STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315497	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	**85 HARRETON ROAD , ALLENDALE, New Jersey, 07401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). Complaint #s: 405801,405803, 405805, 405808, 2562238, 2621056 Survey Dates: 11/23/25-11/25/25 Survey Census: 91 Sample Size: 29 Supplemental Residents: 9 A Recertification survey was conducted to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facility. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F0000		12/15/2025
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F0880	U.S. FOIA (b)(6) who provided care to Resident #5 was educated on infection control by the Infection Preventionist. Staff involved in the identified concerns received education on infection control practices, including proper personal hygiene assistance, laundry handling, and water management requirements. No adverse outcomes were identified. A review was completed of infection control practices related to resident hygiene assistance, laundry services, and the facility's Water Management Plan. The Infection Preventionist or designee reviewed infection control standards with Certified Nursing Assistants related to assisting residents with personal hygiene. The Director of Housekeeping reviewed infection control practices with laundry staff. The Plant Operations Director redesigned the	01/06/2026

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

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

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F0880 SS = F	Continued from page 1 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 1 laundry workflow to ensure clear separation of soiled and clean areas, including installation of a washable plexiglass divider, a permanent ¾ drywall barrier with doorway, directional floor tape, and signage. Laundry staff were inserviced by Director of Housekeeping on the revised workflow, and the Infection Preventionist or designee reviewed appropriate PPE use with laundry staff. The Water Management Team met to revise the Water Management Plan, and the Administrator or designee reviewed plan requirements with the team. The Infection Preventionist or designee will observe infection control practices related to resident hygiene assistance 5 times per week for 4 weeks and then monthly for 3 months. The Infection Preventionist will observe laundry services 3 times per week for 4 weeks and then monthly for 3 months. The Director of Maintenance will review the Water Management Plan once per month for 3 months. Results of the observations will be reviewed through the QAPI process with the Administrator. Any variances will be addressed with corrective action as needed.	01/06/2026

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F0880 SS = F	Continued from page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record reviews, and reviews of facility policies, the facility failed to ensure Infection Control measures were maintained 1. during NJ Exec Order 26.4b1 for one resident (Resident (R) 5) of one resident reviewed for NJ Exec Order 26.4b1 in a total sample of 29 residents, 2. during separation of clean and soiled laundry, and 3. in a water management program for NJ Exec Order 26.4b1. These failures placed residents at risk of cross-contamination of bacteria and increased health complications. Findings include: 1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed that R5 was admitted to the facility on NJ Exec Order 26 with a diagnosis of a NJ Exec Order 26.4b1 NJ Exec Ord. Review of the significant change "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec Order 26 revealed R5 was assessed by staff to be NJ Exec Order 26 NJ Exec Order 26 in NJ Exec Order 26 and was NJ Exec Order 26.4b1 of NJ Exec Ord and NJ Exec Order r. During an observation on 11/24/25 at 9:57 AM, Certified Nursing Assistant (CNA) 3 entered R5's room to provide morning cares. After CNA3 NJ Exec Order 26.4 a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 she did not NJ Exec Order 2 her NJ Exec Order 26.4b1 or use hand hygiene before NJ Exec Order 26.4b on to NJ Exec Order 26.4b1. During an interview on 11/24/25 at 10:18 AM, CNA3 was asked if she had changed her gloves or used hand hygiene after providing NJ Exec Order 26.4b1 to R5. CNA3 stated, "No, I didn't." During an interview on 11/25/25 at 8:44 AM, the U.S. FOIA (b)(6) was informed of the lack of hand hygiene and change of gloves when performing NJ Exec Order 26.4b1 for R5. The U.S. FOIA stated, "CNA3 is very NJ Exec Orde of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. I have in-services all the time, she knows better." 2. Observation on 11/25/25 at 3:35 PM with Laundry Aide (LA)1, the U.S. FOIA (b)(6), and	F0880		01/06/2026

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F0880 SS = F	Continued from page 3 U.S. FOIA (b)(6), revealed that the laundry room was one large room with the three washing machines located nearest the door and the two dryers were located at the back of the room. The folding area was located across the hall in another room. The U.S. FOIA (b)(6) stated, "The soiled laundry is sorted on the unit and then brought to the laundry room and then placed into the washer. After washing, the laundry then goes to the dryer area at the back of the room. After the laundry is dried, it is placed into a bin and then transferred across [the soiled area] to the folding room across the hall." In addition, the soiled area of the laundry room did not contain gowns, gloves, or masks and the bottle of disinfectant, used to clean the bins and doors to the washing machines, was located in a bin, under clean items and on top of clean linen. When asked about having to go across a soiled area with clean laundry, the U.S. FOIA (b)(6) U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) U.S. FOIA (b)(6) stated they understood this could be an issue. During an interview on 11/25/25 at 4:30 PM, U.S. FOIA (b)(6) was asked if she was aware of the situation in the laundry with the clean linen having to pass the soiled linen area to go to the folding area. The U.S. F stated, "No, I was not aware." 3. On 11/25/25 at 6:18 PM, the U.S. FOIA (b)(6) was asked for his water management plan including documentation of a floor plan which indicated where the water from the city entered the facility and how the water moved through the facility and areas where standing water may pool and any testing being done. The U.S. FOIA (b)(6) stated he did not designate potential sites of pooling water or water sources to be tested if needed. Review of the facility procedure titled, "Departmental (Environmental Services)-Laundry and Linen" dated January 2014 revealed, "...The purpose of this procedure is to provide a process for the safe and aseptic handline, washing, and storage of linen...Employee sorting or washing linen must wear a gown and gloves...Keep soiled and clean linen, and their respective hampers and laundry carts, separate at all times..." Review of the facility policy titled, "Legionella Water Management Program" dated September 2022 revealed, "...Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella...The water management program includes the following	F0880		01/06/2026

