Maintenance Director re-educated Maintenance staff on 2/10/2026 on electrical safety standards, including prohibiting modified plugs and requirements for strain relief. The facility will prohibit in-house modification of electrical plugs on patient care equipment and will utilize qualified service providers when repairs are needed. Annual inspection by NJ Exec Order 26.4b1 Company will include a check for modified plugs. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, and who will be responsible The Maintenance Director or designee will conduct and document routine electrical safety inspections monthly during environmental rounds to verify that patient beds and electrical equipment remain free of modified plugs or damaged cords. Findings of routine and annual inspections will be presented by the Maintenance Director at the next QAPI committee meeting and annually. Corrective actions will be taken as indicated to maintain compliance.	03/10/2026

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K0511 SS = F Bldg. 2A	Continued from page 7 NJAC 8:39-31.2(e) - 31.1(c)	K0511		03/10/2026
K0531 SS = F Bldg. 2A	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 01/21/2026, in the presence of the U.S. FOIA (b)(6) U.S. FOIA (b)(6), it was determined that the facility failed to ensure that 2 out of 2 elevators were inspected, tested and maintained in accordance with NFPA 101:2012 Edition, Sections 19.5.3, 9.4.2, 9.4.3 and ASME A17.1, and A 17.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 01/21/2026 revealed that elevator car #1's emergency phone did not function properly. The U.S. FOIA was asked to test the emergency phone which rang at Unit 2 nursing station. The phone rang 5 times before being picked up. The U.S. FOIA asked if the person answering could hear him, the person said hello multiple times and then hung up. The U.S. FOIA was asked if staff would know which elevator had been calling and then respond to the elevator physically. The U.S. FOIA stated that he doubted it.	K0531	K0531 – Elevators (SS = F) 1. Corrective action(s) taken for those residents found to be affected by the deficient practice No residents in the facility were affected by the deficient practice. The Director of Maintenance immediately evaluated the communication systems in both elevators car # 1 and car #2 It was found that the communication systems in both elevators were functioning properly. However, staff need to be reeducated regarding the ability for two-way communication via phone after the prerecorded messages repeats 2 times. The delay in two-way communication due to the prerecorded message presented as a malfunction of the system. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The facility acknowledges that all elevator passengers have the potential to be affected by the deficient practice. The facility has 2 elevators and both communication systems both functioned properly. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Maintenance Director re-educated staff on 2/10/2026 on permanent signage will be posted to alert passengers that there will be a prerecorded message upon pressing the phone button prior to ability to two way communication. Staff responsible for testing were re-educated on proper testing procedures, expected performance, and reporting requirements. The facility will continue to maintain a service agreement with a licensed elevator contractor to ensure timely inspection, testing, and repair. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, and who will be responsible The Maintenance Director or designee will conduct and document monthly elevator safety tests, including emergency phone functionality, presence of posted signage, and response verification for 2 quarters. Maintenance Director or designee will present the results of the audit at the next QAPI meeting for 2 quarters. The Maintenance Director will	03/10/2026

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K0531 SS = F Bldg. 2A	Continued from page 8 The [U.S. FO] tried calling again and after 4 rings the phone was answered. The surveyor could hear a voice saying hello as well as a recording stating that this is elevator 2. The person on the other end hung up. In an interview with the nurse that had picked up the phone, the surveyor asked if she had heard anyone, she responded she had only heard static. Asked if she had heard the recorded voice stating the elevator number, she responded that she had not. The test was attempted from the 2nd elevator with the same results. In an interview with the [U.S. FO], he confirmed all observations. The facility's U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference on 01/22/2026 at 2:30 PM. The U.S. FOIA (b)(6) was unavailable at the time of exit. NJAC 8:39-31.2(e) ASME A 17.1	K0531	Continued from page 8 address any deficiencies immediately and through the contracted elevator service provider.	03/10/2026
K0916 SS = F Bldg. 2A	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 01/21/2026 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure	K0916	Plan of Correction – K-0916 1. How the corrective action will be accomplished for those residents found to be affected: No residents in the facility were affected by the deficient practice . Immediately upon identification on 01/21/2026, Generator #2 was placed back into "Auto" mode by the Director of Maintenance/designee to ensure proper automatic operation in the event of power failure. Generator function was verified to be operating properly. The alarm condition displayed on the remote annunciator was cleared and the generator was tested to verify proper automatic start and load acceptance. The annunciator panel for Generator #2 was observed to confirm accurate alarm status and functionality following correction. Initial vendor was contacted on January 21, 2026 regarding installation of the annunciator panel for Generator #1.	04/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING 2A - NJ EASTERN... B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	111 FINDERNE AVENUE , BRIDGEWATER, New Jersey, 08807

