STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	**301 SICOMAC AVE , WYCKOFF, New Jersey, 07481**

(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 FOO Complaint NJ#s: 263054, 2646177, 2708006, and 2731128 Survey Date: 2/17/26-2/25/26 (LSC) John Oliver Census: 283 Sample: 35 sample + 3 closed records =38 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		02/26/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	It is the policy of the facility to properly label, date, and store all food items to ensure food safety, maintain quality standards, and adhere to professional standards for food service safety. Upon identification of items requiring updated labeling or expiration verification, the items were immediately discarded. No residents were harmed as a result of this action. The facility has determined that all residents have the potential to be impacted by this improved process. On February 24, 2026, the Food Storage and Labeling policy was reviewed and updated, and all dietary and nutritional services staff received immediate re-education regarding proper labeling and dating of opened and prepared foods, labeling of expiration dates for frozen items, and the prompt removal and disposal of expired or improperly labeled items. Procedural changes, including labeling both the date the item was prepared and the expiration date for frozen items, were added as part of the policy. In addition, to reinforce adherence to professional food service safety standards, staff were in-serviced on Dietary and Nutritional Services dress code policy on February 24, 2026 including regulatory requirements related to the use of beard guards	02/26/2026

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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F0812 SS = F	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain kitchen sanitation in a manner intended to prevent the spread of food borne illness and in accordance with professional standards for food service safety. This deficient practice was evidenced by the following: On 2/17/26 at 9:54 AM, during the initial tour of the kitchen, in the presence of the US FOIA (b)(6) and the US FOIA (b)(6) the surveyor observed the following in refrigerator 3: a container of cottage cheese that was labeled with an open date of 2/9/26 and a use by date of 2/12/26. The US FOIA (b)(6) stated that the facility policy was to discard opened items seven days after they were opened. He added that someone probably put the wrong use by date on the label and that today was the last date. The surveyor asked the US FOIA (b)(6) if the open date was 2/9/26 then would the discard date seven days later be 2/16/26. The US FOIA (b)(6) confirmed and threw the item in the garbage. On 2/17/26 at 9:59 AM, in the presence of the US FOIA (b)(6) , the surveyor observed the following in freezer 2: 1. 8 cups with lids that were labeled "sb" which had a sticker with exp (expiration) 2/2/26. 2. 5 cups with lids that were labeled "clams" that had a sticker with use by 2/16/26. 3. 1 cup with lid that was labeled "clam sauce" that had a sticker with use by 1/18/26. On 2/17/26 at 10:00 AM, in the presence of the US FOIA (b)(6) , the surveyor observed the Chef who brought a tray of prepared food from the preparation area to the refrigerator area that had facial hair longer than a quarter inch. The US FOIA was not wearing a beard guard. The surveyor asked the US FOIA (b)(6) if the US FOIA should be wearing a beard guard. The US FOIA (b)(6) stated that the US FOIA should of had a beard guard on. On 2/24/26 at 12:45 PM, the surveyor notified the US FOIA (b)(6)) and US FOIA (b)(6)) the concern that the chef was not wearing a beard guard and four different items located in the refrigerator and freezer were past their use by date. On 2/25/26 at 11:21 AM, in the presence of the	F0812	Continued from page 1 when facial hair exceeds one-quarter inch in length. To ensure ongoing compliance, the Senior Director of Dietary and Nutritional Services or their designee will provide ongoing monitoring and leadership oversight by conducting weekly expiration date audits for four weeks and monthly thereafter. Results will be presented at the quarterly Quality Assurance and Performance Improvement Committee until sustained compliance is achieved in a cumulative three-month period.	02/26/2026

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F0812 SS = F	Continued from page 2 US FOIA (b) the US FOIA (b) stated that they updated the policy on attire for the DNS staff and in-serviced the staff on wearing beard guards. The US FOIA (b) stated that the items were immediately discarded after surveyor inquiry and that they updated the policy to have both the prepared date and use by date. She added that the staff were in-serviced. A review of the facility's "Dining and Nutrition Services Dress Code Policy" with an effective date of 1/26, did not include any information on beard guards. A review of the facility's "Food Storage Standards in DNS Policy" with an effective date of 1/25, included the following: [name redacted] stored in refrigerators and freezers are to be covered, labeled and dated. NJAC 8:39-17.2(g)	F0812		02/26/2026
F0577 SS = D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and	F0577	It is the facility's policy to uphold each resident's right to review the results of the most recent survey, any deficiencies resulting from subsequent complaint investigation(s), and any plan of correction currently in effect for the facility. The community is committed to transparency and to ensuring that residents, resident representatives, and members of the public have clear access to information regarding regulatory compliance and quality improvement activities. While no harm resulted, all residents, resident representatives and the public can benefit from the improved process. Upon notification, the Survey Results Availability Binders were reviewed and updated to ensure inclusion of the Recertification Survey inspection results, Focused Infection Control Survey results, and complaint surveys for the preceding three years. On February 20, 2026 the binders were placed in clearly visible locations readily accessible to residents, their representatives and the public. In addition, a Survey Results Availability poster identifying the binder locations was placed on the public bulletin board in the Commons Reception area. On February 24, 2026 a Survey Results Availability policy was formalized, and an in-service education program was conducted by the Executive Director/Administrator to review regulatory requirements regarding resident, resident representative, and public access to survey results.	02/26/2026

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F0577 SS = D	Continued from page 3 accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to, a.) post the State of New Jersey (State) inspection results in an area that was readily accessible to residents, families, and the public and b.) ensure reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction available for review. This deficient practice was observed in 2 of 2 common areas in the facility (reception desk and west lounge area). The deficient practice was evidenced by the following: On 2/20/26 at 11:35 AM, the surveyor asked Receptionist #1 (R #1) where the facility's survey results was and she responded that she was a Volunteer and she did not know, and she had to ask Receptionist #2 (R #2) who was the regular receptionist. At that time, R #2 was unable, and the surveyor was unable to locate the survey results. On 2/20/26 at 11:40 AM, the surveyor went to the Heritage Manor (HM) West unit and asked the Registered Nurse (RN) who were at the nursing station, where the survey result was, and she stated that she would have to ask someone. Afterward, the RN came back and stated that the survey results were on the other side of the HM West unit. The US FOIA (b)(6) came and accompanied the surveyor to the Hearth Area also known as the lounge area of the HM West unit, at the other end of the unit. The US FOIA showed the white binder "Annual Long Term Care Survey" which was in the book shelf, next to the books. The US FOI confirmed that the survey result binder had the most recent recertification survey results dated 10/8/24, and that there was no other survey results printed and filed in the binder. The US FOI stated that she was unsure what the policy and requirements for posting survey results were. At that same time, the surveyor notified the US FOIA that the survey binder result was not readily accessible, and unable to locate unless someone from the facility knew where it was. The US FOIA did not respond.	F0577	Continued from page 3 To ensure ongoing compliance, the Executive Director/Administrator or designee will audit the contents of the Survey Results Availability Binder to confirm inclusion of inspection results from the preceding three years on a weekly basis for four weeks and monthly thereafter. Audit findings will be presented at the quarterly Quality Assurance and Performance Improvement Committee until sustained compliance is achieved.	02/26/2026

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F0577 SS = D	Continued from page 4 On 2/20/26 at 11:45 AM, the surveyor returned to the reception desk, the main entrance to the facility, and asked R #2 where the facility's survey results were, and she stated that it was inside a cabinet near the entry door, and it should be in the bottom of the cabinet. The surveyor located the cabinet and saw the white binder on the bottom of the cabinet. The survey binder results were not easily accessible. At that same time, the surveyor observed a white binder "Annual Long Term Care Survey" with survey results dated 10/8/24 and a Focus Infection Control (FIC) Survey dated 1/17/24. There were no other survey results in the binder except for the two survey dates. On 2/20/26 at 11:47 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the survey results in the white binder. The US FOIA (b) confirmed that the survey results inside the binder were from 10/8/24 recertification survey and the 1/17/24 FIC Survey. The surveyor asked the US FOIA (b) if she was aware of the regulation regarding survey results and she responded that they were required to put the most recent survey results which was the 10/8/24. The surveyor then asked for the facility's policy about survey results, and she stated that she would get back to the surveyor. On 2/20/26 at 1:50 PM, the US FOIA (b)(6) informed the surveyor that the facility had no policy with regard to the posting of survey results. She further stated that as far as she knew the facility was required to have the last recertification survey which was the October 2024 results in the survey binder for residents and visitors. She further stated that she was not aware that it should be at least the 3 years surveys which could include recertification surveys and other surveys like complaint surveys. At that same time, the surveyor notified the US FOIA (b) of the concern that the survey results were not easily accessible for those two common areas, the reception desk and HM West nursing unit. The surveyor also notified the US FOIA (b) that the RN and R #1 were not aware where the survey results were located. On 2/24/26 at 11:12 AM, the US FOIA (b) provided a copy of "Policy: Survey Binder Availability" with an original date and effective date of 2/26, revealed under Policy: all surveys, certifications, and complaint investigations made of or about Christian Health during the 3 preceding years and any plan of correction in effect will be available for individuals to	F0577		02/26/2026

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F0577 SS = D	Continued from page 5 review. Definitions: "place readily accessible" is an area (such as HM West (Hearth Bookcase) or other area frequented by most residents, visitors or other individuals where individuals wishing to examine survey results do not have to ask to see them. "Results of the most recent survey" means the Statement of Deficiencies (Form CMS-2567) generated by the most recent standard survey and any deficiencies resulting from any subsequent complaint investigation(s).... The [US FOIA (b)] confirmed that the policy was formulated after surveyor's inquiry. On 2/24/26 at 12:31 PM, the survey team met with the [US FOIA (b)(6)], and the surveyor notified them of the above findings and concerns with the posting of survey results. The [US FOIA (b)] stated, "We corrected" the survey binder and put the last three years survey results. The [NJ Exec Ofc] further stated that the survey results were out of the cabinet in the reception desk to be more accessible, after surveyor's inquiry. A review of the facility's survey history revealed that the facility had recertification survey on 6/14/23, FIC survey on 1/15/24, and complaint surveys on 7/2/24 and 12/16/25 which were not filed in the survey binders. NJAC 8:39-9.4(b)(c)	F0577		02/26/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for	F0628	It is the policy of the facility to permit each resident to remain in the facility and to avoid transfer or discharge except in limited and appropriate circumstances. The policy applies to all residents regardless of their payment source. Documentation was present for both residents #365 and #369 in their electronic medical record reflecting emergency transfer notification provided verbally to the resident representatives. Resident #365's representative was sent a copy of the Bed-Hold Notice in writing noting the reason for transfer/discharge by mail by the Director of Admissions on January 4, 2026 and resident #369's representative was sent a copy of the Bed-Hold Notice in writing noting the reason for transfer/discharge by the Director of Admissions on January 9, 2026, January 23, 2026 and January 30, 2026 by mail. For resident #365, the State Long-Term Care Ombudsman was notified via the facility's faxed monthly list sent on January 16, 2026. For resident #369, the State Long-Term Care Ombudsman was notified via the facility's faxed monthly list also sent on January 16, 2026 and again on February 3, 2026 in accordance with regulatory requirements. Both	02/26/2026

