New Jersey Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35A001 | A. BUILDING: ______ B. WING ______ | C 11/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARDINAL VILLAGE | 455 HURFFVILLE-CROSSKEYS ROAD SEWELL, NJ 08080 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| A 000 | Initial Comments<br><br>Initial Comments:<br>COMPLAINT #: NJ188468, NJ188536, NJ189059<br>CENSUS: 96<br>SAMPLE SIZE: 11<br><br>TYPE OF SURVEY: Standard Survey of 91 residential units<br><br>The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.<br><br>The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.<br><br>A Life Safety Code Survey was conducted by the State Agency on 11/25/2025. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs. | A 000 | | |
| A 891 | 8:36-10.5(a) Dining Services<br><br>(a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. | A 891 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/05/26

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| A 891 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and facility policy review, the facility failed to date and label food items and discard items beyond the expiration date. These deficient practice had the potential to affect all 96 residents who currently reside in the facility.<br><br>Findings included:<br><br>An undated facility policy titled, "Dining Services Sanitation and Safety - General," indicated "The community maintains high standards of kitchen sanitation and safe food handling."<br><br>During a concurrent interview and observation on 11/19/2025 at 9:37 AM, there was a undated, unlabeled single cup of fruit cocktail in the refrigerator. Chef #11 stated he did not know why there was a single cup of the fruit cocktail in the refrigerator without a date or label.<br><br>During an observation of the dry storage area on 11/19/2025 at 9:40AM, there was rice in a clear plastic bin with no lid that was not labeled or dated.<br><br>During a concurrent interview and observation of the satellite kitchen refrigerator on 11/19/2025 at 10:15 AM, there was a double package of luncheon meat that had a manufacturer's | A 891 | | |

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| A 891 | Continued From page 2<br><br>expiration date of 11/10/2025. Chef #11 stated, "it should not be in the refrigerator, it needs to be thrown away." Chef #11 stated all expired food should be discarded and he did not know why it was not discarded.<br><br>During an interview on 11/19/2025 at 10:20 AM, the Food Service Director (FSD) stated he expected all opened food items in the refrigerator/freezer/dry storage to be labeled with an opened date. The FSD stated if any staff saw an expired food item they were to dispose of it. The FSD stated the luncheon meat in the satellite kitchen that had an expiration date of 11/10/2025 should have been thrown out on 11/10/2025. The FSD stated the cup of fruit cocktail in the main kitchen refrigerator should have had a label with a prepared date on it.<br><br>During an interview on 11/20/2025 at 3:40 PM, the Executive Director stated she expected all food in the kitchen to be labeled and dated. | A 891 | | |
| A1249 | 8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance<br><br>The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. | A1249 | | |

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| A1249 | Continued From page 3<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the National Fire Protection Association (NFPA) Fact Sheet, the facility failed to ensure the residents were free from fire hazards when the travel distance to a fire extinguishers was greater than 75 feet in 3 (Halls B, C, and D) of 6 halls. Failure to have fire extinguishers properly located and accessible had the potential to delay staff's ability to extinguish fires and minimize the potential harm to residents.<br><br>Findings included:<br><br>The NFPA Fact Sheet titled, "Fire Extinguisher Location and Placement," dated 12/2024, indicated, "Travel distance to the extinguisher can't be more than 75 ft [feet] (22.9 m [meters]).<br><br>On 11/25/2025 at 1:00 PM, the D Hall was observed to have a fire extinguisher located at the beginning of the hall and then approximately 186 feet at the designated Exit at the end of the hall, a travel distance of 93 feet.<br><br>On 11/25/2025 at 1:26 PM, the C Hall was observed to have a fire extinguisher located at the beginning of the hall and then approximately 186 feet at the designated Exit at the end of the hall, a travel distance of 93 feet.<br><br>On 11/25/2025 at 1:59 PM, the B Hall was observed to have a fire extinguisher located at the beginning of the hall and then approximately 186 feet at the designated Exit at the end of the hall, a travel distance of 93 feet. | A1249 | | |

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| A1249 | Continued From page 4 | A1249 | | |

During an interview on 11/25/2025 at 12:40 PM, the Maintenance Director stated he was familiar with the NFPA location requirements for fire extinguishers, but was told by the local fire authority that the code did not apply to the facility. The Maintenance Director confirmed the fire extinguishers were separated by a distance greater than 75 feet on Halls B, C, and D.