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F0880 SS = F	Continued from page 4 elements...A detailed description and diagram of the water system in the facility, including the following: Receiving; Cold water distribution; Heating; Hot water distribution; and Waste...The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: Storage tanks; Water heaters; Filters; Aerators; Showerheads and hoses; Misters, Atomizers, Air washers, and Humidifiers...and Medical devices such as CPAP machines..." NJAC 8:39-19.4	F0880		01/06/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints	F0605	Residents #10, #15, and #4 had AIMS assessments completed to [redacted] for potential [redacted] related to [redacted] medication use. A review was completed for residents receiving [redacted] medications to confirm completion and accuracy of AIMS assessments. No additional residents were identified as requiring intervention. The Director of Nursing or designee reviewed AIMS assessment requirements with licensed nursing staff, including quarterly completion and completion as clinically indicated. The Pharmacy Consultant will continue routine review of residents receiving psychotropic medications to ensure AIMS assessments are completed as required. The Director of Nursing or designee will audit 10 residents receiving psychotropic medications monthly for three months to ensure AIMS assessments are present and accurate. Results of the audits will be reviewed through the QAPI process with the Administrator or designee. Any variances will be addressed and care plans updated as appropriate.	12/22/2025

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F0605 SS = D	Continued from page 5 imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral	F0605		12/22/2025

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F0605 SS = D	Continued from page 6 interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure an [NJ Exec Order 26.4] scale [NJ Exec Order 26.4b1] items to assess the [NJ Exec Order 26.4b1] of the [NJ Exec Order 26.4b1]) was [NJ Exec Order 26] and [NJ Exec Order 26.4b1] timely for three residents (Residents (R)10, R15, and R4) reviewed in a sample of29 residents. This failure placed residents at risk of not receiving care and services related to thei[NJ Exec Order 26.4b1]. Findings include: 1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on [NJ Exec Order 26] with diagnoses that included [NJ Exec Order 2] [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1]. Review of a significant change "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of [NJ Exec Order 26] revealed, R10 had a "Brief Interview of Mental Status (BIMS)" score of [NJ Exec] out of 15 which indicated R10	F0605		12/22/2025

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F0605 SS = D	Continued from page 7 was NJ Exec Order 26.4b1, had NJ Exec Order 26.4b1 for NJ Exec O to NJ Exec Order 26 out of NJ Exec Order 26.4b1, and had been administered an NJ Exec Order 26.4b1 medication during the NJ Exec Order 26.4b NJ Exec Order 26.4b1. Review of the "Order Summary" located in the "Orders" tab of the EMR revealed that R10 was prescribed, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 at bedtime for NJ Exec Order NJ Exec Order 26.4 Review of the NJ Exec Order 26.4 "AIMS" evaluation, provided by the U.S. FOIA (b)(6) revealed Licensed Practical Nurse (LPN) 1 had signed that he had performed the evaluation for R10. Section EP (examination procedure) revealed no documentation that LPN 1 had assessed R10 for NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1) as the EP was blank. In addition, there was no documentation to show that the NJ Exec Order 26.4b1 "AIMS" evaluation had been completed per the "Evaluations" tab in the EMR. During an interview on 11/24/25 at 5:29 PM, the U.S. FOIA stated, "When I reviewed the "Evaluations" tab in the EMR, I found no "AIMS" evaluations for NJ Exec Order 26.4b as it was not NJ Exec Order 26 to be completed by the nurse assigned as the form was marked that R10 was NJ Exec administered an NJ Exec Order 26.4b1 medication. After reviewing the NJ Exec Order 26.4 "AIMS" the U.S. FOIA (b confirmed that the evaluation was not complete. During an interview on 11/24/25 at 5:56 PM LPN 1 confirmed that he had not received any training on how to perform the 'NJ Exec Orde evaluations. LPN 1 further stated, "I should have completed the full assessment." 2. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed that R15 was admitted to the facility on NJ Exec Order 26 with diagnoses that included NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b Review of the annual "MDS" located in the "MDS" tab of the EMR with an ARD of NJ Exec Order 26.4 revealed, R15 had a "BIMS" score of NJ Exec out of 15 which indicated R15 was NJ Exec Order 26.4b1, had NJ Exec Order 26.4b1, and was administered an NJ Exec Order 26.4b1 medication during the NJ Exec Order 26.4b NJ Exec Order 26.4b1. Review of the "Order Summary" located in the	F0605		12/22/2025