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F0628 SS = D	Continued from page 6 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under	F0628	Continued from page 6 residents were discharged. The facility has determined that all residents and their representatives who have been transferred on an emergency basis have the potential to be impacted by the improved process. On February 24, 2026 the Transfer and Discharge (including AMA) policy was reviewed and updated to include additional regulatory content requirements for the resident’s Emergency Transfer Notice/Bed Hold Reserve Payment-Secondary Notice, includingthe facility’s bed-hold reserve payment information, Long-Term Care Ombudsman’s contact information, and resident’s right to appeal. On February 24, 2026 an in-service education program was conducted by the Admissions Director for all admissions staff regarding the timely provision of written notification to residents and their representatives as soon as practicable following an emergency transfer. A transfer/discharge list along with copies of the Emergency Transfer Notice/Bed Hold Reserve Payment-Secondary Notice will be sent to the State Ombudsman Office monthly. To ensure ongoing compliance, the Director of Admissions or their designee will conduct an audit of five charts weekly for four weeks, followed by five chart audits monthly thereafter of all residents who have been transferred or discharged from the facility to ensure the electronic medical record includes the updated Emergency Transfer Notice/Bed Hold Reserve Payment-Secondary Notice in writing in a language they can understand. Audit results will be discussed with the Quality Assurance and Performance Improvement Committee at each quarterly meeting until sustained compliance has been achieved.	02/26/2026

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F0628 SS = D	Continued from page 7 paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F0628		02/26/2026

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F0628 SS = D	Continued from page 8 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	F0628		02/26/2026

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F0628 SS = D	Continued from page 9 (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to include in the written notification of transfer that was provided to the Resident or Resident Representative (RR), the facility's bed hold reserve payment and the Long-Term Care Ombudsman (LTCO) information and appeals rights for 2 of 2 residents, (Resident #365 and Residents #369), reviewed for hospitalizations. This deficient practice was evidenced by the following: 1.On 2/25/26, Surveyor #1 (S #1) reviewed the hybrid (electronic and paper) medical records (MR) of Resident #365. A review of Resident #369's Resident Face Sheet (RFS, an admission summary), reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, [redacted] The MR revealed a New Jersey Universal Transfer Form (UTF) that the resident was transferred to a [redacted] for [redacted] and to rule out [redacted] A review of Resident #365's discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #365's [redacted] was [redacted] Further review of the MDS indicated that the resident was transferred to a [redacted]. A review of Resident #365's electronic MR included	F0628		02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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F0628 SS = D	Continued from page 10 a letter to the RR dated [redacted], which included that the resident was transferred to the [redacted] and admitted with a [redacted] and that attached was a copy of the "Notice of Bed-Hold Policy-Secondary Notification." The letter did not include the bed hold reserve payment amount. The letter did not include the LTCO information or the resident's appeal rights. 2.On 2/18/26 at 12:51 PM, Surveyor #2 (S #2) reviewed the hybrid MR of Resident #369. A review of Resident #369's RFS reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted] A review of Resident #369's most recent discharge MDS reflected that the resident had a BIMS score of [redacted] out of 15, which indicated that Resident #369's [redacted] was [redacted] Further review of the MDS indicated that the resident was transferred to a [redacted] A review of Resident #369's electronic MR included a letter to the RR dated [redacted], which included that the resident was transferred to the [redacted] and admitted with NJ Exec Order 26.4b1) and that attached was a copy of the "Notice of Bed-Hold Policy-Secondary Notification." The letter did not include the bed hold reserve payment amount. The letter did not include the LTCO information or the resident's appeal rights. On 2/20/26 at 9:31 AM, S #2 interviewed the US FOIA (b)(6) regarding the written notification required when a resident was transferred to the hospital. The US FOIA (b)(6) stated that after the confirmation that the resident was admitted to the hospital, the next morning the letter with the bedhold information was sent to the RR. S #2 asked if the bed reserve payment information was on the letter. The US FOIA (b)(6) stated that the price was not on the letter and that it	F0628		02/26/2026

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F0628 SS = D	Continued from page 11 may be in the admission agreement. She added that this was a secondary notice and that the first notice was in the admission agreement which had the usual per diem rate and fee schedule. On 2/24/26 at 12:45 PM, S #2 notified the US FOIA (b)(6) [redacted]) the concern that Resident #369's written emergency transfer notification did not include the bed hold reserve payment and the LTCO and appeal information. On 2/25/26 at 11:27 AM, in the presence of the US FOIA (b)(6) stated that they changed the notice to include the appeal process and reserve payment. The US FOIA (b) [redacted] stated that the admission staff were in-serviced on the new process. A review of the facility's "Transfer and Discharge (including AMA) Policy" with an effective date of 11/25, included the following: Policy: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source…10. Emergency Transfers to Acute Care…g. Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. The US FOIA (b) [redacted] revealed in the letter that was signed by the DSS that the letter was to inform of the bed hold policies of the facility. In accordance with NJ (New Jersey) Medicaid guidelines, the facility will reserve your bed for a period of 10 days if you are a Medicaid recipient…For short term resident whose payment is Medicare or private insurance, the bed hold provisions noted above for private pay residents will apply… The policy did not provide any information regarding the contents for the notice of transfer and bed hold notice. A review of the facility's "Admission Process Policy" with an effective date of 4/2025, included the following: I. Bedhold: Pursuant to the terms outlined in the Admission Contract, Resident's bed will be held in the following manner: a. Private Pay Residents: Preference regarding bed-hold is indicated at the time of admission. If bed-hold is elected, resident's bed will be held until return or until facility is otherwise notified to release bed-hold by resident or responsible party. b. Medicaid Residents: Resident's bed will be held for a period of 10 days as per current regulation. If resident has	F0628		02/26/2026

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F0628 SS = D	Continued from page 12 not returned to the facility before the end of the 10-day hold period expires, the resident may be readmitted to a different room (if previous room is no longer available) or placed on a waiting list and offered the next available bed. c. Beds will not be held for Short-Term Rehab patients. Primary Notice of Bedhold Policy is provided upon Admission. Secondary Notice of Bedhold Policy is provided the morning following confirmed discharge by contacting Resident Representative via mail with copy of notification to review the policy; email confirmation is provided if email is available. NJAC 8:39-4.1(a)31; 5.1	F0628		02/26/2026
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure that the completion of the Minimum Data Set (MDS), a [NJ Exec Order 26.4b1] [redacted], was done in a timely manner. This deficient practice was identified for 1 of 35 residents reviewed for resident assessments (Resident # 85), and was evidenced by the following: On 2/17/26 at 11:42 AM, the surveyor observed Resident #85 sitting up on a bed and a [US FOIA (b)(6)] [redacted] assisting the resident with the lunch tray. On 2/18/26 at 10:56 AM, the surveyor observed the resident lying in bed. The surveyor asked Resident #85 if they were okay, the resident [NJ Exec Order 2] [redacted] their head, and then closed their eyes. On 2/18/26 at 11:03 AM, the surveyor interviewed	F0637	The facility is committed to ensuring each resident who experiences a significant change in status is comprehensively assessed using the Centers for Medicare & Medicaid Services Resident Assessment Instrument process. For resident #85, a review of the resident face sheet reflected diagnoses including, but not limited to, displaced intertrochanteric fracture of the right femur, subsequent for closed fracture with routine healing, and a history of falling. A review of the quarterly Minimum Data Set with an assessment reference date of September 19, 2025, revealed a Brief Interview of Mental Status outcome of impaired cognition, lower body dressing with supervision or touching assistance requirement and changes in ambulation status. While no harm resulted and the resident's care needs continued to be addressed, the facility identified an opportunity to strengthen the documentation accuracy within the comprehensive assessment process for residents experiencing significant changes. To prevent future issues, on February 24, 2026, the Minimum Data Set Manager re-educated the Minimum Data Set coordinators on the criteria used to determine when a significant change assessment is required, as outlined in the Resident Assessment Instrument Manual. On February 26, 2026, the Minimum Data Set Manager and Director of Nursing implemented an audit tracker using the Minimum Data Set Resident-Level Quality report to ensure that significant change assessments are identified and completed in a timely manner. Initial review of the tracker did not identify additional discrepancies. To ensure ongoing compliance, the Director of Nursing and Minimum Data Set Manager will audit five charts weekly for four weeks, followed by	02/26/2026

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F0637 SS = D	Continued from page 13 the US FOIA (b)(6)) who stated that she was on duty when the resident [redacted] or [redacted] in the hallway. The US FOIA also stated the resident was trying to NJ Exec Order 26.4b1 from their cart, the resident was with a US FOIA (b) and the resident [redacted] their [redacted] and [redacted] The US FOIA further stated that an [redacted] was done which revealed a [redacted] of the [redacted] was sent out to the [redacted] and had [redacted] The US FOIA stated that the resident used to [redacted] received [redacted] when the resident was re-admitted but did not follow directions, was not NJ Exec Order 26.4b1, had NJ Exec Order 26.4b1, and a NJ Exec Order 26.4b1 was now being used for NJ Exec Order 26.4b1 On 2/18/26 at 4:15 PM, the surveyor reviewed the medical record for resident #85. A review of the Resident face sheet (an admission summary) reflected that the resident had diagnoses which included but not limited to NJ Exec Order 26.4b1 [redacted] A review of the Care Plan (CP) revealed for Activities of Daily Living (ADL) dated [redacted]. A CP for [redacted] dated [redacted], additional detail- [redacted]. It involves [redacted] the NJ Exec Order 26.4b1 ") to NJ Exec Order 26.4b1 and using [redacted] like NJ Exec Order 26.4b1 for proper [redacted], as needed for [redacted] NJ Exec Order 26.4b1 as NJ Exec Order 26.4b1. A review of the Order Summary revealed the following: Monitor NJ Exec Order 26.4b1 to [redacted] and [redacted] every shift dated [redacted]; Notify US FOIA (b)(6) to evaluate for [redacted] removal today as per NJ Exec Order 26.4b1 [redacted] dated [redacted] as needed dated [redacted], [redacted] RLE dated [redacted] A review of the quarterly MDS (MDS) with an assessment reference date (ARD) of [redacted],	F0637	Continued from page 13 monthly audits of five charts thereafter. Audit results will be reported to the Administrator monthly, with findings evaluated by the Quality Assurance and Performance Improvement Committee at each quarterly meeting until sustained compliance is achieved.	02/26/2026