During an interview on 11/25/2025 at 2:10 PM, the Executive Director stated, "I would have to agree with you," when the location of the fire extinguishers was discussed as separated by more than 75 feet on Halls B, C, and D.

A1315 | 8:36-18.4(b) Infection Prevention and Control Services | A1315

(b) The facility shall have written policies and procedures establishing timeframes, requiring annual Mantoux tuberculin skin tests for all employees except those exempted under (a) above.

This REQUIREMENT is not met as evidenced by:
Based on interview, document review, and facility policy review, the facility failed to follow written policies and procedures that required annual NJ Exec Order 26.4b1 for 5 of 5 personnel files reviewed.

Findings included:

An undated facility policy titled, "Screening Employees and Residents for Tuberculosis," indicated "4. Retesting will be done using the one-step method: * Annually * Anytime exposure

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| A1315 | Continued From page 5<br>to TB is expected."<br><br>The facility "Employee List," dated 11/17/2205, indicated Dietary Aid (DA) #3's date of hire was NJ Exec Order 26.4b1 Home Health Aid (HHA) #1's date of hire was NJ Exec Order 26.4b1; Licensed Practical Nurse (LPN) #2's date of hire was NJ Exec Order 26.4b1; LPN #4's date of hire was NJ Exec Order 26.4b1 and Registered Nurse (RN) #5's date of hire was NJ Exec Order 26.4b1<br><br>The personnel files for DA #3, HHA #1, LPN #2, LPN #4, and RN #5 revealed no evidence of annual NJ Exec Order 26.4b1.<br><br>During an interview on 11/20/2025 at 9:18 AM, DA #3 stated she was screened for NJ Exe when she first started about NJ Exec Order 26.4b1 prior, and had not been tested since hired.<br><br>During an interview on NJ Exec Order 26.4b1 at 10:28 AM, LPN #2 stated she had not had a NJ Exe test since hired in NJ Exec Orde<br><br>During an interview on 11/20/2025 at 11:05 AM, RN #5 stated she used to get NJ Exe testing done annually, but it had been a NJ Exec Order 26.4b1 since she had one.<br><br>During an interview on 11/20/2025 at 1:03 PM, LPN #4 stated she had not had a NJ Exe test since hired in NJ Exec Orde<br><br>During an interview on 11/20/2025 at 2:05 PM, HHA #1 stated she had not had a NJ Exe test done since NJ Exec Orde<br><br>During an interview on 11/20/2025 at 3:35 PM, the Executive Director stated the facility had not been performing annual NJ Exe testing of staff. | A1315 | | |

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| A1623 | Continued From page 6 | A1623 | | |
| A1623 | 8:36-23.17(b)(7) Assisted Living Programs<br><br>(b) The assisted living program shall notify the Department of Health and Senior Services immediately by telephone at (609) 633-9034 or (609) 392-2020 after business hours, followed within 72 hours by written confirmation, of the following:<br><br>7. All suspected cases of abuse, neglect or exploitation of residents which have been reported to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to submit their written investigation for a case of NJ Exec Order 26.4b1 within 72 hours for 1 of 3 reportable events reviewed.<br><br>Findings included:<br><br>Email correspondence addressed to the Executive Director (ED) dated NJ Exec Order 26.4b1, indicated the Department of Health (DOH) requested information related to the NJ Exec Order 26.4b1 of Resident #1 and Resident #2. Per email correspondence dated NJ Exec Order 26.4b1 at 12:15 PM, the ED forwarded the requested information to the DOH related to the investigation of Resident #1 and Resident #2 case of NJ Exec Order 26.4b1.<br><br>During an interview on 11/20/2025 at 3:35 PM, the ED stated the investigation was sent to the DOH on NJ Exec Order 26.4b1 at 12:15 PM. She stated that | A1623 | | |

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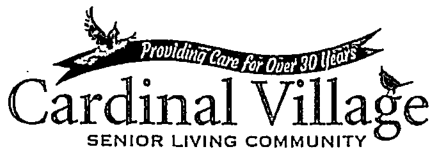
| A1623 | Continued From page 7<br>it was usually sent within three days, so it was technically due on NJ Ex Order 26.4(b)(1). | A1623 | | |

POC # 2 received 1/9/26
Accepted 1/9/26




**For - A891**

1. **The corrective action will be accomplished for those items found to have been affected by the deficient practice:**

   A. Dating and labeling food –Expired/unlabeled foods were found and thrown away, on 11/19/25. Each food service worker opening a container is to label the container with the opened and discard dates. Refrigerators & dry storage areas are to be checked every morning by the cook on duty expired/unlabeled foods are to be thrown out.