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F0605 SS = D	Continued from page 8 "Orders" tab of the EMR revealed the following NJ Exec Order 26.4b1 medications for R15: NJ Exec Order 26.4b1 daily every hours for NJ Exec Order 26.4b1." NJ Exec Order 26.4b1 at bedtime for Review of an "AIMS" located in the "Evaluations" tab of the EMR revealed that R15 was evaluated for The score documented on the assessment was NJ Exec Order 26.4b1 Review of the "Order Summary" located in the "Orders" tab of the EMR revealed, twice daily for , dated Review of the "Comprehensive Care Plan" located in the "Care Plan" tab of the EMR did not show a focus, goal, or interventions for the use of for R15's NJ Exec Order 26.4b1. Review of the evaluation, provided by the revealed Registered Nurse (RN) 1 had signed that he had the evaluation for R15. Review of the EP section of the "AIMS" revealed R15 was assessed to have had and the score of During an interview on 11/24/25 at 5:29 PM, the stated, "I reviewed the and it appears that in an was performed and the score was . was . After the evaluations were moved to the quarterly assessments and were During an interview on 11/24/25 at 6:05PM, RN 1 was asked if the evaluation, which showed that R15 had despite the previous evaluations and being administered a medication for was correct. RN 1 stated, "Yes." RN 1 was asked if he had any training on performing "AIMS" assessments. RN 1 stated, "No, I have not." RN 1was directed to Section #14 in which he documented that the did r in . RN 1 was asked if R15 had NJ Exec Order 26.4b1, why was this marked a "No." RN 1 stated, "That was wrong." 3.Review of R4's "Admission Record," located in	F0605		12/22/2025

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F0605 SS = D	Continued from page 9 the EMR under the "Profile" tab, revealed R4 was [redacted] to the facility on [redacted] with diagnoses that included NJ Exec Order 26.4b1, [redacted] and NJ Exec Order 26.4b1 [redacted]). Review of R4's "Care Plan," dated [redacted] and located under the "Care Plan" tab in the EMR, revealed a focus of [redacted] in NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1). Interventions included administering medications as ordered, monitoring and documenting for side effects and adverse reactions, and reporting findings to physicians or designees as clinically indicated. Review of R4's "Physician Order," dated [redacted] and located under the "Orders" tab in the EMR, revealed R4 was to receive NJ Exec Order 26.4b1 [redacted]) oral tablet [redacted] give one tablet mouth one time a day for [redacted]. Review of R4's "Quarterly Evaluation," dated [redacted] and [redacted] and located under the "Evaluations" tab in the EMR, revealed no documented evidence R4 was [redacted] for [redacted] NJ Exec Order 26.4b1 [redacted]. Both evaluations were marked that the resident [redacted] NJ Exec Order 26.4b1 an [redacted] medication and the [redacted] section of both forms was left blank. Review of R4's quarterly "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab and with an ARD of [redacted], revealed R4 had a "BIMS" score of [redacted] out of 15, which indicated R4 was [redacted] NJ Exec Order 26.4b1. The "MDS" recorded R4 received an [redacted] medication daily. During an interview on 11/25/25 at 10:49 AM, the U.S. FOIA (b)(6) [redacted]) confirmed the [redacted] evaluations should be completed for residents receiving [redacted] medications, and those evaluations should be documented on the Quarterly Evaluation form. The [redacted] confirmed the AIMS evaluation had NJ Exec Order 26.4b1 for R4 and should have been done since the resident was on [redacted]. Review of an undated facility policy titled, "Abnormal Involuntary Movement Scale (AIMS)" revealed, "…Residents using antipsychotic medications will be monitored for side effects and adverse consequences. The Abnormal Involuntary Movement Scale (AIMS) examination procedure may be used as	F0605		12/22/2025

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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
F0605 SS = D	Continued from page 10 an adjunct to periodically evaluate patients for signs of tardive dyskinesia (TD), to evaluate the effectiveness of treatment for TD, and to follow the severity of TD over time…" NJAC 8:39-4.1(a)6	F0605		12/22/2025
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for	F0645	A new [NJ Exec Order 26.] was completed for Resident #10. A review was completed for residents admitted to the facility to ensure [NJ Exec Order 26.] screenings were completed and accurate. No additional concerns were identified. The Administrator or designee reviewed PASARR requirements with the Social Worker, including verification of accuracy at the time of admission. The Social Worker will complete a new PASARR for any resident identified with an inaccurate screening. The Social Worker or designee will conduct monthly audits for three months to ensure all residents admitted during the review period have a completed and accurate PASARR. Results of the audits will be reviewed through the QAPI process with the Administrator or designee. Any variances will be addressed with updates to the plan of care as needed.	12/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315497	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

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F0645 SS = D	Continued from page 11 determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to ensure the admission [redacted] for [redacted] and [redacted] was [redacted] for one resident (Resident (R)10) of two residents reviewed for PASARR in a total sample of 29 residents. This failure placed residents at [redacted] of [redacted] the [redacted] services. Findings include: Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on [redacted] with diagnoses that included [redacted]	F0645		12/22/2025