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K0916 SS = F Bldg. 2A	Continued from page 9 that the emergency generator was provided with a remote annunciator that was in accordance with NFPA 99 Sections 6.4.1.1.16.2 and 6.4.1.1.17 - 6.4.1.1.17.5. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:58 PM revealed the annunciator panel for Generator number 2, at the Unit 2 nursing station. The annunciator was in silent alarm with "Not in Auto" blinking in red. In an interview at the time, the [redacted] was asked what the alarm meant. The [redacted] replied that one of his maintenance staff must not have placed the generator back in Auto after last testing it. When asked if this meant the generator would not turn on if needed, the [redacted] confirmed that would be the result. In an interview at 1:05 PM, the [redacted] was asked the location of the annunciator panel for Generator #1. The [redacted] stated that the facility did not have an annunciator panel for Generator #1. The facility's U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference on 01/22/2026 at 2:30 PM. The U.S. FOIA (b)(6) was unavailable at the time of exit. NJAC 8:39-31.2(e)	K0916	Continued from page 9 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by generator system deficiencies. The Maintenance Director or designee conducted an inspection of all emergency generators to verify generators are in the "AUTO" position. This inspection included verification that alarms are audible/visible, correctly identified, and readily observable by staff. Any additional deficiencies identified were corrected immediately. Maintenance will continue scheduled weekly visual checks of general panels. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility immediately began contacting qualified generator service providers to perform the necessary work to install a hard-wired remote annunciator panel for Generator #1 in a location readily observable by staff. The following actions were taken and work performed: The Maintenance Director re-educated the Maintenance staff on the following dates: 3/1/26, 3/4/26, 3/5/26 and 3/6/26 regarding conducting generator tests and the importance of putting the switch to "AUTO" position upon conclusion of the generator test as well as immediate response to annunciator alarms. The revised generator test checklist was implemented to ensure compliance after each generator test. An interim monitoring process has been implemented to include the following: Twice daily visual checks of generator status (including confirmation of "Auto" mode have been implemented at the generator site for Generator #1. Additionally, the annunciator panel for Generator #2 is visually inspected twice daily for any lights/alarms Maintenance staff available on-call for emergency	04/21/2026

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K0916 SS = F Bldg. 2A		K0916	Continued from page 10 response Documentation of findings are recorded on the Daily Inspection Sheet. Immediate notification of Maintenance Director of any negative findings. The following actions and work have been performed to ensure that Generator #1 is equipped with a hard-wired, remote annunciator panel readily observable by staff: Initial contact with generator service provider #1 on 1/21/26 to begin the process of sourcing an annunciator panel for Unit 1 nurses station. Technician from generator service provider #1 visits on 2/3/26 and 2/12/26 to evaluate options for annunciator. Follow up call on 2/16, 2/17 calls to generator service provider #1. Email to generator service provider #1 on 2/18. 2/18 reply from generator service provider #1 regarding coordination of electrical work and continuing to source annunciator panel for our generator. 2/19 and 2/25 follow up call to generator service provider #1 3/2/26 call to generator service provider #1 to expedite the ordering/work 3/2/26 Generator service provider #1 informs that supplier has the digital control panel but no annunciator for our model generator. 6-8 week lead time to get annunciator. Generator service provider #2 contacted on 3/3/26 due to long lead time quoted by generator service provider #1. Informed that they could obtain an annunciator panel for our generator. Generator service provider #2 informs us that electrician is scheduled for 3/6/26 to run wire. Facility signs labor rate form/agreement to expedite the work. Electrician performs work 3/6/26, however length of wiring was 20 feet short. Additional wiring ordered and electrician returned on 3/11/26 to complete wire installation in preparation for the annunciator panel to be installed and connected to Generator #1. Generator service provider #2 technician visit on 3/11/26 afternoon to connect the wiring to the generator and the annunciator however this work	04/21/2026

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K0916 SS = F Bldg. 2A		K0916	Continued from page 11 could not be completed as the annunciator was deemed incompatible with our analog generator. 3/12/26 message to generator service provider #2 to evaluate further options. Requested lead time for compatible annunciator. Generator service provider #2 earliest availability for Master Technician to provide further evaluation is on 3/20/26. Current situation is that there are two potential options available as follows: Option #1 is to implement an analog annunciator compatible with our generator which is older, making it difficult to source the part. Option #2 is to convert to digital which will entail a controller, a digital annunciator panel and the wiring that has already been installed. Decision will be made after 3/20/26 evaluation by Master Technician from generator service provider #2. Due to the age of the generator system and the need for specialized equipment procurement and installation, the facility requires additional time beyond 60 days. Decision has been made to proceed with Option #1 to implement an analog annunciator compatible with our generator. Parts ordered and electrician scheduled to perform additional wiring work followed by installation of the analog annunciator panel by generator service provider #2. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Maintenance Director or designee will conduct and document weekly checks of generator operational status to confirm generators remain in the “AUTO” position and alarms are functioning correctly. Results will be presented at the QAPI committee meeting by the Maintenance Director or designee for 2 quarters. Any deficiencies will be addressed immediately The Director of Maintenance or designee will review generator testing logs weekly for 90 days to ensure compliance. Results of monitoring will be reported to the facility’s QAPI Committee by the Maintenance Director or designee monthly for three months, with additional follow-up as needed.	04/21/2026

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K0920 SS = F Bldg. 2A	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 01/21/26 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to prohibit the use of power strips for patient-care-related electrical equipment (PCREE) and the use of extension cords as a substitute for fixed wiring in accordance with NFPA 101: 2012, Sections 19.5,19.5.1,9.1 and 9.1.2, NFPA 70: 2011 Edition, Sections 400.8 and 590.3 (D), NFPA 99: 2012 Edition, Sections 10.2.3.6 and 10.2.4. These deficient practices had the potential to affect all residents and were evidenced by the following: ********** An observation at 10:24 AM, revealed a window mounted air conditioner unit plugged into a power strip located under a desk in the Activity office. In an interview at the time, the U.S. FO confirmed the observation. An observation at 10:45 AM, revealed a power strip	K0920	K0920 – Electrical Systems: Power Strips and Extension Cords (SS = F) 1. Corrective action(s) taken for those residents found to be affected by the deficient practice No residents in the facility were affected by the deficient practice. The facility immediately removed all non-compliant power strips and extension cords identified during the survey. The window-mounted air conditioner in the Activity Office was unplugged from the power strip and connected to an approved electrical outlet. In resident rooms B-3 and B-10, patient-care-related electrical equipment, including the patient bed and nebulizer, was disconnected from power strips and plugged directly into approved wall outlets. All removed power strips and extension cords were taken out of service to eliminate unsafe electrical conditions. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The facility acknowledges that all residents have the potential to be affected by the deficient practice. The Maintenance Director or designee conducted a facility-wide inspection of all resident rooms, patient care areas, offices, and ancillary spaces to identify improper use of power strips or extension cords, including use with patient-care-related electrical equipment or as a substitute for fixed wiring. Any additional non-compliant devices identified were removed immediately and corrected. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Maintenance Director re-educated staff, residents and families on 2/10/26 on the distinction between patient care-related electrical equipment and non-patient care related electrical equipment, including that power strips may not be used for patient beds, nebulizers, or other patient-care-related equipment. Maintenance approval is required prior to installing any electrical equipment in patient care or non-patient care areas. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, and who will be responsible Monthly room inspections on 8 rooms at a time. The Maintenance Director or designee will conduct and document routine environmental and electrical safety rounds to monitor for improper use of power strips	03/10/2026

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K0920 SS = F Bldg. 2A	Continued from page 13 with electronic devices as well as a patient bed plugged into it in resident room [redacted] In an interview at the time, the [redacted] confirmed the observation. An observation at 10:51 AM, revealed a power strip with electronic devices, including a nebulizer, plugged into it in resident room [redacted] In an interview at the time, the [redacted] confirmed the observation. The facility's U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference on 01/22/2026 at 2:30 PM. The [redacted] was unavailable at the time of exit. NJAC 8:39-31.2(e)	K0920	Continued from page 13 or extension cords. Findings will be presented by the Maintenance Director at the QAPI committee meeting for 2 quarters. Corrective actions will be implemented immediately when non-compliance is identified.	03/10/2026
K0923 SS = F Bldg. 2A	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with	K0923	K0923 – Gas Equipment: Cylinder and Container Storage (SS = F) 1. Corrective action(s) taken for those residents found to be affected by the deficient practice No residents in the facility were affected by the deficient practice. The Maintenance Director ordered and installed signage immediately for the oxygen cylinder storage room doors identified. The newly installed precautionary sign is readable from a distance of at least 5 feet and includes the required wording: "CAUTION: OXIDIZING GAS(ES) STORED WITHIN – NO SMOKING." Both doors to the oxygen storage room were inspected to ensure signage is properly mounted, visible, and unobstructed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The facility acknowledges that all residents have the potential to be affected by the deficient practice. The Maintenance Director or designee conducted an inspection of all medical gas cylinder storage locations throughout the facility to verify that required precautionary signage was corrected promptly. 3. What measures will be put into place or systemic	03/10/2026

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K0923 SS = F Bldg. 2A	Continued from page 14 precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 01/21/2026 and 01/22/2026 in the presence of the U.S. FOIA (b)(6) U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that "A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure" holding oxygen cylinders in accordance with NFPA 99:2010 Edition, Sections 11.3.4, 11.3.4.1 and 11.3.4.2.This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 01/21/2026 at 12:15 PM, revealed a set of doors leading into the piped-in oxygen storage room. The room contained cylinders in use as well as back-up cylinders. On the front of the right-hand door there was one 8.5-inch x 11" sign stating, "Danger No Smoking No Open Flames". In an interview at the time the U.S. FOIA confirmed the observation. In an interview on 01/22/2026, it was explained to the U.S. FOIA (b)(6) and the U.S. FOIA that the proper signage was to read: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING. The facility's U.S. FOIA (b)(6) and	K0923	Continued from page 14 changes made to ensure that the deficient practice will not recur. Maintenance Director re-educated Maintenance staff on 2/10/2026 on medical gas storage requirements, including signage content and placement. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, and who will be responsible The Maintenance Director or designee will monitor compliance that signage remains in place and visible for 1 quarter. Findings will be presented at the next QAPI meeting. Corrective actions will be taken immediately if deficiencies are identified.	03/10/2026

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K0923 SS = F Bldg. 2A	Continued from page 15 U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference on 01/22/2026 at 2:30 PM. The U.S. FOIA (b)(6) was unavailable at the time of exit. NJAC 8:39-31.2(e)	K0923		03/10/2026

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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 from 01/21/2026 through 01/22/2026. The facility was found to be in NON-COMPLIANCE with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		03/10/2026
E0025 SS = F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of	E0025	CMS-2567 Plan of Correction-E0025 (SS=F) Deficiency: Arrangement with Other Facilities – Emergency Preparedness Element 1: How the Corrective Action Will Be Accomplished for Those Found to Be Affected An apparent cause analysis was performed to determine the cause of the deficient practice. It was determined that the Emergency Preparedness manual that was provided to the surveyor was not the current version, due to human error of not disposing of the outdated manual. An updated copy of the manual was immediately provided to key individuals and departments in the facility, including the Maintenance Director. Element 2: How the Facility Will Identify Other Areas That May Be Affected A comprehensive review of all Emergency Preparedness manuals was completed. All documentation was reviewed including the letter of annual review, transfer agreements, transportation agreements, emergency notification procedures, and emergency menus. All other Emergency Preparedness Manuals were found to have the correct and most up to date information approved in 2025. Element 3: Measures Put Into Place or Systemic	03/10/2026

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: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

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N J EASTERN STAR HOME	**111 FINDERNE AVENUE , BRIDGEWATER, New Jersey, 08807**

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E0025 SS = F	Continued from page 1 limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is NOT MET as evidenced by: Based on documentation review and interviews on 01/22/2026, in the presence of the U.S. FOIA (b)(6) U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that the Emergency Preparedness Plan (EPP) included arrangements, agreements, or memorandums of understanding (MOU) with other facilities for evacuation and relocation. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review on 01/22/2026 at 12:00 PM revealed: Letter of annual review was dated 12/27/2023 Transfer agreement with the local hospital was dated 11/15/2023 Transfer agreement with secondary hospital was dated 12/01/2023 last update to the emergency menu was dated October of 2023 The Emergency Notification letter was last updated 02/15/2024 Transport Agreement with Ambulance service was last updated 02/16/2021 Transfer agreement with sister facility was last updated 04/05/2024 In an interview at 2:30 PM, the U.S. FOIA (b)(6) U.S. FOIA (b)(6) confirmed the documentation review. The facility's U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference	E0025	Continued from page 1 Changes Made to Ensure the Deficient Practice Will Not Recur The Administrator inserviced all department heads on the importance of ensuring that their manuals are the most current copies and that outdated manuals be disposed of annually upon updating of the Emergency Preparedness Plan. Element 4: How the Facility Will Monitor Its Corrective Actions to Ensure Sustained Compliance Annual audits of the Emergency Preparedness Plan Books and all associated agreements will be conducted by the Emergency Preparedness/EVS Director. Audit results will be reviewed by the QAPI Committee annually.	03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0025 SS = F	Continued from page 2 on 01/22/2026 at 2:30 PM. The U.S. FOIA (b)(6) was unavailable at the time of exit. NJAC 8:39-31.2(e)	E0025		03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING **2A - NJ EASTERN...** B. WING	(X3) DATE SURVEY COMPLETED **04/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	**111 FINDERNE AVENUE , BRIDGEWATER, New Jersey, 08807**

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K0000 Bldg. 2A	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 4/12/2026 in relation to the 1/23/2026 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		04/21/2026

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: 315419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 4/21/2026 in relation to the 1/23/2026 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		04/21/2026

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