   B. Items beyond expiration date – Expired/unlabeled food were thrown away on 11/19/25. Refrigerators & dry storage are to be checked every morning for expired foods. No luncheon meats are to be left in the satellite kitchen, take what is needed each day and return excess to the Main kitchen to avoid excess/expired foods being left in the satellite kitchen

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

   A. All residents could have been affected by this deficient practice

3. **Measures or systemic changes put into place to ensure that the deficient practice will not recur by:**

   A. Dating and labeling food –
      a. Each food service worker opening a container is to label the container with the opened and discard date. Refrigerators & dry storage areas are to be checked for labels every morning by the cook on duty expired/unlabeled foods are to be thrown out. A log is to be kept daily of food found past the expiration date.
      b. The dietary staff were given verbal instruction on how to properly label food on 11/19 and 11/20 by the Food Service Director, staff are reminded of this during pre-shift meetings daily with the cooks under the direction of the Food Services Director.

   B. Items beyond expiration date –
      a. Refrigerators & dry storage areas are to be checked for labels every morning and night by the cook on duty expired/unlabeled foods are to be thrown out.
      b. No luncheon meats are to be left in the satellite kitchen, the cook on duty is to take what is needed each day and return excess to the main kitchen to

avoid excess/expired foods being left in the satellite kitchen. A log is to be kept daily of food found past the expiration date.

c. The dietary staff were given verbal instruction on 11/19 and 11/20 by the Food Service Director on removing food that is beyond it's expiration date, staff are reminded of this during pre-shift meetings daily with the cooks under the direction of the Food Services Director.

4. **The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:**

   A. The Food Service Director or designee will review daily logs weekly as part of Quality Assurance beginning January 15, 2026.

   B. The Administrator or designee will review logs quarterly as part of Quality Assurance beginning Q1 2026.

5. **Plans submitted have a correction date of:**

   a. January 15, 2026

   b. Responsibility –Food Service Director

approved 1/9/26

455 Hurffville-Cross Keys Road, Sewell, NJ 08080 | www.cardinalvillage.com
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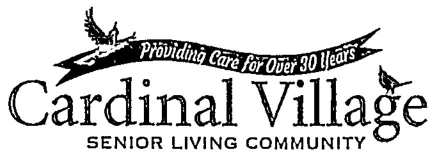



For - A1249

1. **The corrective action will be accomplished for those residents found to have been affected by the deficient practice:**

   A. Failed to ensure residents were free from fire hazards when the travel distance to fire extinguishers was greater than 75 feet Halls B, C, & D. - Two additional Fire extinguishers were added to each of the above mentioned halls on 11/28/25.

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

   A. All residents could have been affected by this deficient practice

3. **Measures or systemic changes put into place to ensure that the deficient practice will not recur by:**

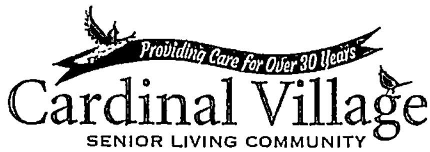
   A. Two additional Fire extinguishers had been added on 11/28/25 to each affected hall B, C, D, and one additional fire extinguisher was added to E Hall on the same date. The current maximum distance down these hallways between fire extinguishers is 63 feet.
      a. Two additional fire extinguishers for the main hall were mounted on January 7, 2026

4. **The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:**

   A. Fire extinguishers are checked monthly by the maintenance department, to ensure they are in working order.
   B. The Maintenance director will audit monthly to ensure fire extinguishers do not exceed 75 feet in distance from one another within the Assisted Living. The Maintenance Director will review the National Fire Protection Association fact sheet monthly to ensure accuracy.
   C. The Administrator or designee will review the results of monthly audits at the Quarterly QA Review Meetings, to confirm compliance.