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F0645 SS = D	Continued from page 12 NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. Review of the NJ Exec Order 26.4b1" located in the "Miscellaneous" tab of the EMR and completed by the hospital U.S. FOIA (b)(6), revealed that in Section NJ Exec Order 26.4b1 stated, "Does the individual have a diagnosis or evidence of a NJ Exec Order 26.4b1 limited to the following disorders NJ Exec Order 26.4b1 ..." the section was marked NJ Exec." Review of a NJ Exec Order 26.4b1 "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1 revealed, R10 had a "Brief Interview of Mental Status (BIMS)" score of NJ Exec Order 26.4b1 out of 15 which indicated R10 was NJ Exec Order 26.4b1, had NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1, and was administered an NJ Exec Order 26.4b1 medication, NJ Exec Order 26.4b1 medication and NJ Exec Order 26.4b1 medications during the NJ Exec Order 26.4b1. During an interview on 11/23/25 at 12:57 PM, R10 stated, "I have NJ Exec Order 26.4b1 and have been NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 hospitals NJ Exec Order 26.4b1, but it's been NJ Exec Order 26.4b1 years I was admitted." During an interview on 11/24/25 at 4:00 PM, U.S. FOIA (b)(6)) was asked if she reviews new admission "PASARR's" for complete documentation. The U.S. FOIA stated, "Yes, I typically do that." The U.S. FOIA further stated, NJ Exec Order 26.4b1 previous PASARR was NJ Exec Order 26.4b1 by this most recent PASARR, now that I am looking at it, it is NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 diagnoses are not documented on the page and R10's NJ Exec Order 26.4b1 treatment was not included, and NJ Exec Order 26.4b1 just had a NJ Exec Order 26.4b1 assessment, though it was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1." The U.S. FOIA confirmed that a new NJ Exec Order 26.4b1 should have been done as the one from the hospital was incorrect. Review of the facility policy titled, "Admission Criteria" dated 2001, revealed, "…All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process…" NJAC 8:39-5.1(a)	F0645		12/22/2025

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F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure [redacted] was provided during [redacted] for one resident (Resident (R) 49) of four residents reviewed for ADLs (Activities of Daily Living) in a total sample of 29 residents. This failure placed the residents at risk of a diminished quality of life. Findings include: Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R49 was admitted to the facility on [redacted] with diagnoses that included [redacted], NJ Exec Order 26.4b1 and [redacted]. Review of the annual "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of [redacted] revealed R49 had a "Brief Interview of Mental Status (BIMS)" score of [redacted] out of 15 which indicated R49 was [redacted] in [redacted] and [redacted] with [redacted]. Review of the [redacted] "NJ Exec Order 26.4b1 Care Plan" located in the "Care Plan" tab of the EMR revealed, "I have an [redacted] Performance [redacted] secondary to [redacted]." The "Care Plan" did not contain documentation of approaches/interventions for [redacted] or [redacted]. During an observation on 11/23/25 at 2:52 PM, R49 was observed to have [redacted] in which it was [redacted] and [redacted]. R49 was [redacted] if staf[redacted] when they [redacted]. [redacted] stated, "Yes, they [redacted] During an interview on 11/23/25 at 2:55 PM, Certified Nurse Aide (CNA) 2 was asked if R49 was receiving ADL [redacted]. CNA2 stated, "When I [redacted], but you have to [redacted] with [redacted]. I can't speak to anyone else though." CNA2 further stated, "They [CNAs] are supposed to [redacted] when a [redacted] is	F0677	Residents #49 [redacted] inclusive of [redacted]. A review was completed for residents dependent on staff for ADL assistance to confirm hygiene and grooming needs were met. No additional concerns were identified. The Assistant Director of Nursing or designee reviewed ADL care expectations with nursing staff, with emphasis on hair care during bathing for residents dependent on staff. The Director of Nursing or designee will conduct audits of ADL care for 10 residents weekly for one month, followed by audits of 5 residents weekly for two additional months. Results of the audits will be reviewed through the QAPI process with the Administrator. Any variances will be addressed with corrective action and care plan updates as appropriate.	12/22/2025

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F0677 SS = D	Continued from page 14 given." During an interview on 11/25/25 at 5:15 PM, the U.S. FOIA (b)(6) stated, "After you told me about R49's [redacted], I went to check on [redacted]." The [redacted] confirmed that R49's [redacted] had [redacted]. The [redacted] further stated, "Some of the aides use [redacted] in the residents' [redacted] even though they are not [redacted]. R49 is [redacted] and does [redacted] in [redacted] Review of the facility policy titled, "Activities of Daily Living (ADLs), Supporting" dated 2001 revealed, "...Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene...Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with...hygiene (bathing, dressing, grooming, and oral care)..." NJAC 8:39-4.1(a)22	F0677		12/22/2025
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to provide timely [redacted] for one (Resident (R)5) of two residents reviewed for [redacted] in a total sample of 29 residents. This failure placed the resident at [redacted] of [redacted]. Findings include: Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R5 was admitted to the facility on [redacted]	F0684	Resident #5 was [redacted], and a comprehensive [redacted] assessment was completed with [redacted] identified. A review was completed for residents requiring staff assistance with turning and repositioning. No additional concerns were identified. The Director of Nursing or designee reviewed turning and repositioning requirements with nursing staff for residents requiring assistance. The Assistant Director of Nursing or designee will audit turning and repositioning practices for 5 residents weekly for four weeks and then monthly for three months. Results of the audits will be reviewed through the QAPI process with the Administrator. Any variances will be addressed with corrective action and care plan updates as needed.	12/22/2025