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F0637 SS = D	Continued from page 14 revealed a Brief Interview of Mental Status (BIMS) with NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 ; NJ Exec Order 26.4b1; and transferred NJ Exec Order 26.4b1 A review of the comprehensive MDS dated NJ Exec Order 26.4 revealed, the resident with NJ Exec Order 26.4b1 NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 attempted due to NJ Exec Order 26.4b1 or NJ Exec Orde ; NJ Exec Order 26.4b1. There was no NJ Exec Orde MDS done when the resident was re-admitted on NJ Exec Order 26.4 The resident was re-admitted with NJ Exec Order 26.4b1, a NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1. On 2/20/26 at 11:32 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the resident was on NJ Exec Order 2 program from NJ Exec Order 26.4b1 She further stated that the resident came from the hospital with NJ Exec Order 2 and NJ Exec Order 26.4b1, was NJ Exec Order 2 before that, had a NJ Exec Order 26.4b1, and NJ Exec Order 2 NJ Exec Order 26.4b1; NJ Exec Order 26.4b1; no progress in NJ Exec Order 2 and reached NJ Exec Order 26.4b1 The US FO stated, "I would say, a NJ Exec Order 26.4b1, based on decline of NJ Exec Order 26.4b1", the resident was NJ Exec Order 26.4b1 now NJ Exec Order 26.4b1, NJ Exec Order 26 were now NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 prior level was NJ Exec Order 26 NJ Exec Order 26.4b1 and now NJ Exec Order 26.4b1. She further stated that she did not think "we discussed" NJ Exec Order 26.4b1 at that time. A review of the NJ Ex evaluation on NJ Exec Order 26 , revealed transfers NJ Exec Order 26.4b1) was NJ Exec Order 2 . A review of the NJ Exec Order 26.4b1) evaluation on NJ Exec Order 26 revealed NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 and on NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 On 2/20/26 at 11:51 AM, the surveyor interviewed the US FOIA (b)(6) who stated, "My US FOIA (b)(6) for the Long-Term Care" was responsible for scheduling assessment for NJ Exec Order 26.4b1 MDS, with two or more NJ Exe She further stated that if there were two	F0637		02/26/2026

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F0637 SS = D	Continued from page 15 areas of a [redacted] "we" do a NJ Exec Order 26.4b1, as per the Resident Assessment Instrument (RAI) Manual (guidance to assess residents' clinical and functional needs). On 2/20/26 at 11:59 AM, interviewed the [redacted] who stated, "I" did not complete this particular MDS, but multiple areas were triggered a NJ Exec Order 26.4b1 to be done. She also stated that the US FOIA (b)(6) [redacted] would let us know a [redacted] sometimes US FOIA (b)(6) would let us know of BIMS and if there were [redacted] the US FOIA (b)(6) for NJ Exec Order 26.4b1. She further stated, "we" communicate as a team and send a notification. She added that If they did not have their baseline, then "we" triggered the NJ Exec Order 26.4b1. US FOIA (b)(6) stated that she categorized all the ADLs as one area and would require another area of [redacted] On 2/20/26 at 1:11 PM, both the US FOIA (b)(6) [redacted] provided the surveyor with an e-mail dated 10/17/25 from US FOIA (b)(6) addressed to [redacted] regarding a possible Significant Change. There was no evidence of a [redacted] MDS being completed at this time. On that same date and time, the surveyor asked, according to the RAI manual, what was the timeframe to do a NJ Exec Order 26.4b1 assessment from the resident's physical status change. The US FOIA (b)(6) responded, "I was not involved in resident's care, we did a team meeting 12/23/25, and [redacted] proceeded", the team did not designate a NJ Exec Order 26.4b1. US FOIA (b)(6) further stated, "if I was doing that MDS I would trigger a [redacted] ". Furthermore, the US FOIA (b)(6) confirmed, it was 14 days to complete a [redacted] from the day of the determination of a [redacted] The surveyor asked, this e-mail was dated 10/17/25, and the resident was re-admitted on [redacted] should a [redacted] been completed before the [redacted], and the US FOIA (b)(6) responded "Yes". On 2/24/26 at 12:32 PM, the survey team met with the US FOIA (b)(6) [redacted]) and the US FOIA (b)(6) [redacted]) regarding the concern with [redacted] not being completed within two weeks of resident not returning to their baseline.	F0637		02/26/2026

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F0637 SS = D	Continued from page 16 On 2/25/26 at 11:22 AM, the survey team met with the US FOIA (b)(6) stated with regard to the missed [redacted] "we" did an in-service, everybody was educated on the real time to do a [redacted] A review of the facility's "Policy: MDS 3.0 Completion" revealed under Policy Explanation and Compliance Guidelines...#2 (d) SCSA-a comprehensive assessment completed within 14 days of the identification of a status change that meets the requirements.....a major decline or improvement in a resident's status that will not normally resolve itself without intervention by staff.....impacts more than one area of the resident's health status... NJAC 8:39-11.1; 11.2(i)	F0637		02/26/2026
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days	F0640	The facility is committed to ensuring the capability to transmit to the Centers for Medicare & Medicaid Services information for each resident contained in the Minimum Data Set in a format that conforms to standard record layouts and that submissions occur within the required fourteen-day timeframe following completion of the assessment. Following observations, interviews, and record reviews, a review identified that transmission confirmation for completed Minimum Data Set assessments for residents #132 and #347 required follow-up verification. The two assessments were promptly resubmitted and subsequently accepted, resulting in submission outside the required timeframe. While no harm resulted and resident care and services were not affected from these transmission issues, any resident with a Minimum Data Set assessment could be impacted by incomplete transmission and late submission. Starting on February 24, 2026, the Minimum Data Set Manager began downloading and reviewing transmission confirmation reports following each submission. Additionally, on February 26, 2026, the Minimum Data Set Manager implemented an additional audit process using the Minimum Data Set validation report from the Centers for Medicare & Medicaid Services and compared it with the weekly electronic medical record submission report to verify successful transmission and acceptance. To ensure ongoing compliance, the Director of Nursing and Minimum Data Set Manager will audit five charts weekly for four weeks, followed by monthly audits of five charts thereafter. Audit results	02/26/2026

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F0640 SS = D	Continued from page 17 after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, it was determined that the facility failed to complete and transmit the Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, within 14 days as required, for 2 of 38 residents, (Resident #132 and Resident #347), reviewed for MDS, in accordance with federal guidelines. This deficient practice was evidenced by the following: According to the Resident Assessment (RAI) Manual, dated [NJ Exec Order 26.4b1], RAI-required Assessment Summary: -The Admission (Comprehensive) assessment, the MDS completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The CAA(s) (Care Area Assessment) Completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The Care Plan Completion date is no	F0640	Continued from page 17 will be reported to the Administrator monthly, with findings evaluated by the Quality Assurance and Performance Improvement Committee at each quarterly meeting until sustained compliance is achieved.	02/26/2026

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F0640 SS = D	Continued from page 18 later than CAA(s) Completion date + 7 calendar days. The Transmission date is no later than Care Plan Completion date + 14 calendar days. -The Discharge MDS assessment return not anticipated, the MDS completion date is the Discharge Date + 14 calendar Days. The Transmission date is MDS Completion date + 14 calendar days. On 2/19/26 at 11:17 AM, the surveyor interviewed the [redacted] regarding MDS. Both the [redacted] informed the surveyor that the facility followed the RAI Manual when completing an MDS assessment. They further stated that an "Entry MDS" to be completed and submitted or transmitted within seven days, for "Discharge MDS" to be completed within 14 days and plus another 14 days for transmission, and for "Quarterly and comprehensive MDS" to be completed within 14 days and plus 14 more days for transmission. On that same date and time, the surveyor asked if they had issues of not completing and transmitting the MDS within RAI manual timelines or requirements, or did they have late completion and transmission of MDSs. The [redacted] responded that there were one or two that were late but for the most part they were able to complete and transmit MDSs in a timely manner. The surveyor then asked the [redacted] for transmission reports for Resident #132 and Resident #347, and she stated that she would get back to the surveyor. On 2/19/26 at 12:40 PM, the [redacted] met with the surveyor and provided copies of MDS transmission reports for Residents #132 and #347. The [redacted] stated while showing the documents that Resident #347's Discharge MDS with an assessment reference date (ARD) of [redacted], was completed and submitted but did not show in the transmission report that it was transmitted or accepted by CMS. The [redacted] stated that she thought it was a glitched with the electronic records that they were using. On that same date and time, she also stated that for Resident #132's MDS, the comprehensive MDS with an ARD of [redacted], was submitted but it did not show in the transmission report that it was transmitted or accepted by CMS, and it was "probably a glitch" also. On 2/19/26 at 12:53 PM, the surveyor reviewed the	F0640		02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	301 SICOMAC AVE , WYCKOFF, New Jersey, 07481

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F0640 SS = D	Continued from page 19 MDS provided by the [US FOIA (b)(6)] and MDS in the electronic medical records, and revealed: 1.Resident #132's comprehensive MDS assessment with an ARD of [NJ Exec Order 2], admission date of [NJ Exec Order 2], Care Plan Completion date was [NJ Exec Order 26.4(b)], completion date was on [NJ Exec Order 26] and was submitted (or transmitted) on [NJ Exec Order 2]. The comprehensive MDS was transmitted late, after 300 days, which should have been transmitted no later than Care Plan Completion date + 14 calendar days. 2.Resident #347's Discharge MDS assessment return not anticipated (DRNA) with an ARD of [NJ Exec Order 26], was completed on [NJ Exec Order 26] and was transmitted on [NJ Exec Order 2]. The discharge MDS was transmitted late, after 112 days, which should have been transmitted MDS Completion date + 14 calendar days. On 2/20/26 at 9:43 AM, the [US FOIA (b)(6)] confirmed that Resident #132's MDS was submitted on [NJ Exec Order 26] for an ARD of [NJ Exec Order 2], which was the admission MDS because it was not transmitted and they did not know it was not transmitted until surveyor's inquiry. The DRNA MDS of Resident #347 was submitted [NJ Exec Order 2] for an ARD of [NJ Exec Order 26], which was transmitted after surveyor's inquiry. On 2/24/26 at 12:31 PM, the survey team met with the [US FOIA (b)(6)] and the surveyor notified them of the above findings and concerns with regard to late transmissions of MDSs of Residents #132 and #347. A review of the facility's "MDS.0 Completion Policy" that was provided by the [US FOIA (b)] with an effective and original date of 10/25, revealed under Policy Explanation and Compliance Guidelines...2. Types of OBRA (Omnibus Budget Reconciliation Act of 1987, in MDS refers to federal nursing home regulations establishing mandatory, standardized assessment schedules for all residents in certified facilities, regardless of payer type) Assessments: a. Entry Tracking 1. Complete and submit with every entry into the facility no later than entry date + 7 calendar days...b. Admission Assessment-completed within 14 days of admission counting the day of admission as day #1 when:...f. Discharge Assessment-completed using the discharge date as the ARD, must be completed within 14 days of the discharge date/ARD.... On 2/25/26 at 11:21 AM, the survey team met with the [US FOIA (b)(6)] for responses for the above concerns, the [US FOIA (b)] did not provide additional	F0640		02/26/2026

