

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315465	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 HUDSON AVENUE , UNION CITY, New Jersey, 07087	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH).</p> <p>Complaints: NJ2675374, NJ595907, NJ368474, 2622423, 368472, 368473, 368471, 2620699</p> <p>Survey Dates: 12/01/2025-12/04/2025</p> <p>Survey Census: 124</p> <p>Sample Size: 30</p> <p>THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.</p>	F0000		01/23/2026

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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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 406001	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
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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		01/23/2026
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 review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "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 02/01/2021: 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	There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements during the 7 a.m. to 3 p.m. (day shift) from 6/23/2024 to 6/29/2024, 7/28/2024 to 8/3/2024, 6/1/2025 to 6/7/2025, 8/3/2025 to 8/9/2025, 9/14/2025 to 9/20/2025, 11/30/2025 to 12/13/2025 All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement ratios. The following measures have been put into place to prevent the deficient practice from recurring: Advertisement / Job postings for CNAs have been posted on social media websites as well as flyers posted in local supermarkets and stores that we are hiring. Facility updated and increased sponsorships of advertisements on job search platforms. Incentives are offered to CNAs to work extra shifts such as bonuses and raffles. Human Resources has reached out to CNA schools to advise we are hiring and willing to train new graduates.	01/23/2026

Office of Primary Care and Health Systems Management

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S0560	<p>Continued from page 1 direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>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.</p> <p>1. For the week of Complaint staffing from 06/23/2024 to 06/29/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:</p> <p>-06/23/24 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.</p> <p>-06/24/24 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.</p> <p>-06/25/24 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs.</p> <p>-06/26/24 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs.</p> <p>-06/27/24 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs.</p> <p>2. For the week of Complaint staffing from 07/28/2024 to 08/03/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows:</p> <p>-07/31/2024 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs.</p> <p>-08/01/2024 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs.</p> <p>-08/02/2024 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs.</p> <p>-08/03/2024 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs.</p> <p>3. For the week of Complaint staffing from 06/01/2025 to 06/07/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:</p> <p>-06/01/25 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs.</p>	S0560	<p>Continued from page 1</p> <p>Facility implemented a no call out raffle to deter employees from calling out.</p> <p>4. The Administrator/Designee will review the staffing schedule weekly to monitor the staffing ratio on the day shift for 3 months.</p> <p>All results of the monitoring will be presented to the Quality Assurance Performance Improvement Committee quarterly for 3 quarters.</p>	01/23/2026

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S0560	Continued from page 4 -12/11/25 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -12/12/25 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -12/13/25 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs.	S0560		01/23/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 1/27/2026 in relation to the 12/19/2025 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		

Office of Primary Care and Health Systems Management

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 12/17/25 and 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. Manhattanview Center for Rehabilitation and Healthcare is a five-story building built in the 1950's. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The 150 KW diesel generator powers approximately 60% of the building per the U.S. FOIA (b)(6) . The current occupied beds are 124 of 127.	K0000		01/23/2026
K0161 SS = F Bldg. 01	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered	K0161	K161 The facility immediately contacted their vendor to install fireproofing on an eight feet long steel I-beam supporting the first floor in the basement laundry storage room. This was completed on 1/10/2026. All residents have the potential to be affected. The Maintenance Director conducted regular environmental rounds to ensure all areas that require fireproofing have the adequate fireproofing needed. The maintenance director/designee will make weekly environmental rounds checking for adequate fireproofing for one month and then monthly for 3 months. Findings will be reported quarterly for 3 quarters to the Quality Assurance Performance Improvement committee.	01/10/2026

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K0161 SS = F Bldg. 01	<p>Continued from page 1</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to maintain the fireproofing on the steel I-beams in accordance with NFPA 101, Life Safety Code (2012 Edition) Section 19.1.6.1. This deficient practice had the potential to affect all 124 residents and was evidenced by the following:</p> <p>Observation on 12/17/25 at 12:08 PM revealed an area of approximately 2-foot by 6-inches of fireproofing was missing off an eight feet long steel I-Beam supporting the first floor in the basement laundry storage room.</p> <p>During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the fireproofing was missing off the I-Beam in the basement laundry storage room.</p> <p>NJAC 8:39-31.2(e)</p>	K0161		01/10/2026
K0271 SS = F Bldg. 01	<p>Discharge from Exits</p> <p>CFR(s): NFPA 101</p> <p>Discharge from Exits</p>	K0271	<p>1. The facility immediately contacted their vendor to install a handrail by the stairs outside the low side stairway in accordance with NFPA 101 Life safety code. This was completed on 1/12/2026</p>	01/28/2026