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F0684 SS = D	Continued from page 15 with diagnoses that included NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 , and NJ Exec Order 26.4b1 NJ Exec Orde Review of the NJ Exec Order 26.4b1 "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec Order 26. revealed R5 had a "Brief Interview of Mental Status (BIMS)" score of NJ Exec O out of 15 which indicated R5 was NJ Exec Order 26.4b1 in NJ Exec Order 26.4, had NJ Exec Order 26.4b1 NJ Exec Orde, and was NJ Exec Order 26.4b1 of NJ Exec Orde and NJ Exec Order 2. Review of the 02/14/25 "ADL [activities of daily living] NJ Exec Order 26.4b1 Care Plan" revealed, "I have an ADL NJ Exec Order 26.4b1 NJ Exec Orde related to NJ Exec Order 26.4b1." During an interview on 11/23/25 at 2:29 PM, Family Member (FM) 1 was asked if staff were NJ Exec Order 26.4b1 R5 NJ Exec Order 26. FM1, who asked to remain anonymous, stated " . . . I do not believe they are NJ Exec Order 26.4b1 NJ Exec every NJ Exec hours." During an observation on 11/24/25 at 8:52 AM, R5 was lying on NJ Exe back with her eyes closed. On 11/24/25 at 9:57 AM, Certified Nursing Assistant (CNA) 3 entered R5's room with supplies to provide morning cares. CNA 3 left the room after providing care and R5 was NJ Exec Order 26.4b1 off NJ Exe NJ Exec O until 10:29 AM when two flat pillows NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 however, R5 NJ Exec Order 26.4b NJ Exec Order 26.4 on . CNA3 was asked at on 11/24/25 at 10:33 AM why wasn't R5 NJ Exec Order on NJ Exec Order 26 NJ Exec O NJ Exe was on NJ Exec NJ Exec O prior to cares. CNA3 stated that there were two pillows NJ Exec Order 26.4b1 of NJ Exe prior to starting cares and when she works with NJ Exe , that is how NJ Exec is NJ Exec Order 26.4b1 by just NJ Exec Order 26.4b1. During an interview on 11/24/25 at 11:41 AM, CNA1 entered the room. The two flat pillows were NJ Exec O to R5's NJ Exec Order 26 , however, R5 was NJ Exe on the bed. CNA1 confirmed that R5 had NJ Exec Order 26.4b1 and it should be NJ Exec Orde every NJ hours. CNA1 NJ Exec Order 26.4b1 R5 NJ Exec Order 26.4b1 with pillows to NJ Exec Order 26.4b1 During an observation on 11/24/25 at 2:50 PM, R5 was observed on NJ Exec Order 26.4b1 , in the NJ Exec Order 26.4b1 NJ Exec was NJ Exec Order in NJ Exec Orde. During an interview on 11/25/25 at 8:44 AM, the	F0684		12/22/2025

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F0684 SS = D	Continued from page 16 U.S. FOIA (b)(6) NJ Exec Order 26.4b1 and was aware the survey team had spoken to CNA1 and CNA3 regarding the NJ Exec Order 26.4b1 needs for R5. The U.S. FOIA further stated, "There is no excuse for it." Review of the facility policy titled, "Repositioning" dated May 2013, revealed, "...The purpose of this procedure is to provide guidelines for the evaluation of resident positioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed-or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relied for residents..." NJAC 8:39-27.1(a) NJAC 8:39-27.2(b)	F0684		12/22/2025
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and review of facility policy, the facility failed to utilize the physician ordered NJ Exec Order 26.4b1 or a NJ Exec O for or two of two residents (Residents (R) 5 and R81) reviewed for NJ Exec Order 26.4b1 in a total sample of 29. This failure placed the residents at NJ Exec of further NJ Exec Order 26.4b1) and NJ Exec Order 26.4b	F0688	Residents #5 and #81 were assessed by NJ Exec Order 2 and NJ Exec Order 26.4b1 interventions to address NJ Exec Order 2 and NJ Exec Order 26.4b1 needs. A review was completed for residents with limited mobility or range of motion needs to ensure appropriate equipment and therapeutic interventions were in place. No additional concerns were identified. The Director of Nursing or designee reviewed prevention of contractures and loss of range of motion with nursing and rehabilitation staff. The Rehab Director or designee will evaluate 10 residents monthly for appropriate treatment and services related to mobility and range of motion, followed by evaluation of 5 residents monthly for two additional months. Results of the audits will be reviewed through the QAPI process with the Administrator. Any variances will be addressed and care plans updated as appropriate.	12/22/2025

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F0688 SS = D	Continued from page 17 NJ Exec Order 26.4b1 Findings include: 1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R5 was admitted to the facility on NJ Exec Order 26 with a diagnosis that included a NJ Exec Order 26.4b1 NJ Exec Or Review of the "Order Summary" located in the "Orders" tab of the EMR revealed an order dated NJ Exec Order 26 to 'NJ Exec Order 26.4b1 for NJ hours twice daily." Review of the NJ Exec Order 26.4b1 "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec Order 26 revealed, R5 had a staff assessed "Brief Interview of Mental Status (BIMS)" of NJ Exec O out of 15 which indicated R5 was NJ Exec Order 26.4b1 . During an observation on 11/23/25 at 11:43 AM, R5 was lying in bed with NJ Exe NJ Exec O NJ Exec O at the NJ Exec Or and NJ Exe hands were lying on NJ Exec Order 26.4 . There were NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 observed. NJ Exec Order 26 NJ Exec Or was observed to be NJ Exec Order 26.4b1 than NJ Exec NJ Exec NJ Exec Order 26.4b1 were observed on the dresser to the left of R5's bed. During an interview on 11/23/25 at 2:07 PM, Family Member (FM)1, who asked to remain anonymous, stated "They do not NJ Exe any NJ Exec Order 26.4b s NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 . NJ Exec has NJ Exec Orde but I'm not sure if they are NJ Exec Orde then NJ Exe or NJ Exe ." During an observation and interview on 11/24/25 at 11:48 AM, Licensed Practical Nurse (LPN)2 confirmed that R5 did NJ Exec Order 26.4b1 or NJ Exec O NJ Exec Order 26.4b During an observation on 11/25/25 at 7:44 AM, R5 was observed to have a NJ Exec Order 26 NJ Exec O on NJ Exe chest instead of NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 were on the dresser to the left of R5's bed. 2. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed R81 was admitted to the facility on NJ Exec Order 26 with a diagnosis of a NJ Exec Order 26.4b1 . Review of the quarterly "MDS" located in the "MDS" tab of the EMR with an ARD of NJ Exec Order 26 revealed, R81 had a "BIMS" score of NJ Ex out of 15 which	F0688		12/22/2025