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F0640 SS = D	Continued from page 20 information. NJAC 8:39 - 11.1	F0640		02/26/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete a portion of the Minimum Data Set (MDS), an assessment tool that facilitates the plan of care, to accurately reflect the resident's status for 2 of 38 residents reviewed (Residents #304 and #367).	F0641	The facility is committed to ensuring accurate Minimum Data Set coding in accordance with the Centers for Medicare & Medicaid Services Resident Assessment Instrument process. Following observations, interviews, and record reviews, a review identified opportunities to update Minimum Data Set coding for residents #304 and #367. Further review of resident #304 Minimum Data Set indicated under Section [redacted] that the resident's current [redacted] use was coded as '[redacted]'. The Minimum Data Set was subsequently reviewed and determined to require correction. On [redacted], Resident #304's Minimum Data Set was modified to correctly state, '[redacted]'. On February 25, 2026, resident #367 Minimum Data Set coding reflected in Section [redacted] that the assessment was coded as '[redacted] - Discharge assessment - return not anticipated," and Section A2105, Discharge Status, was coded as '[redacted] - [redacted]". Section [redacted] indicated that active discharge planning was already occurring for the resident to return to the community. The Minimum Data Set was reviewed and modified to ensure Section A2105 accurately reflected the resident's discharge status. While no harm resulted from these coding issues and the residents' care and services continued to be appropriately provided, any resident with a Minimum Data Set could be impacted by inaccurate coding. To prevent future issues, on February 25, 2026, the Minimum Data Set Manager re-educated the Minimum Data Set coordinators on proper coding practices, as outlined in the Resident Assessment Instrument Manual. Additionally, on February 26, 2026, the Minimum Data Set Manager and Director of Nursing implemented a monthly audit tracker utilizing the Minimum Data Set Resident-Level Quality report to monitor coding accuracy related to resident health conditions and discharge assessments. To ensure ongoing compliance, the Director of Nursing and Minimum Data Set Manager will audit five charts weekly for four weeks, followed by monthly audits of five charts thereafter. Audit results	02/26/2026

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F0641 SS = D	Continued from page 21 This deficient practice was evidenced by the following: 1.On 2/17/26 at 10:32 AM, Surveyor #1 (S #1) observed Resident #304 lying in bed asleep. Resident #304's [NJ Exec Order 26.4b] stated that sometimes the resident went outside with staff to [NJ Exec Order] On 2/18/26 at 11:02 AM, S #1 interviewed the US FOIA (b)(6) who stated that Resident #304 was allowed to [NJ Exec Order 26.4b1] a day but that the resident did not [NJ Exec Orde] every day. A review of Resident #304's Resident Face Sheet (RFS, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: [NJ Exec Order 26.4b1] [redacted] A review of Resident #304's individualized comprehensive care plan (CP) reflected a focus area for [NJ Exec Order 26.4] A review of Resident #304's most recent comprehensive Minimum Data Set (cMDS) reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [N] out of 15, which indicated that Resident #304's [NJ Exec Order 26.4] was [NJ Exec Order 26.4b1] [redacted] Further review of the MDS indicated under Section [N] that the resident's current [NJ Exec Order 2] use was coded as no. The MDS was coded incorrectly. On 2/24/26 at 11:15 AM, S #1 interviewed the MDS US FOIA (b)(6) regarding the process for MDS assessment for a resident that [NJ Exec Order 26] The [US FOIA (b)(6)] stated that on the comprehensive there was a question for [NJ Exec Order 2] use. S #1 asked if Resident #304 [NJ Exec Order 26] The [US FOIA (b)(6)] stated that Resident #304 [NJ Exec Order 26] S #1 asked the [US FOIA (b)(6)] to view Resident #304's last cMDS. The [US FOIA (b)(6)] stated that she was not the one that did Resident #304's cMDS and that she would have to talk to the person who did. On 2/24/26 at 11:58 AM, S #1 interviewed the US FOIA (b)(6)) who stated that Resident #304 had [NJ Exec Order 2] since [NJ Exec] had been at the facility. S #1 asked the [US FOIA (b)] if Resident #304's MDS should indicate that the resident [NJ Exec Order 26] and the [US FOIA (b)] stated that she would expect it to be on the MDS.	F0641	Continued from page 21 will be reported to the Administrator monthly, with findings evaluated by the Quality Assurance and Performance Improvement Committee at each quarterly meeting until sustained compliance is achieved.	02/26/2026

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F0641 SS = D	Continued from page 22 On 2/24/26 at 12:45 PM, S #1 notified the [US FOIA (b)(6)] the concern that Resident #304's MDS was not coded accurately for the resident's [NJ Exec Order 2] use. On 2/25/26 at 11:26 AM, in the presence of the [US FOIA (b)(6)] the [US FOIA (b)] stated that the MDS was modified and that education was provided to staff on MDS accuracy. The [US FOIA (b)] did not provide any additional information. The facility did not provide a policy regarding MDS accuracy. 2. On 2/25/26 at 10:30 AM, Surveyor #2 (S #2) reviewed the MDS Section A revealed under Section A0310G, Type of Discharge, was coded as '[NJ] - Unplanned". Further review of the MDS Section A0310F reflected that the assessment was coded as '[NJ E] - Discharge assessment - return not anticipated," and Section A2105, Discharge Status, was coded as [NJ Exec O] ". Section Q0400 indicated that active discharge (d/c) planning was already occurring for the resident to return to the community. A review of the Nursing Progress Note (PN) dated [NJ Exec Order] at 4:04 PM, revealed that the resident was discharged to home at 3:00 PM. The PN further indicated that the Resident's Representative (RR) and resident were informed of all d/c instructions, physician follow-up appointments, and medication reconciliation was completed. The resident left the building [NJ Exec O] and [NJ Exec Order 26.4b1] with all [NJ Exec Order 26.4b1] A review of the Medical Discharge Summary, electronically signed on [NJ Exec Orde], reflected a d/c date of [NJ Exec Order], with a condition noted as [NJ Exec Orde] and follow-up with the primary care physician was scheduled within 35 days. A review of the CP dated [NJ Exec Order] revealed d/c goals including: the resident would be discharged within 30 days, would attain and be discharged at optimal level of functioning, and would be discharged to the appropriate level of care. All goals were documented as "Discharged" with an effective date of [NJ Exec Order]. A review of the [NJ Exec Order] d/c summaries [NJ Exec Order 26]	F0641		02/26/2026

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F0641 SS = D	Continued from page 23 [redacted] all signed on [redacted] consistently documented the d/c reason as "Discharged to [redacted] and reflected that the patient made progress throughout the plan of treatment and was discharged with [redacted]. None of the therapy documentation indicated an unplanned or emergent d/c. On 2/25/26 at 10:55 AM, S #2 interviewed the [redacted] regarding the inaccuracy identified in Resident #367's MDS. The [redacted] stated, "It is planned because he is going home". When asked if she saw the section checked off as unplanned, she responded, "Yes I see it," and further stated, "It should have been planned". She further stated that it was not a d/c [redacted]. She also stated that if the resident went home or to another facility it was usually a planned d/c. She added that a [redacted] completed the MDS assessment and the cause of the inaccuracy was human error. A review of the facility's "MDS 3.0 Assessment Process Policy", reviewed on 10/2025, by the [redacted] revealed under Policy that the current version of the RAI Manual will be utilized when conducting a comprehensive assessment. The MDS 3.0, according to federal regulations, requires the facility to conduct accurate and standardized assessments of each resident's functional capacity using the RAI, including for d/c planning... NJAC 8:39-33.2(d)	F0641		02/26/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Complaint #2708006 Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to, a.) administer a medication (med) to a resident (Resident # 239) without a valid physician's order (PO) and b.) document the administration of med and reason as to why med was not administered according to PO	F0658	The facility's policy is to provide services as outlined in the comprehensive care plan, while consistently maintaining professional quality standards. Resident #239 was discharged from the facility on [redacted] and resident #371 was discharged on [redacted]. On February 24, 2026, a review of resident #239 closed record dated [redacted], reflected a nursing note indicating that the resident received a medication that had been prepared for another resident. The documentation reflected that the medication was [redacted] a medication commonly used to treat [redacted]. An investigation was completed in December 2025 which confirmed [redacted] were noted. The provider and responsible party were notified at that time. The nurse involved received re-education, and additional education was provided to the nursing staff regarding adherence to safe medication administration practices.	02/26/2026

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F0658 SS = D	Continued from page 24 (Resident #371), in accordance with professional standards and facility's policies and procedures. The deficient practices were identified on 2 of the 38 residents medications reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.On 2/19/26, Surveyor #1 (S #1) reviewed the electronic and paper medical record (MR) for Resident #239. A review of the MR revealed a Resident Face Sheet (RFS, an admission summary) that reflected that the resident was previously admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of Resident #239's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Exec Order 26 [redacted], reflected, in Section NJ Exec Order 26.4b1 Status, that the resident had a Brief Interview for Mental Status (BIMS) score of NJ E [redacted] out of 15, which indicated that Resident #239 had NJ Exec Order 26.4b1 [redacted]. On 2/24/26 at 11:39 AM, S #1 interviewed the US FOOD [redacted] for the unit where Resident #239 had	F0658	Continued from page 24 A review of resident #371 identified that documentation related to administration of the as-needed medication, NJ Exec Order 26.4b1 [redacted] during episodes of NJ Exec Order 2 [redacted] or NJ Exec Order 26 [redacted] required clarification. While no harm resulted, all residents who have routine and an as- needed medication order outlined in their plan of care can benefit from the improved process. To ensure all residents requiring routine and as needed medications receive the highest standard of care, additional education was provided to nursing staff on February 24, 2026, emphasizing adherence to the safe medication administration process and appropriate documentation for routine and as-needed medication. Additionally, the Pharmacy Consultant will provide a monthly report regarding medication errors and as-needed medication utilization for ongoing monitoring and review. The Assistant Director of Nursing/Team Lead will review five residents' routine and as needed medication orders to verify accurate administration and documentation. These audits will be monitored by the Director of Nursing weekly for four weeks, followed by monthly reviews of five charts thereafter to maintain adherence to the established protocols. Audit findings will be reported to the Administrator each month. The effectiveness of these measures will be evaluated by the Quality Assurance and Performance Improvement Committee during each quarterly meeting, until sustained compliance is achieved.	02/26/2026