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K0271 SS = F Bldg. 01	<p>Continued from page 2</p> <p>Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.</p> <p>18.2.7, 19.2.7</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to ensure stairs located outside the exit door were equipped with a handrail in accordance with NFPA 101 Life Safety Code (2012 Edition) section 7.2.2.4.1.1. and 7.2.2.4.1.6. This deficient practice had the potential to affect all 60 residents who resided in that wing of the facility and was evidenced by the following:</p> <p>Observation on 12/17/25 at 12:32 PM revealed that the stairs outside low side stairway were not provided with at least one 1 ½ inch in diameter circular, graspable handrail. The stairway was a designated exit.</p> <p>During an interview at the time of observation, the U.S. FOIA (b)(6) confirmed that the stairs did not have a handrail.</p> <p>NJAC 8:39-31.2(e)</p>	K0271	<p>Continued from page 2</p> <p>2. All residents who reside on that wing of the facility have the potential to be affected by this practice.</p> <p>3. U.S. FOIA (b)(6) has been in serviced by the Administrator on the importance of ensuring that all stairs have handrails in accordance with NFPA 101 Life safety code.</p> <p>4. Director of Maintenance/ designee will audit all stairways inside and outside the facility to ensure they have handrails in accordance with NFPA 101 Life safety code monthly x 6 months and will report findings to the Quality Assurance Performance Improvement Committee quarterly for 3 quarters.</p>	01/28/2026
K0293 SS = F Bldg. 01	<p>Exit Signage</p> <p>CFR(s): NFPA 101</p> <p>Exit Signage</p> <p>2012 EXISTING</p> <p>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.</p> <p>19.2.10.1</p> <p>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was</p>	K0293	<p>. The Director of Maintenance immediately installed a continuous illuminated exit sign at the low side stairway in accordance with NFPA Life safety code on 12/18/2025.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. U.S. FOIA (b)(6) has been in serviced by the Administrator on the importance of having continuous illuminated exit signs at all required exits.</p> <p>4. Director of Maintenance/ designee will check weekly x 4 weeks and then monthly x 6 months to ensure that all required exits have continuous illuminated exit signs and will report findings to the Quality Assurance Performance Improvement Committee quarterly for 3 quarters.</p>	01/28/2026

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K0293 SS = F Bldg. 01	<p>Continued from page 3 determined that the facility failed to provide continuously illuminated exit signs from the Low Side stairway in accordance with NFPA 101 Life Safety Code (2012 Edition) section 7.10.1.2.1. This deficient practice had the potential to affect all 124 residents and was evidenced by the following:</p> <p>An observation on 12/17/25 at 1:20 PM revealed that the designated low side exit stair for residents and staff as indicated on the emergency plan on the corridor wall did not have an exit sign going into the first-floor foyer before going outside.</p> <p>During an interview at the time of observation, the U.S. FOIA (b)(6) confirmed there were no illuminated exit signs on the stairway.</p> <p>NJAC 8:39-31.1(c), 31.2(e)</p>	K0293		01/28/2026
K0311 SS = F Bldg. 01	<p>Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure two of 10 fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect all 124 residents and was evidenced by the following: Observations on 12/17/25 between 11:30 AM and 2:05 PM of all the facility's stairways' fire rated</p>	K0311	<p>1.The facility immediately ordered fire exit hardware in accordance with NFPA 101 Life safety code to be installed on 2 fire rated door assemblies for stairway exit doors. The fire exit hardware was installed on 1/5/2026.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. Director of Maintenance audited all fire rated door assemblies in the facility to ensure they are equipped with fire exit hardware in accordance with NFPA 101 Life safety code. The U.S. FOIA (b)(6) was educated by the administrator on the importance of having fire exit hardware installed on stairway exit doors.</p> <p>4. Director of Maintenance/ designee will audit all fire rated door assemblies in the facility to ensure they are equipped with fire exit hardware in accordance with NFPA 101 Life safety code monthly x 6 months and will report findings to the Quality Assurance Performance Improvement Committee quarterly for 3 quarters.</p>	01/28/2026