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F0688 SS = D	Continued from page 18 indicated R81 was NJ Exec Order 26.4b1 in and had NJ Exec Order 26.4b1) Review of the "Comprehensive Care Plan" dated revealed, "I have or related to: Interventions included on the wheelchair." There were no interventions for R81's During an interview and observation on 11/23/25 at 1:42 PM, R81 was lying in bed with and hand close to There was or R81 stated, "This is from my " R81 was if staf with a R81 stated, ." Review of the current "Order Summary" located in the "Orders" tab of the EMR revealed no order for , , or for the NJ Exec Order 26.4b1. During an observation on 11/24/25 at 8:49 AM, R81 was observed in bed. right hand contain a or . This observation was verified by Certified Nursing Assistant (CNA)1. During an interview on 11/25/25 at 12:45 PM, the was told about the NJ Exec Order 26.4b1 and for R5 and R18. The stated, "We need to follow up with this." Review of the facility policy titled, "Resident Mobility and Range of Motion" dated July 2017 revealed, "...Residents with limited range of motion will receive treatment and services to increase and/or prevent further decrease in ROM..." NJAC 8:39-27.1(a)	F0688		12/22/2025
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F0700	Resident #68 was assessed for the of and informed consent was obtained. A review was completed for residents utilizing bed rails to ensure proper assessment, consent, and care planning. No additional concerns were identified. The Director of Nursing or designee reviewed the facility policy regarding bed rail use with nursing, rehabilitation, and maintenance staff.	12/22/2025

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F0700 SS = D	Continued from page 19 §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails; documented discussion related to risk versus benefits; and signed informed consent prior to [redacted] use for one of four residents (Resident (R)68) reviewed for [redacted] out of 29 sampled residents. The lack of alternate [redacted] measures and proper assessment/consent increased the potential for NJ Exec Order 26.4b1 . Findings include: Review of R68's "Admission Record" in the "Profile" tab of the electronic medical record (EMR) revealed [redacted] was admitted to the facility on [redacted] with diagnosis of NJ Exec Order 26.4b1 . Review of R68's admission "Minimum Data Set (MDS)" assessment under the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of [redacted] revealed a "Brief Interview for Mental Status (BIMS)," score of [redacted] out of 15 indicating NJ Exec Order 26.4b1 . This MDS revealed that R68 was [redacted] to [redacted]. Review of R68's "Care Plan" located under the "Care Plan" tab of the EMR dated [redacted] revealed no care plan for [redacted]. Review of R68's "Physician Orders" located under the "Orders" tab in the EMR dated [redacted] revealed no order for [redacted] Review of R68's "MQS Admission/Readmission Evaluation" located under "Assessments" tab in the	F0700	Continued from page 19 The Director of Nursing or designee will audit bed rail use for 10 residents weekly for four weeks, followed by monthly audits for three months. Results of the audits will be reviewed through the QAPI process with the Administrator. Any variances will be addressed with updates to care plans as appropriate.	12/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315497	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

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F0700 SS = D	Continued from page 20 EMR dated [redacted] stated [redacted] assessment [redacted] were [redacted]. Interview and observation on [redacted] 11:40 AM and [redacted] at 10:10 AM revealed R68 in bed with [redacted] on the [redacted]. R68 stated the [redacted] on [redacted] bed [redacted] was admitted, and that the [redacted] was [redacted] in the [redacted], and the [redacted] was at times. R68 stated that [redacted] did [redacted] the [redacted] as an [redacted] when [redacted] or [redacted] from the [redacted]. During an interview on 11/25/25 at 10:06 AM Licensed Practical Nurse (LPN)5 verified the facility did not get informed consent prior to [redacted] use or explore alternatives before implementing [redacted] use. During an observation and interview on 11/25/25 at 10:20 AM, Registered Nurse/Unit Manager (RN)1 stated he was unaware that R68 had [redacted] on [redacted] bed and he was not sure if there was signed informed consent for the resident to have [redacted] He observed R68 in bed with [redacted]. He also stated he was unaware that [redacted] admission [redacted] did [redacted]. RN1 stated that he considered [redacted] a [redacted]. He confirmed there was no signed informed consent for the [redacted] During an interview on 11/25/25 at 12:33 PM, the U.S. FOIA (b)(6) stated that on the subacute unit where new residents were admitted all beds had bedrails. She stated she expected staff to evaluate and screen any resident prior to implementing [redacted] and to obtain informed consent. Review of the facility policy titled "Bed Safety and Bed Rails" revised August 2022 revealed, "resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. The use of bed rails or side rails (including temporarily raising the side rails for episodic used during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternative interdisciplinary evaluation, resident assessment, and informed consent." NJAC 8:39-27.1(a)	F0700		12/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060201	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