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F0658 SS = D	Continued from page 25 resided and asked if they remembered the resident and if there were any concerns the resident voiced. The [US FOIA] stated that they did recall the resident somewhat but wanted to check their notes and get back to S #1. On 2/24/26 at 11:49 AM, S #1 interviewed the [US FOIA (b)] assigned to the unit where Resident #239 had resided and asked if they remembered the resident and if there were any concerns the resident voiced. The [US FOIA] stated that they did remember the resident but wanted to check their notes for anything specific and get back to S #1. On 2/24/26 at 1:08 PM, S #1 asked the [US FOIA (b)(6)] about the information requested from the US FOIA (b)(6) The [US FOIA (b)] stated that they would check. On 2/25/26 at 9:51 AM, the [US FOIA (b)] provided the requested information that S #1 requested for Resident #239. The provided documents revealed incident reports and timelines, progress notes (PN), individual statements, and records of remedial education. A review of the document titled Statement Form dated [NJ Exec Order 26], reflected a statement from a nurse that they had given the resident a med intended for another resident. The statement reflected that the med was [NJ Exec Order 26.4b1] (a med used for [NJ Ex Order 26.4(b)] NJ Exec Order 26.4b1). A second Statement Form dated [NJ Exec Order 26], reflected a statement from a different nurse that the resident had reported to them that another nurse had given them an [NJ Exec Order 26.4b1]" and they refused a [NJ Exec Order] that was offered because they were not on that med. A document titled Record of Additional/Remedial Education dated [NJ Exec Order 26.4b] reflected that the nurse who stated that they gave med to the wrong resident received additional education on safe med administration. The facility did not provide any further pertinent information. A review of the facility's "Policy: Medication Administration", dated effective 1/26, the policy	F0658		02/26/2026

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F0658 SS = D	Continued from page 26 reflected under, 3. Identify resident/patient using 2 identifiers: photo in the MAR (Medication Administration Record) and or patient/resident identification wrist band, and/or ask and confirm the resident/patient's name if cognitive intact...10. Ensure that the six rights of med administration are followed. a. Right resident b. right drug... 2.On 2/17/26 at 10:51 AM, Surveyor #2 (S #2) observed Resident #371's door with posted sign for [redacted]). Inside the room, the Resident Representative (RR) was seated in a regular chair and Resident #371 was on bed, [redacted] and [redacted] The RR informed S #2 that the resident [redacted] from [redacted] and [redacted]". S #2 reviewed the MR for Resident #371. A review of the RFS, reflected that Resident #371 was admitted to the facility with the diagnoses which included but not limited to; [redacted] A review of the MDS) revealed that it was in progress and to be completed. A review of the PO, dated [redacted], order for ondansetron [redacted]) tablet (tab), give 1 tab [redacted] by [redacted] every 8 hours as needed (PRN) for [redacted] The above order for [redacted] was transcribed to the Resident Medication Administration Record (RMAR) as PRN med. The RMAR was signed for PRN on [redacted] A review of the PN, dated [redacted] at 11:58 AM, electronically signed by Registered Nurse #1 (RN #1), under action, "keeping in mind that patient (also known as resident) [redacted] 11-7 shift after previous [redacted] (as reported by Registered Nurse #2 (RN #2)..." Further review of the PN revealed the following	F0658		02/26/2026

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F0658 SS = D	Continued from page 27 documentations: -On [redacted] at 7:09 AM, electronically signed by RN #2, "Resident had 1 x [redacted] at 6:20 AM..." -On [redacted] at 11:50 PM, electronically signed by [redacted], "Patient c/o (complaint of) [redacted] tab PRN given with [redacted] results..." -On [redacted] at 2:54 PM, electronically signed by RN #3, under response: "PRN [redacted] (also known as [redacted] given for [redacted] with [redacted] Further review of the MR revealed that there was no documented evidence that the PRN [redacted] was administered on [redacted] at 7:09 AM or as to why the med was not administered when the resident had [redacted]. In addition, there was no documented evidence that the RMAR was signed by nurses when the PRN [redacted] was administered on [redacted] at 11:50 PM and [redacted] at 2:54 PM according to the PN. On 2/24/26 at 12:31 PM, the survey team met with the [redacted] and S #2 notified them of the above findings and concerns with regard to PRN ondansetron. A review of the facility's "Policy: Medication Administration" that was provided by the [redacted] with an effective date of 1/26, revealed under policy, medications (meds) are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice...Policy Explanation and Compliance Guidelines:..11. Review MAR to identify med to be administered...17. Sign MAR after administered... On 2/25/26 at 11:21 AM, the survey team met with the [redacted] in responses to the above concerns. The [redacted] stated that the ondansetron administered should have been signed by the nurse in the RMAR and should have followed the PO. She also acknowledged that there should have been documentation as to why the PRN ondansetron was not administered and the non-pharmacological interventions were tried first prior to giving med. NJAC 8:39-11.2(b); 29.2 (b)(d)	F0658		02/26/2026
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition	F0693	The facility's policy is to provide [redacted] for residents at risk of [redacted], and ensure that [redacted] is monitored closely in accordance with [redacted] and physician orders and recommendations.	02/26/2026

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F0693 SS = D	Continued from page 28 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: REPEAT DEFICIENCY Based on interview and record review, it was determined that the facility failed to follow the physician's orders with regard to NJ Exec Order 26.4b1 [redacted] administration to assure the NJ Exec Order 26.4b1 was administered. This deficient practice was identified for 1 of 2 residents, (Residents #11), reviewed for NJ Exec Order 26.4b1 This deficient practice was evidenced by the following: On 2/24/26 at 12:53, the surveyor reviewed the closed medical records of Resident #11 and revealed: A review of the Resident Face Sheet (an admission summary) revealed that Resident #11 was admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted]. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of NJ Exec Order [redacted], with a	F0693	Continued from page 28 All residents receiving enteral nutrition can benefit from the strengthened documentation process. On February 24, 2026, a review of resident #11's closed electronic medical record identified an opportunity to improve documentation related to the NJ Exec Order 26.4b1 administered during the month of NJ Exec Order 26 [redacted]. To enhance the care of all residents receiving supplemental caloric support via enteral nutrition, re-education was conducted for the nursing staff on February 26, 2026. This training focused on the importance of accurately documenting the total volume of enteral nutrition administered, ensuring that daily weights are recorded in the Medication Administration Record, and promptly notifying physicians of any variances from ordered nutritional support. To ensure compliance and documentation accuracy, the Quality and Clinical Education Manager will conduct weekly audits of five medical records for residents receiving nutritional support via tube feeding weekly for four weeks and five charts monthly thereafter. The Director of Nursing will oversee these audits to ensure compliance, and audit findings will be reported to the Administrator monthly. The effectiveness of these measures will be evaluated by the Quality Assurance and Performance Improvement Committee during each quarterly meeting until sustained compliance is achieved.	02/26/2026

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F0693 SS = D	Continued from page 29 brief interview for mental status (BIMS) score of [redacted] out 15, indicated that resident's [redacted] was [redacted]. In Sectio [redacted], Resident #11 was coded as [redacted] through a [redacted] while a resident. A review of the physician's order (PO) dated [redacted], indicated the resident was [redacted] A review of the PO dated [redacted], reflected an order for [redacted] method via [redacted]) for 18 hours or until [redacted] has been delivered. Stop time: 1 PM (1:00 PM). The above order for [redacted] was transcribed to the Resident Medication Administration Record (RMAR), plotted at 1:00 PM, and signed by nurses as administered from [redacted]. The following dates were signed by nurses with [redacted] documented was not according to the PO of [redacted] [redacted] documented was [redacted] [redacted] documented was [redacted] [redacted] was blank [redacted] documented was [redacted] [redacted] was blank On 2/25/26 at 8:59 AM, the surveyor interviewed the US FOIA (b)(6)) and asked what the facility's process and expectation for the nurses with regard to PO in the RMAR was. The [redacted] responded, to follow the orders and clarify if needed. The surveyor notified the [redacted] of the above findings and concerns with PO with regard to [redacted] of [redacted] was not followed. A review of the facility's "Policy: Enteral Feeding and Accidental Tube Displacement" that was provided by the DON, with an effective date of 11/25, reflected under enteral feedings, preparation, 1. Verify physician's order…III. Additional Nursing Care/Responsibilities/Documentation…2. Document amount of residual, type and amount of feedings as administered… On 2/25/26 at 11:21 AM, the survey team met with the US FOIA (b)(6) [redacted] for responses for the above concerns. The	F0693		02/26/2026

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F0693 SS = D	Continued from page 30 US FOIA (b)(6) did not provide additional information. NJAC 8:39-25.2(c)2; 27.1 (a)	F0693		02/26/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Repeat Deficiency Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary NJ Exec Order 26.4b1 care and services of residents that were receiving [redacted] according to the standard of clinical practice and the facility's policy and procedure, specifically, ensuring the appropriate rate of NJ Exec Order delivery was set for 1 of 3 residents, Resident #172 and by documenting the date and time the NJ Exec Order NJ Ex Order was changed for 1 of 3 residents, Resident #102. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of	F0695	The facility is committed to ensuring physician orders pertaining to the use of continuous oxygen are followed and that care aligns with professional standards, the comprehensive person-centered care plan, and each resident's goals and preferences. On February 17, 2026, the NJ Exec Order 26.4b1 for resident #102 was observed to require updated dating, and the NJ Exec Order 26.4b required replacement according to facility protocol. As a result, both the NJ Exec Order and NJ Exec Order 26.4b were immediately replaced and appropriately dated. On February 17, 2026, the surveyor observed resident #172's NJ Exec Order 26.4b1 setting documented at NJ Exec Order 26.4b1. A review of the medication administration record revealed an order for NJ Exec Order [redacted]. The NJ Exec Order 26.4b1 was promptly adjusted to align with the physician's order, and staff were provided with additional education regarding verification of NJ Exec Order settings in accordance with the resident's care plan and physician orders. While NJ Exec Order 26 resulted in either situation, all residents on an NJ Exec Order therapy regimen can benefit from this improved process. The clinical educators provided additional education to the nursing staff on February 24, 2026 regarding the facility policy for oxygen tubing management, humidifier replacement and appropriate dating of equipment. In addition, the Assistant Director of Nursing/Team Lead conducted rounds to verify adherence to the oxygen therapy policy and procedure, which included dating tubing, proper storage of tubing and the placement and dating of humidifiers. These rounds were completed on February 24, 2026. For residents on continuous oxygen therapy, the respiratory therapist will conduct weekly rounds to ensure the current physician order and oxygen settings continue to meet the resident's needs. The respiratory therapist will immediately communicate any findings to the Assistant Directors of Nursing or Team Lead and work with nursing to adjust the order and care plans, if necessary.	02/26/2026