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K0311 SS = F Bldg. 01	<p>Continued from page 4 door assemblies, revealed two doors on the 3rd floor (High Side stair and Low Side stair) were equipped with panic hardware and not approved fire exit hardware. Only approved panic hardware shall be used on door assemblies that are not fire-rated door assemblies. Only approved fire exit hardware shall be used on fire-rated door assemblies.</p> <p>During an interview at the time of observations, the U.S. FOIA (b)(6) confirmed the stairway exit doors were not equipped with fire exit hardware.</p> <p>NJAC 8:39-31.2(e) NFPA 80</p>	K0311		01/28/2026
K0351 SS = F Bldg. 01	<p>Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING</p> <p>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.</p> <p>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure all sprinklers used in the facility had at least six spare sprinkler heads in the sprinkler cabinet in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (2010 Edition) Section 6.2.9.1. This deficient practice had the</p>	K0351	<ol style="list-style-type: none"> The facility had their sprinkler vendor come in to provide additional spare sprinkler heads in sprinkler cabinet and to include upright sprinkler heads in accordance with NFPA 13. This was completed on 1/9/2026. All residents have the potential to be affected by this practice. U.S. FOIA (b)(6) has been in serviced by the administrator on the importance of ensuring all sprinklers used in the facility has at least 6 spare sprinkler heads in the sprinkler cabinet in accordance with NFPA 13. Director of Maintenance/ designee will audit all sprinkler cabinets in the facility to ensure all sprinklers used in the facility has at least 6 spare sprinkler heads in the sprinkler cabinet in accordance with NFPA 13, monthly x 6 months and will report findings to the Quality Assurance Performance Improvement Committee quarterly for 3 quarters. 	01/28/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0351 SS = F Bldg. 01	<p>Continued from page 5 potential to affect all 124 residents and was evidenced by the following:</p> <p>An observation on 12/17/25 at 12:04 PM of the spare sprinkler cabinet in the sprinkler room revealed only four quick response sprinklers and no upright sprinklers were in the spare sprinkler cabinet. Standard and quick response pendent sprinklers are located on all five floors and upright sprinklers are located in the basement sprinkler room.</p> <p>During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed that only four quick response spare sprinklers and no upright spare sprinklers were present in the sprinkler cabinet.</p> <p>NJAC 8:39-31.1(c), 31.2(e)</p> <p>NFPA 13, 25</p>	K0351		01/28/2026
K0712 SS = F Bldg. 01	<p>Fire Drills</p> <p>CFR(s): NFPA 101</p> <p>Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to ensure fire drills were conducted quarterly using the fire alarm system on the first shift between 7:00 AM and 3:00 PM and on the second shift between 3:00 PM and 9:00 PM in accordance with NFPA 101 Life Safety Code (2012 Edition) sections 19.7.1.6 and 19.7.1.4. This deficient practice had the potential to affect all 124 residents and was evidenced by the following:</p> <p>A review of the facility's untitled fire drill records revealed the facility failed to use the fire alarm</p>	K0712	<p>K 712</p> <ol style="list-style-type: none"> The facilities fire drill vendor and U.S. FOIA (b)(6) were immediately informed and educated on the requirement of using the fire alarm system when conducting a fire drill between the hours of 6:00 AM and 9:00 PM. All residents have the potential to be affected by this practice. A Fire Drill Checklist has been created and will be completed for every drill, confirming: Alarm activation, Shift conducted, staff response, resident response and any identified issues. Director of Maintenance/ designee will audit all fire drills conducted monthly x 6 months to ensure they are using the fire alarm system when conducting a fire drill between the hours of 6:00 AM and 9:00 PM and will report findings to the Quality Assurance Performance Improvement Committee quarterly for 3 quarters. 	01/10/2026

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K0712 SS = F Bldg. 01	Continued from page 6 system when conducting a fire drill on the first shift on March 18, 2025, from 7:00 AM to 8:30 AM and on the second shift on January 12, 2025, from 5:45 PM to 6:15 PM, July 16, 2025, from 7:30 PM to 8:00 PM and October 23, 2025, from 3:00 PM to 3:30 PM. The documentation indicated the facility used a coded announcement which was only permitted between the hours of 9:00 PM and 6:00 AM. During an interview on 09/23/25 at 12:40 PM, the U.S. FOIA (b)(6) confirmed that the fire alarm system was not used for the fire drills. NJAC 8:39-31.2(e)	K0712		01/10/2026

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 12/17/25. The facility was found to be in compliance with 42 CFR 483.73	E0000		01/23/2026

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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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 4/20/2026 in relation to the 12/19/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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