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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		12/15/2025
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	No adverse outcomes related to access to care were identified. A review of staffing processes was completed to ensure resident care needs are met based on daily census. The Director of Nursing or designee reviewed required CNA staffing ratios with the Staffing Coordinator. The Administrator or designee contacted the facility Recruiter to communicate current staffing needs, and a weekly meeting was established to review recruitment strategies. The Staffing Coordinator and Director of Nursing or designee meet five times per week to review upcoming staffing needs. Staffing software is utilized to allow off-shift Certified Nursing Assistants to pick up open shifts. Referral bonuses and sign-on bonuses are offered to support recruitment and retention. The Administrator or designee will review Resident Council meeting minutes monthly for three months to identify any concerns related to staffing. The Director of Nursing or designee will audit staffing ratios daily. Results of these reviews will be reviewed through the QAPI process with the Administrator or designee. Any variances will be addressed with revisions to the plan will be completed.	12/22/2025

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

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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. 1. For the week of Complaint staffing from 07/14/2024 to 07/20/2024, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -07/14/24 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAS. -07/15/24 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAS. -07/16/24 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAS. -07/18/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAS. -07/19/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAS. -07/20/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAS. 2. For the week of Complaint staffing from 08/04/2024 to 08/10/2024, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -08/04/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -08/05/24 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. -08/06/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -08/07/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -08/08/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -08/09/24 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs.	S0560		12/22/2025

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S0560	Continued from page 2 3. For the week of Complaint staffing from 10/13/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -10/13/24 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/14/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -10/15/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -10/16/24 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -10/18/24 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. -10/19/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. 4. For the week of Complaint staffing from 02/02/2025 to 02/08/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -02/02/25 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. -02/03/25 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -02/04/25 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -02/05/25 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. -02/06/25 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -02/07/25 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -02/08/25 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. 5. For the week of Complaint staffing from 07/13/2025 to 07/19/2025, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as	S0560		12/22/2025

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S0560	Continued from page 3 follows: -07/13/25 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -07/14/25 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -07/19/25 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. 6. For the week of Complaint staffing from 09/14/2025 to 09/20/2025, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -09/20/25 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.	S0560		12/22/2025

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 2/9/2026 in relation to the 11/25/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		02/09/2026

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

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 2/9/2026 in relation to the 11/25/2025 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		02/09/2026

Office of Primary Care and Health Systems Management

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315497	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - ALLENDALE ...** B. WING	(X3) DATE SURVEY COMPLETED **11/25/2025**

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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 11/25/25 and 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. Allendale Rehabilitation and Healthcare Center is a one-story building built in 1967. It is composed of Type II protected construction. The facility is divided into four - smoke zones. The 100 KW diesel generator powers approximately 60% of the building per the Maintenance Director. The current occupied beds are 92 of 119.	K0000		12/15/2025
K0351 SS = F Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING 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. 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. 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.	K0351	No adverse outcome was identified related to the presence of differing sprinkler head types within the referenced compartment at the time of survey. The affected area was limited to the identified compartment. A facility-wide review was conducted to confirm consistency of sprinkler head types within all other compartments. The Director of Maintenance engaged the contracted fire protection vendor to replace and standardize the sprinkler heads within the laundry room to ensure consistency with NFPA requirements. The Director of Maintenance or designee will conduct monthly visual inspections of sprinkler heads to confirm consistency within compartments for a period of three months. Findings will be reviewed as part of the facility's QAPI process. Any identified variances will be addressed promptly.	01/06/2026

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

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K0351 SS = F Bldg. 01	Continued from page 1 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) This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the fire suppression system sprinkler heads were the same throughout a compartment in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2012 Edition) Section 8.3.3.2. This deficient practice had the potential to affect all 92 residents and was evidenced by the following: Observations on 11/25/25 at 1:09 PM revealed two quick response sprinklers and four standard response sprinklers were in the same compartment in the laundry room. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the quick response sprinklers and the standard response sprinklers were installed in the same compartment. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K0351		01/06/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K0353	No adverse outcome was identified related to the lapse in documented hydrostatic testing of sprinkler system gauges. The scope was limited to maintenance documentation and testing compliance. The Director of Maintenance contacted the contracted vendor to complete the required hydrostatic testing of the sprinkler system gauges. The next required testing interval has been entered into NJ Exec On for tracking in accordance with NFPA timelines. The Director of Maintenance or designee will review NJ Exec On scheduled life safety tasks on a monthly basis for three months to ensure timely completion. Compliance will be reviewed through QAPI, and any variances will be addressed.	01/06/2026

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K0353 SS = F Bldg. 01	Continued from page 2 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on document review, interview, and observation, it was determined that the facility failed to ensure the fire department connection (FDC) was hydrostatic tested every five years and the sprinkler gauges were replaced or calibrated every five-years in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) section 6.3.2.1. and 13.2.7.2. This deficient practice had the potential to affect all 92 residents and was evidenced by the following: A review of the facility's untitled "sprinkler system records" revealed no documented evidence that the FDC was hydrostatic tested within the last five years. An observation on 11/25/25 at 1:25 PM revealed the fire sprinkler gauges were not replaced or calibrated. The gauges had a date of 2018. During an interview on 11/25/25 at 2:25 PM, the U.S. FOIA (b)(6) confirmed that fire department connection had not been hydrostatic tested, and the gauges were not replaced or calibrated. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K0353		01/06/2026
K0355 SS = F Bldg. 01	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 observations, document review and interview, it was determined that the facility failed to ensure travel distance to fire extinguishers were within 75 feet in accordance with NFPA 10 Standard	K0355	No adverse outcome was identified related to fire extinguisher travel distance at the time of survey. The affected location was limited to the identified subacute unit. All other areas of the facility were reviewed and found to be compliant. The Director of Maintenance coordinated with the contracted vendor to install fire extinguishers outside of room 40 (newly labelled room 71) and an additional fire extinguisher outside of room 37 (newly labelled room 86) on the subacute unit to ensure compliance with the 75-foot travel distance requirement. Please note the facility has changed room numbers on the unit since the time of survey reflected in submitted floor plan.	01/06/2026

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K0355 SS = F Bldg. 01	Continued from page 3 for Portable Fire Extinguishers (2010 Edition) section 6.2.1.1 and Table 6.2.1.1. This deficient practice had the potential to affect all 92 residents and was evidenced by the following: Observations on 11/25/25 at 2:15 PM revealed that fire extinguishers were located more than 200 feet apart. One fire extinguisher was located across from room 25 in the sub-acute wing and the next closest fire extinguisher was outside the U.S. FOIA (b)(6) office. Fire extinguishers can be placed 150 feet apart from each other. An observation on 11/25/25 at 2:28 PM revealed from room 32 and 33 near exit door 28 to the closest fire extinguisher at room NJ Ex in the sub-acute wing was 118 feet. A review of the facility's "diagram" provided by the U.S. FOIA (b)(6) showed a fire extinguisher located outside room NJ Ex However, the extinguisher and mounting bracket or box were not present outside room NJ Ex During an interview at the time of observation, the U.S. FOIA (b)(6) confirmed the travel distance to the fire extinguishers was more than 75 feet. The U.S. FOIA (b)(6) stated that the sub-acute area was previously the Assisted Living area and was remodeled a few years ago and changed to sub-acute care this year. NJAC 8:39-31/1(c), 31.2(e) NFPA 10	K0355	Continued from page 3 The Director of Maintenance or designee will conduct monthly audits of fire extinguisher placement for three months to confirm compliance. Results will be reviewed through QAPI and corrective action taken as needed.	01/06/2026
K0511 SS = F Bldg. 01	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:	K0511	No adverse outcome was identified related to the exposed non-metallic sheathed cable at the electrical panel. The issue was isolated to the identified electrical panel. All other electrical panels were inspected, and no additional findings were noted. The Director of Maintenance corrected the condition by properly concealing the non-metallic sheathed cable in the electrical closet near Room 11 on the subacute unit.	12/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315497	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALLENDALE ... B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

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K0511 SS = F Bldg. 01	Continued from page 4 Based on observation and interview, it was determined that the facility failed to ensure non-metallic sheath cable wiring was concealed in walls or conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) section 334.10 (5). This deficient practice had the potential to affect all 92 residents and was evidenced by the following: An observation on 11/25/25 at 2:11 PM revealed non-metallic sheath cable wiring was exposed from electrical panel CC1PR through a block wall in the electrical closet near room 11 in the Subacute Unit. During an interview at the time of observation, the U.S. FOIA (b)(6) confirmed the wiring was exposed. NJAC 8:39-31.2(e) NFPA 70	K0511	Continued from page 4 The Director of Maintenance or designee will audit electrical panels monthly for three months to ensure continued compliance. Findings will be reviewed through QAPI, and corrective action will be implemented if needed.	12/22/2025
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills 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. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on document review and interview, it was determined that the facility failed to ensure the fire alarm included the transmission of a fire alarm signal in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.1.4. This deficient practice had the potential to affect all 92 residents and was evidenced by the following: A review of the facility's untitled "fire drill records" revealed the facility failed to transmit an alarm signal to the fire alarm system monitoring company for 12 out of 12 months.	K0712	No adverse outcome was identified related to the fire drill process at the time of survey. The concern related to procedure adherence during fire drill execution. The Administrator reviewed fire drill requirements with the Director of Maintenance, including the requirement to transmit an alarm signal to the monitoring company during drills. The Administrator or designee will review fire drill documentation monthly for three months to ensure proper alarm transmission is included. Compliance will be monitored through QAPI, and any variances will be addressed.	12/22/2025

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K0712 SS = F Bldg. 01	Continued from page 5 During an interview on 11/25/25 at 12:45 PM, the U.S. FOIA (b)(6) confirmed that the fire alarm signal was not transmitted to the fire alarm monitoring company because of the ongoing renovations. NJAC 8:39-31.1(c), 31.2(e)	K0712		12/22/2025

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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 11/25/25. The facility was found to be in compliance with 42 CFR 483.73, Long Term Care Facilities.	E0000		12/15/2025

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: 315497	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - ALLENDALE ...** B. WING	(X3) DATE SURVEY COMPLETED **02/28/2026**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 2/28/2026 in relation to the 11/25/2025 Recertification 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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