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F0695 SS = D	Continued from page 31 nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.On 2/17/26 at 10:25 AM, during the initial tour of the facility, the surveyor observed Resident #102 in bed, sleeping, with an NJ Exec Order 26.4b1 applied and NJ Exec Order 26.4b1 to an NJ Exec Order 26.4b1 The surveyor observed that the NJ Exec Order 26.4b1 was set to deliver NJ Exec Order 26.4b1 and the NJ Exec Orde was connected to a NJ Exec Order 26.4b1 The surveyor observed that the NJ Exec Orde and NJ Exec Order 26.4b1 had the date of NJ Exec Orde written in marker. The surveyor reviewed the electronic medical record (eMR) for Resident #102. A review of the Resident Face Sheet (RFS; an admission record) that reflected that the resident was admitted to the facility with diagnoses which included but not limited to NJ Exec Order 26.4b1 A review of the resident's Quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Exec Order 26.4, Section NJ E revealed a Brief Interview of Mental Status (BIMS) score of N of 15, indicating that the resident had NJ Exec Order 26.4b1 A review of the resident's Physician Order Sheets (POS) (a list of the resident's active medication and other orders) revealed the following orders: 1) an order that reflected Monitoring: Check for use of NJ Exec Schedule: Every week on Thursday... 2) NJ Exec Order 26.4b1 A review of the Resident Medication Administration Record (RMAR) revealed an order for the 11:00 PM-7:00 AM shift that reflected: Check for use of NJ Exec Order 26.4b1 weekly - NJ Exec Order 26.4b1	F0695	Continued from page 31 Furthermore, the Assistant Directors of Nursing/Team Lead, in collaboration with the respiratory therapist, will conduct weekly rounds for four weeks for residents receiving oxygen therapy to verify the tubing and humidifiers are appropriately dated and equipment is functioning according to facility policy. These audits will be monitored weekly by the Director of Nursing for four weeks, followed by monthly reviews of five charts thereafter to maintain adherence to the established protocols. Audit findings will be reported to the Administrator each month. The effectiveness of these measures will be evaluated by the Quality Assurance and Performance Improvement Committee at each quarterly meeting.	02/26/2026

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F0695 SS = D	Continued from page 32 and [redacted]. The RMAR also reflected that the order was documented as completed on [redacted] and [redacted]. A review of the resident's Comprehensive Care Plan (CCP) revealed an intervention that reflected: Check for use of NJ Exec Order 26.4b1 [redacted] 2. On 2/17/26 at 10:27 AM, the surveyor observed Resident #172, in their room, seated in a wheelchair (w/c) with an NJ Exec Order 26.4b1 to a [redacted]. The surveyor asked the resident how they use their [redacted]. The resident stated that they use it all the time and need it day and night. The surveyor observed the [redacted] setting reflected [redacted]. The surveyor reviewed the eMR for Resident #172. A review of the RFS reflected that the resident was admitted to the facility with diagnoses which included but not limited to NJ Exec Order 26.4b1 [redacted] A review of the resident's cMDS, with an ARD of NJ Exec Order 26.4b1, revealed a BIMS score of [redacted] of 15, indicating that the resident had [redacted]. Section [redacted] revealed that the resident was receiving [redacted]. A review of the resident's POS revealed the following orders: 1) an order that reflected: NJ Exec Order 26.4b1 [redacted]. A review of the RMAR revealed an order for [redacted]. A review of the resident's CCP revealed an intervention that reflected: NJ Exec Order 26.4b1 [redacted] On 2/20/26 at 10:23 AM, the surveyor interviewed the US FOIA (b)(6)) about the policy for NJ Exec Order 26.4b1 and [redacted] settings. The [redacted] stated that both the NJ Exec Order 26.4b1 and nurses are responsible for [redacted] and appropriate settings. On 2/24/26 at 12:31 PM, the survey team met with the US FOIA (b)(6) [redacted]	F0695		02/26/2026

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F0695 SS = D	Continued from page 33 and [US FOIA (b)(6)]), and the surveyor notified them of the observations for Resident #102 and #172. The surveyor asked the [US FOIA (b)] who was responsible for [NJ Exec Order 26.4b1] settings. The [US FOIA (b)] stated that both the [NJ Exec Order 26.4b1] and nurses were responsible for [NJ Exec Order 26.4b1] and appropriate settings. On 2/25/26 at 11:22 AM, the survey team met with the [US FOIA (b)(6)] stated that education was conducted for staff relating to [NJ Exec Order 26.4b] and [NJ Exec Order 26.4b] dating and correct settings. The [US FOIA (b)] did not provide any further pertinent information. A review of the facility's "Policy: Respiratory Therapy", date effective 2/26, the policy reflected, under Subject: Oxygen Therapy, Procedure: 14: Change all disposable equipment weekly or per Institution's infection control guidelines... NJAC 8:39-11.2(b); 27.1(a)	F0695		02/26/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F0755	It is the facility's policy to ensure residents are provided with routine or emergency drugs, biologicals, and that medications are obtained and administered in accordance with established agreements and physician orders. Residents #4, #11 and #369 have been discharged. A review of resident #11 closed medical record identified an opportunity to strengthen documentation related to the [NJ Exec Order 26.4b] parameter order. The resident was discharged prior to annual recertification. A review of resident #369 closed medical record identified an opportunity to strengthen documentation related to the [NJ Exec Order 26.4b1] administered. The resident was discharged prior to annual recertification. On February 24, 2026, the facility was informed that the review of resident #4 medical record identified an opportunity to strengthen documentation related to the [NJ Exec Order 26.4b1] dose administered. The resident was discharged on [NJ Exec Order 26.4b1]. While [NJ Exec Order 26] resulted, all residents that have medications with parameter order outlined in their	02/26/2026

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F0755 SS = D	Continued from page 34 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure a.) the NJ Exec Or [redacted] medications were administered for Resident #11, in accordance with the physician's orders (PO) and b.) the NJ Exec Orde [redacted] was administered and documented in accordance with the PO for Residents #4 and #369. The deficient practices were identified on 3 of the 38 residents medications reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 2/24/26 at 12:53, Surveyor #1 (S #1) reviewed the closed medical records of Resident #11 and revealed:	F0755	Continued from page 34 plan of care can benefit from the improved process. On February 24, 2026 the clinical educators provided additional education to nursing staff regarding the facility policy on medication administration and documentation requirements, specifically related to blood pressure parameters and insulin parameter orders. To ensure consistent quality of care for all residents with parameter orders, the Assistant Director of Nursing/Team Lead will review five residents' charts with parameter orders weekly for four weeks and monthly thereafter to verify orders are implemented and documented in accordance with physician orders and facility policy. These audits will be monitored by the Quality Nurse weekly for four weeks, followed by monthly reviews of five charts thereafter to maintain adherence to the established protocols. Audit findings will be reported to the Administrator each month. The effectiveness of these measures will be evaluated by the Quality Assurance and Performance Improvement Committee during quarterly meetings, with adjustments made as needed to achieve sustained compliance.	02/26/2026

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F0755 SS = D	Continued from page 35 A review of the Resident Face Sheet (RFS; an admission summary) revealed that Resident #11 was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of [redacted] with a brief interview for mental status (BIMS) score of [redacted] out 15, indicated that resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. A review of the PO dated [redacted], reflected an order for NJ Exec Order 26.4b1 [redacted]. A review of the PO dated [redacted], reflected an order for NJ Exec Order 26.4b1 give NJ Exec Order 26.4b1 [redacted]. The above order for [redacted] was transcribed to the Resident Medication Administration Record (RMAR), plotted as PRN, and signed by nurses as administered on NJ Exec Order 26.4b1 with following [redacted] [redacted] at 4:44 PM, [redacted] [redacted] at 10:00 AM, [redacted] [redacted] at 7:05 PM, [redacted] Further review of the PRN PO for [redacted] revealed NJ Exec Order 26.4b1 [redacted] at 7:05 PM, which was four hours prior to bedtime, and the PO was not followed.	F0755		02/26/2026

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F0755 SS = D	Continued from page 36 The above order for [NJ Exec Order 26.4b1] was transcribed to the RMAR, plotted at 8 AM, and signed by nurses as administered, and there were no documented evidence that the [NJ Ex] was obtained when the med was administered from [NJ Exec Order 26.4b1] according to PO. On 2/25/26 at 8:59 AM, S #1 interviewed the [US FOIA (b)(6)] and asked what the facility's process and expectation for the nurses with regard to PO in the RMAR and medications (meds) with parameters were. The [US FOIA (b)] responded, to follow the orders and clarify if needed. The [US FOIA (b)] further stated that the parameters for [NJ Ex] should be monitored and documented in the RMAR. On that same date and time, S #1 notified the above findings and concerns with PO with regard to meds [NJ Exec Order 26.4b] and [NJ Exec Order 26.4b1] and the order with regard to parameters were not followed. The [US FOIA (b)] also reviewed and printed the [NJ Ex] of the resident for [NJ Exec Order 26.4b1] from the Monitoring tab of the electronic medical records, and she acknowledged that the [NJ Ex] did not include information that the [NJ Ex] was checked at 8 AM, or at least an hour before and an hour after as required in the PO for [NJ Exec Order 26.4b1] The [US FOIA (b)] also provided a copy of the [NJ Ex Order 26.4(b)(] administration audit report that showed that the resident received the [NJ Exec Order 26.4b] med on [NJ Exec Order 26.] at 7:05 PM. The [US FOIA (b)] further stated that the bedtime hour was at 9:00 PM, and the 7:05 PM time when the [NJ Exec Order 26.4b] was administered did not follow the PO. A review of the facility's "Policy: Medication Administration" that was provided by the [US FOIA (b)] with an effective date of 1/26, revealed under policy, meds are administered by licensed nurses as ordered by physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection…Policy Explanation and Compliance Guidelines:..8. Obtain and record vital signs, when applicable or per PO. When applicable, hold med for those vital signs outside the physician's prescribed parameters… On 2/25/26 at 11:21 AM, the survey team met with the [US FOIA (b)(6)] and [US FOIA (b)] for responses for the above concerns. The [US FOIA (b)(6)] did not provide additional information. 2. On 2/17/26 at 11:00 AM, Surveyor #2 (S #2) observed Resident #4 lying in bed.	F0755		02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0755 SS = D	Continued from page 37 On 2/18/26 at 10:25 PM, S #2 reviewed the electronic medical record of Resident #4. A review of Resident #4's RFS reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] A review of Resident #4's most recent comprehensive MDS reflected that the resident had a BIMS score of [redacted] out of 15, which indicated that Resident #4's [redacted]. A review of Resident #4's [redacted] RMAR included the following order: [redacted] per prescriber's instructions. [redacted] dosing requires [redacted] [redacted] Further review reflected that the nurse did not indicate how many units of [redacted] were given at the 4:30 PM time on [redacted] and at the 9:00 PM time on [redacted] and [redacted] On 2/19/26 at 10:10 AM, S #2 interviewed the [redacted] who stated that the [redacted] result, how many units of [redacted] where administered and the nurses initials were documented in the RMAR. S #2 asked the [redacted] to view Resident #4's RMAR. The [redacted] stated that the nurse should have written the dose given. On 2/19/26 at 10:17 AM, S #2 interviewed the	F0755		02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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F0755 SS = D	Continued from page 38 US FOIA (b)(6)) who stated that she would expect the units given would be documented since the dose depended on the [redacted] result. 3. On 2/18/26 at 12:51 PM, S #2 reviewed the hybrid (electronic and paper) medical records of Resident #369. A review of Resident #369's RFS reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted]. A review of Resident #369's most recent Discharge Assessment Return Anticipated MDS (DRAMDS) reflected that the resident had a BIMS score of [redacted] out of 15, which indicated that Resident #369's [redacted] was [redacted]. A review of Resident #369's [redacted] RMAR included the following order: NJ Exec Order 26.4b1 [redacted]	F0755		02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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F0755 SS = D	Continued from page 39 Monitoring: [redacted] with a start date: [redacted] Further review reflected that the nurse did not indicate how many units of [redacted] were given at the 4:30 PM time on NJ Exec Order 26.4b1 and at the 9:00 PM time on NJ Exec Order 26.4b1 [redacted] On 2/20/26 at 12:22 PM, S #2 interviewed the [redacted] who stated that for NJ Exec Order 26.4b1 order the expectation was for the nurse to document the [redacted] given, the [redacted] the [redacted] result and the nurses initials. The surveyor asked the [redacted] to view Resident #369's RMAR. The [redacted] confirmed that the [redacted] given was not documented on some shifts and that she was going to look into it. On 2/24/26 at 12:45 PM, S #2 notified the US FOIA (b)(6) [redacted] the concern that Resident #4 did not have the dosage of [redacted] documented for multiple days and shifts on the [redacted] RMAR and Resident #369 did not have the dosage of [redacted] documented for multiple days and shifts on the [redacted] RMAR. On 2/25/26 at 11:27 AM, in the presence of the US FOIA (b)(6) stated that she educated the nurse that had missed documenting the dose and that she also in-serviced all staff. A review of the facility's "Timely Administration of Insulin Policy" with an effective date of 11/25, included the following, Policy: It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. Policy Explanation and Compliance Guidelines: 4. Procedure: f. Document on the medication administration record the time and location of the insulin injection. The policy did not contain any information on [redacted] dosage or documenting the amount of [redacted] given per [redacted]. NJAC 27.1(a)	F0755		02/26/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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-	F0757	The facility is committed to ensuring all residents who receive psychoactive medications- including anti-psychotic, anti-anxiety agents, mood stabilizing agents, anti-depressants, sedative hypnotics or related medications- are appropriately monitored for effectiveness of therapy, potential side effects, and that documentation reflects the clinical indication for use in accordance with professional standards of practice.	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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F0757 SS = D	Continued from page 40 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of the medical records and other facility documentation, it was determined that the facility failed to, a.) provide adequate monitoring for the use of [redacted] medications (meds) for 1 of 6 residents reviewed for [redacted] meds (Resident #371) and b.) ensure that the resident did not receive an unnecessary medication (med) by duplicate and incomplete med orders, for 1 out 3 residents, (Resident #374), observed during the med pass observation. The deficient practice was evidenced by: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as	F0757	Continued from page 40 On February 24, 2026, the facility was informed that a review of resident #371's medical record identified an opportunity to enhance care plan documentation related to monitoring of the [redacted] medication [redacted]. The medication was being used [redacted] to support management of [redacted] and [redacted] associated with [redacted] treatment. The care plan required clarification to reflect the specific clinical use of the medication. Resident #371 has since been discharged. While [redacted], all residents that have [redacted] use of [redacted] medications can benefit from the improved process. The medical records of residents currently receiving psychoactive medications for off-label indications were reviewed to ensure that care plans appropriately reflect monitoring parameters and clinical indications for use. To ensure consistent quality care for all residents on psychoactive medications, the Quality Nurse will complete reviews for five residents' charts with psychoactive medication orders weekly for four weeks and five charts monthly thereafter to verify that monitoring parameters and indications for use are appropriately reflected in the resident's care plan. These audits will be monitored by the Director of Nursing weekly for four weeks, followed by monthly reviews thereafter to maintain adherence to the established protocols. Audit findings will be reported to the Administrator each month. The effectiveness of these measures will be evaluated by the Quality Assurance and Performance Improvement Committee during quarterly meetings until sustained compliance is achieved.	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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F0757 SS = D	Continued from page 41 performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.On 2/17/26 at 10:51 AM, Surveyor #1 (S #1) observed Resident #371's door with posted sign for NJ Exec Order 26.4b1). Inside the room, the Resident Representative (RR) was seated in a NJ Exec Order chair and Resident #371 was on bed, awake and NJ Exec Order 26.4b1. The RR informed S #1 that the resident NJ Exec from home, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1". S #1 reviewed the medical records for Resident #371. A review of the Resident Face Sheet (RFS, an admission summary) reflected that Resident #371 was admitted to the facility with the diagnoses which included but not limited to; NJ Exec Order 26.4b1 [redacted] A review of the Minimum Data Set (MDS), an assessment tool, revealed that it was in progress and to be completed. A review of the Physician's Orders (PO), dated NJ Exec Order 2, order for NJ Ex Order 26.4(b)(1 (also known by the brand name NJ Exec Order 26.4b1 [redacted] route once daily at bedtime for NJ Exec Order 26.4b1. The order was discontinued on NJ Exec Order 2. A review of the PO dated NJ Exec Order 2, order for NJ Exec Order 26.4b1 tab, give 1 tab NJ Exec Order 26.4b1 once daily at bedtime for NJ Exec Order 26.4b1 Schedule: every day at 9:00 PM (9 PM). A review of the PO dated NJ Exec Order 2, monitor NJ Exec Orde) as per care plan (CP) for NJ Exec Order 26.4b1	F0757		02/26/2026

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F0757 SS = D	Continued from page 42 meds… The above order to monitor [NJ Exe] was transcribed to the Resident Medication Administration Record (RMAR), plotted for 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM, and signed by nurses as monitored. There was no documented [NJ Exe] in the RMAR. The RMAR was initialed by nurses. A review of Resident #371's Care Plan Activity Report (CPAR) revealed a focus on [NJ Exec Order 26.4b1] with an effective date of [NJ Exec Order 26.4b] etiology: resident receives [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4b1] and at risk for side effects (s/e). Additional detail: [NJ Exec O] [NJ Exec O] Further review of Resident #371's CPAR revealed there was no documented evidence that a [NJ Exe] for med [NJ Exec Order 26.4b1] to adequately monitor the use of this NJ Exec Order 26.4b1 On 2/24/26 at 12:31 PM, the survey team met with the US FOIA (b)(6) and the surveyor notified them of the above findings and concerns with regard to no adequate monitoring for the use of [NJ Exec Order 26.4b1] med [NJ Exec Order 26.4b1] and there was no CP for the [NJ Exe] of the med according to the PO. A review of the facility's "Policy: Psychotropic Drug Use" that was provided by the [US FOIA (b] with an effective date of 11/25, revealed under purpose, to ensure that all resident's receiving antipsychotic, anti-anxiety agents…antidepressants…for the treatment of specific behavioral disturbances will be monitored for effectiveness of therapy and occurrence of potential s/e and will be documented appropriately… On 2/25/26 at 11:21 AM, the survey team met with the US FOIA (b)(6) stated that she acknowledged the lack of documentation for [NJ Exec Order 26.4b1] and there was no CP for [NJ Exec Order 26.4b1] She further stated that whoever completed the baseline CP, it was missing the [NJ Exe] to adequately monitor the [NJ Exec Order 26] for the use of [NJ Exec Order 26.4b1] 2. On 2/19/26 at 9:41 AM, Surveyor #2 (S #2) observed the US FOIA (b)(6) assigned to administer medications (meds) to Resident #374, prepare and administer due meds to Resident #374. During the observation, S #2 observed an order on the resident's RMAR that the [US FOIA] was preparing to administer.	F0757		02/26/2026

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F0757 SS = D	Continued from page 43 The order reflected: NJ Exec Order 26.4b1 [redacted] nce daily as needed (PRN) Protocol: Mix with NJ Exec Order 26.4b1 [redacted] at 5:16 PM. S #2 asked the US FOIA [redacted] why they were giving the med and what it was for, and the US FOIA [redacted] stated that it was for NJ Exec Order 26.4b1 [redacted] and the resident needs it. S #2 asked the [redacted] if med order that were PRN should have a reason to be given. The US FOIA [redacted] stated yes, they should and that the order in question should be a routine regularly scheduled order for the resident since they need it. S #2 observed the US FOIA [redacted] administered the resident's due meds and concluded the observation. S #2 reviewed the electronic medical record (EMR) for resident #374. The EMR revealed: A review of the RFS reflected the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of Resident #374's comprehensive MDS with an assessment reference date (ARD) of NJ Exec Order 26. [redacted] reflected, in Section NJ B [redacted] that the resident had a Brief Interview for Mental Status (BIMS) score of NJ B [redacted] out of 15, which indicated that Resident #65 was NJ Exec Order 26.4b1 [redacted] A review of the resident's RMAR revealed the following: An order scheduled for the 9:00 AM med pass that was discontinued after the observation of administration to the resident and not documented as given. NJ Exec Order 26.4b1 [redacted] once daily PRN NJ Exec Order 26.4b1 [redacted] at 5:16 PM.	F0757		02/26/2026

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F0757 SS = D	Continued from page 44 An order for the same timeframe with a start date of [NJ Exec Order 26.4b1] 9:59 AM (after the observation and surveyor inquiry) and documented as given. [NJ Exec Order 26.4b1] once daily as PRN For: [NJ Exec Order 26.4b1] at 9:59 AM. An order that reflected to be used PRN: [NJ Exec Order 26.4b1] ute once daily PRN for [NJ Exec Order 26.4b1] at 8:06 PM. A review of the resident's order summary, order details revealed that the order in question was discontinued by the LPN after the observation and S #2's inquiry and the new order was added. As reflected by: First Entered By: (name redacted) on [NJ Exec Order 26.4b1] at 9:59 AM; First Completed By: (name redacted) on [NJ Exec Order 26.4b1] at 9:59 AM; Med [NJ Exec Order 26.4b1] once daily PRN. On 2/24/26 at 12:31 PM, the survey team met with the [US FOIA (b)(6)] for concerns. S #2 notified the [US FOIA (b)(6)] of the results of the med pass observation and the concern with Resident #374's med orders being incomplete and duplicate. S #2 notified the [US FOIA (b)(6)] that the original PRN order had no indication for use and an additional PRN for the same med with an indication for use existed. S #2 notified the [US FOIA (b)(6)] that the LPN changed the order after the observation and S #2's inquiry and documented that the new order was given. On 2/25/26 at 11:22 AM, the survey team met with the [US FOIA (b)(6)] stated that the order for Resident #374 was changed as S #2's had previously stated. The [US FOIA (b)(6)] did not provide any further pertinent information. A review of the facility's "Policy: Medication Orders", date effective 11/25, the Policy reflected under 3.k. PRN orders should also specify the	F0757		02/26/2026

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F0757 SS = D	Continued from page 45 condition, for which they are being administered... The policy did not reflect anything relating to duplicate med orders. NJAC 8:39- 27.1(a); 29.2(d); 33.2(a)	F0757		02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060204	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		02/26/2026
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: REPEAT DEFICIENCY Complaint #2646177 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for 1 of 14 day shifts, reviewed as follows: 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.	S0560	It is the facility's policy to maintain Certified Nursing Assistants staffing ratios in accordance with New Jersey Department of Health regulations instituted on February 1, 2021. The facility has determined that all residents have the potential to be affected. Staffing professionals will continue proactive outreach to the facility's pool of nurse aides on a daily basis to support coverage of open shifts. When unexpected call-outs occur, the facility will implement established staffing contingency processes, including requesting staff from the current shift to remain if able, contacting available staff to fill open shifts, offering shift incentives when appropriate, and utilizing agency personnel as needed to maintain staffing coverage. To ensure ongoing compliance, the Director of Nursing or their designee will provide ongoing monitoring and leadership oversight by conducting daily staffing reviews to verify adherence to regulatory staffing requirements for 4 weeks and monthly thereafter. Results will be presented at the quarterly Quality Assurance and Performance Improvement Committee until sustained compliance is achieved.	02/26/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060204	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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CHRISTIAN HEALTH CARE CENTER	301 SICOMAC AVE , WYCKOFF, New Jersey, 07481

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S0560	Continued from page 1 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 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. For the 2 weeks of staffing prior to survey from 02/01/2026 to 02/14/2026 the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: 02/13/26 had 32 CNAs for 282 residents on the day shift, required at least 35 CNAs. On 2/25/26 at 10:21 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she was aware of the mandated CNA staffing ratios and that they were meeting the ratios. A review of the facility's "Emergency Staffing Policy" with a reviewed date of 3/2025, revealed that the policy did not include any information regarding CNA ratios.	S0560		02/26/2026
S1410	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(b)(1) (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.	S1410	It is the policy of the facility that all new employees undergo pre-placement tuberculosis screening in accordance with regulatory requirements. Employee #1 was due for the NJ Exec Order 26.4b1 with a due date of NJ Exec Order 26.4b1; documentation was subsequently received on August 25, 2023. The first step in the process was re-initiated on March 12, 2026 with the NJ Exec Order 26.4b1 test scheduled to be administered one to three weeks later in accordance with policy. Employee #2 provided an updated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and is now compliant with the facility's NJ Exec Order 26.4b1 screening policy. No action was taken for Employee #3 as the individual was no longer employed by the facility at the time of review. The facility has determined that all residents, staff members and the public can benefit from the	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060204	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	301 SICOMAC AVE , WYCKOFF, New Jersey, 07481

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S1410	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, a review of employee personnel files and health medical records, facility policy, it was determined that the facility failed to ensure that all new employees received a NJ Exec Order 26.4b1 t upon employment and had the results documented or had a current NJ Exec Order 26.4b1 This deficient practice was identified for 3 of 124 new employee files reviewed and was evidenced by the following: 1.Surveyor #1 (S #1) reviewed new employee files and revealed the following: Employee #1, a Certified Nurse Aide (CNA), hired on NJ Exec Order 26.4b1, had NJ Exec Order 26.4b1 test completed "elsewhere" according to the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 test or an alternative NJ Ex screening was completed upon hire. Employee #2, a Licensed Practical Nurse (LPN), hired on NJ Exec Order 26.4b1 had a NJ Exec Order 26.4b1 result that had a "service date" completed NJ Exec Order 26.4b1. There was no additional documentation in the file to indicate any NJ Exec O test or alternative NJ Ex screening was completed upon hire. 2. Surveyor #2 (S #2) reviewed new employee files and revealed, Employee #3, a CNA, hired on NJ Exec Order 26.4b1, the employee NJ Exec Order 26.4b1 Record had no documentation for the NJ Exec test, NJ Exec Order 26.4b1, in the following sections: "Results NJ Ex Order 26.4(b)(1))," "Date," and "Read by." On 2/20/26 at 9:58 AM, S #2 interviewed the Employee Health RN who stated that the NJ Exec Order 26.4b1 should be completed within one year prior to the employee's start date. On 2/24/26 at 12:35 PM, S #2 notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) notified of the above concerns. A review of the facility's "Mantoux Tuberculin Baseline Screening and Testing Policy", revealed under Procedure that all employees upon employment shall receive a two-step Mantoux tuberculin skin test. The facility shall act on the results of the Mantoux tuberculin skin tests administered to new employees.	S1410	Continued from page 2 improved process. On February 26, 2026, the Tuberculosis - Baseline and Annual Screening, Testing, and Education Policy was reviewed and updated. Employee Health and Human Resources staff were educated by the Vice President of Human Resources regarding documentation requirements for tuberculosis screening, including that employees must provide documentation of a chest x-ray completed within the last five years prior to the start date demonstrating no evidence of active pulmonary disease. In addition, the policy was updated to clarify that the two-step Mantoux test second step will be completed within three weeks to align with regulatory requirements. All newly hired employees' Mantoux test records will include documented results, administration dates, reading dates, and the name of the individual interpreting the results. To ensure ongoing compliance, the Vice President of Human Resources or their designee will audit all new hire files monthly for six months to verify compliance with Mantoux test timeframes and documentation requirements. Results will be shared with the Licensed Nursing Home Administrator and reviewed through the quarterly Quality Assurance and Performance Improvement meetings until sustained compliance is achieved.	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060204	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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S1410	Continued from page 3 The policy did not further address a timeframe for completing a [NJ Exec Order 26.4b1] prior to an employee's start date.	S1410		02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	**301 SICOMAC AVE , WYCKOFF, New Jersey, 07481**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/20/2026 in relation to the 02/25/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060204	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/20/2026 in relation to the 02/25/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - CHRISTIAN ...** B. WING	(X3) DATE SURVEY COMPLETED **02/25/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 02	INITIAL COMMENTS 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 02/17/26 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Christian Health Care Center is composed of four buildings: 1. Building #7 -Heritage Manor East (HME)-53,048 sq ft type II – protected construction, Nursing care and support/ laundry services Built in 1964, 132 beds. Complete dry sprinkler system 2. Building #8- South Gate - 52,936 sq ft type II – protected construction, mental health and behavioral health Built in 1988, 98 beds. 3. Building #9 - Commons- 29,452 sq ft type II – protected construction, Business/Administrative use Built in 1988- dry sprinkler system. 4. Building #10- Heritage Manor West (HMW) - 37,807 sq ft type II – protected construction, Post acute unit Built in 1988, 120 beds. Christian Health has a bi-fuel (diesel/natural gas) generator that supplies 100% of all four building per Director of Plant Operations. Occupied beds were 223 of 350.	K0000		02/26/2026
K0351 SS = E Bldg. 02	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	K0351	It is the policy of the facility to ensure the Nursing Home is protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Upon discovery that the pendent sprinkler head in the storage room across from the pantry on Heritage Manor West was installed 18 inches below the ceiling, Plant Operations immediately contacted the	03/11/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CHRISTIAN ... B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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K0351 SS = E Bldg. 02	Continued from page 1 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. 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 pendent sprinklers were installed within 12-inches of the ceiling in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) Section 8.6.4.1.1.1. This deficient practice had the potential to affect all 24 residents who resided on the Heritage Manor West wing of the facility and was evidenced by the following: An observation on 02/17/26 at 3:38 PM of Heritage Manor West storage room across from the pantry revealed the pendent sprinkler was 18-inches down from the ceiling. This measurement was taken by maintenance staff using the facility measuring tape. During an interview at the time of observations, the US FOIA (b)(6) confirmed the sprinkler was too low in the storage room. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K0351	Continued from page 1 sprinkler vendor to correct the issue. The existing sprinkler head was scheduled to be raised to the appropriate height, and an additional sprinkler head was installed on the opposite side of the header in the storage room to ensure proper coverage. The facility has determined that all 24 residents residing on Heritage Manor West could be impacted by the improperly installed and positioned automatic sprinkler head. Plant Operations staff immediately inspected the remaining storage closets on Heritage Manor West to verify that all pendent sprinkler heads were installed within 12 inches of the ceiling. No additional issues were identified. Plant Operations staff were in-serviced on NFPA 13 requirements related to sprinkler head placement, including maintaining pendent sprinkler heads within 12 inches of the ceiling and ensuring proper coverage when obstructions are present. The in-service was conducted by the Director of Plant Operations on February 19, 2026. Attendance records and photographic documentation of the updated installation were maintained for reference. To ensure compliance, the Director of Plant Operations or their designee will review all modifications to the fire sprinkler system to ensure they comply with NFPA 13 2010 edition prior to any installations with the fire sprinkler vendor. Moving forward, the Director of Plant Operations or their designee will document the review of any planned modifications to the fire sprinkler system with the architect and fire sprinkler vendor. This documentation will be reported at the Safety Committee meeting every other month as modifications are planned; and to the Quality Assurance and Performance Improvement Committee quarterly until sustained compliance is achieved. All corrective work was completed by March 11, 2026 as documented in work order number 15564.	03/11/2026
K0355 SS = E Bldg. 02	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.	K0355	It is the policy of the facility to ensure wet fire extinguishers are hydrostatically tested every 5 years in accordance with NFPA 10, Standard for Portable Fire Extinguishers. Upon discovery that a fire extinguisher had not received the required hydrostatic testing, Plant Operations immediately replaced the extinguisher with a compliant unit and contacted the vendor to	03/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CHRISTIAN ... B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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K0355 SS = E Bldg. 02	Continued from page 2 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure one of four wet chemical fire extinguishers were hydrostatic tested every five-years in accordance with NFPA 10 Standard for Portable Fire extinguishers (2010 Edition) Table 8.3.1. This deficient practice had the potential to affect all 223 residents and was evidenced by the following: An observation on 02/17/26 at 2:14 PM of the kitchen on the first floor revealed a wet chemical fire extinguisher near the exit door was hydrostatic tested in 2020. The fire extinguisher was not hydrostatic tested as scheduled in 2025. During an interview at the time of observation, the US FOIA (b)(6) confirmed the wet chemical fire extinguisher was not hydrostatic tested. NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 96	K0355	Continued from page 2 schedule the hydrostatic test which was completed on March 9, 2026. The facility has determined that all residents, staff and the public could be impacted when wet fire extinguishers are not hydrostatically tested every 5 years. Plant Operations immediately inspected the remaining units throughout the facility to verify that all fire extinguishers were within the required hydrostatic testing timeframe, and no additional issues were identified. Plant Operations staff were in-serviced on NFPA 10 regulatory requirements related to hydrostatic testing of wet fire extinguishers every five years. The in-service was conducted by the Director of Plant Operations on February 19, 2026. Attendance records and photographic documentation of the fire extinguisher compliant unit were maintained as evidence. To ensure continued compliance, Plant Operations added a preventive maintenance schedule within the computerized Maintenance Management System to track and trigger the required 5-year hydrostatic fire extinguisher testing of all wet fire extinguishers for January 2031. The preventative maintenance program will be reported to the Safety Committee at its next scheduled meeting in 2026, and future hydrostatic testing results will be reported following completion of the next testing cycle in 2031. All work was completed on March 9, 2026, as documented in work order number 15565.	03/11/2026

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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 02/17/26. The facility was found to be in compliance with 42 CFR 483.73	E0000		02/26/2026

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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K0000 Bldg. 02	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/26/2026 in relation to the 02/25/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/26/2026 in relation to the 02/25/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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