5. **Plans submitted have a correction date of:**
   c. January 15, 2026
   d. Responsibility – Maintenance Director

approved 1/15/26




For - A1315

1. **The corrective action will be accomplished for those staff found to have been affected by the deficient practice:**

   A. The facility failed to follow written policies and procedures that required annual NJ Exec Order 26.4b1 of employees. – All employees were given yearly instruction via Relias modules (10/2025 being the most recent) to notify their director if they have been NJ Ex Order 26.4(b)(1)

      a. All employees not tested for NJ Exec Order this year have completed a NJ Exec Order questionnaire between November 30, 2025 and December 29, 2025

2. **The facility will identify other staff having the potential to be affected by the same deficient practice:**

   A. All staff have the potential to be affected by this deficient practice

3. **Measures or systemic changes put into place to ensure that the deficient practice will not recur by:**

   A. All current employees have completed a TB questionnaire between November 30, 2025 and December 29, 2025
   B. All staff will be required to fill out a TB Questionnaire yearly to confirm they have not been exposed to Tuberculosis.
      a. TB testing using the one-step method will be used anytime exposure is expected

4. **The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:**

   A. An audit of a 5% sample of Staff Records will be completed by Business Office Director or designee each month, beginning January 2026, to ensure all employee files are accurate and updated.
   B. Ongoing compliance, patterns, trends, and findings will be reviewed at Quarterly Quality Assurance Meetings, beginning with a review of Q1 in 2026.

5. **Plans submitted have a correction date of:**
   e. January 15, 2026
   f. Responsibility – Business Office Director

NJ Exec Order 26 approved 1/9/26

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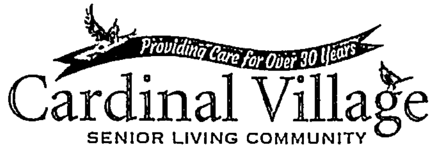


**For - A1623**

1. **The corrective action will be accomplished for those residents found to have been affected by the deficient practice:**

   A. The facility failed to submit their written investigation for a case of NJ Exec Order 26.4b1 within 72 hours. – For Resident's 1 & 2 The email failed to go through on NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 upon realization of the drafted email not being sent the email was sent on NJ Exec Order 26.4b1

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

   A. All residents could have been affected by this deficient practice

3. **Measures or systemic changes put into place to ensure that the deficient practice will not recur by:**

   A. Each email to DOH regarding investigations will be verified by the Executive Director to have been sent within the 72-hour timeframe to ensure timely reporting.

4. **The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:**

   A. An audit of reportable events will be completed by the Executive Director or designee each month, beginning January 2026, to ensure all emails to DOH regarding investigations have been sent within the 72-hour timeframe.

   B. Ongoing compliance, patterns, trends, and findings will be reviewed at Quarterly Quality Assurance Meetings, beginning with a review of Q1 in 2026.

5. **Plans submitted have a correction date of:**

   g. January 1, 2026

   h. Responsibility – Executive Director

NJ Exec Order 26.4b1 approved 1/9/26

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# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 35A001 | A. Building<br>B. Wing | 1/9/2026 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARDINAL VILLAGE | 455 HURFFVILLE-CROSSKEYS ROAD<br>SEWELL, NJ 08080 |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| ITEM (Y4) | DATE (Y5) | ITEM (Y4) | DATE (Y5) | ITEM (Y4) | DATE (Y5) |
|---|---|---|---|---|---|
| ID Prefix A0891<br>Reg. # 8:36-10.5(a)<br>LSC | Correction Completed<br>01/15/2026 | ID Prefix A1249<br>Reg. # 8:36-17.7<br>LSC | Correction Completed<br>01/15/2026 | ID Prefix A1315<br>Reg. # 8:36-18.4(b)<br>LSC | Correction Completed<br>01/15/2026 |
| ID Prefix A1623<br>Reg. # 8:36-23.17(b)(7)<br>LSC | Correction Completed<br>01/01/2026 | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| **REVIEWED BY CMS RO** ☐ | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 11/25/2025 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |