STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315176	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT MEDFORD	**185 TUCKERTON ROAD , MEDFORD, New Jersey, 08055**

(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 Complaint #: 2684037, 2693874, 2718861 Survey Date: 3/16/26 Census: 108 Sample Size: 7 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		05/12/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F0690	What corrective action will be accomplished for those residents affected by the deficient practice? Resident #2, was identified to be affected by the deficient practice. Facility contacted the [redacted] office, confirmed new appointment [redacted]. Resident was seen on [redacted], with additional follow up appointments. [redacted] recommendations were documented. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with an indwelling catheter have the potential to be affected by the same deficient practice. Nursing completed a review of residents with an indwelling catheter for any follow up recommendations. The review did not show any other residents missing consultants recommendations or follow up documentation. What measures will be put into place or what systemic changes will be made to ensure the	05/12/2026

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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F0690 SS = D	Continued from page 1 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: COMPLAINT #2718861 Based on interviews and review of pertinent facility documentation on 3/13/26 and 3/24/26, it was determined that the facility failed to provide a timely follow - up management and care of a resident's [redacted] to address [redacted] recommended procedures. This deficient practice was identified for one of two residents (Resident #2) reviewed for [redacted] care and was evidenced by the following: A review of the Admission Record revealed that Resident #2 was admitted to the facility with diagnoses that included but were not limited to: [redacted] and [redacted] Review of Resident #2's quarterly Assessment Minimum Data Set (MDS,) an assessment tool used to facilitate the management of care, dated [redacted], indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating that the resident was [redacted] the interview. Further review of the MDS revealed that the resident was [redacted] on staff for [redacted] The MDS also indicated that the resident had an [redacted] A review of Resident #2's care plan (CP) indicated that Resident #2 had an [redacted]; with intervention to observe and to report changes to the medical doctor. A review of Resident #2's progress notes (PN)	F0690	Continued from page 1 deficient practice will not recur? The Director of Nursing began re-education to nurse management and nursing staff on April 20, 2026 on: timely follow up on consultant recommendations and timely documentation on outcome and or recommendations. The Unit Managers or Designee will review consultant consult sheets weekly to ensure timely follow up on consultant recommendations and document recommendations in the resident medical record. How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing and/or Designee will audit resident Consultant sheets once a week for 30 days to ensure timely follow up of recommendations and documentation in the resident medical record. The results of the audit will be reviewed during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 6, 2026. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	05/12/2026

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F0690 SS = D	Continued from page 2 revealed a nursing note dated [redacted] at 2:44 PM, indicated that the resident went for [redacted] appointment. A nursing note dated [redacted] at 4:03 PM, stated that the resident returned from the [redacted] appointment and that the doctor recommended, "future [redacted] schedule." A review of the Resident #2's electronic medical record (EMR) revealed a visit summary from the [redacted] appointment dated [redacted], which indicated that the resident would be scheduled for the following [redacted] and a [redacted] There was no documented evidence that the facility followed up with the [redacted] regarding the aforementioned [redacted] or that the facility contacted the resident's medical doctor regarding having issues scheduling appointment for the [redacted] A Review of the EMR revealed that the resident was admitted to the [redacted] on [redacted] with an [redacted] Further review of the PNs revealed a nursing noted dated [redacted] at 5:11 PM that indicated that the resident had [redacted], had not been [redacted] and was [redacted] The note further indicated that an order was obtained to [redacted] the resident [redacted] for [redacted] During an interview on 3/13/26 at 4:06 PM, the [redacted] stated that Resident #2 was last seen by [redacted] on [redacted] and that the [redacted] office was expected to schedule an [redacted] When asked if the facility had followed-up to contact the office to schedule, he stated that Central supply (CS) staff made attempts to call the [redacted] office and that the office had not provided a date. When asked if the attempts to schedule the resident's appointment was documented; he stated that the Central supply staff did not document in the EMR. During an interview on 3/13/26 at 12:04 PM, Central supply (CS) staff stated that she was responsible for scheduling appointments for residents.	F0690		05/12/2026

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F0690 SS = D	Continued from page 3 During a follow-up interview on 3/13/26 at 4:56 PM, the CS stated that a residents' return from their medical appointments, she scheduled any upcoming appointments and scanned the documents into the computer to be uploaded into the resident's medical record. When asked about the follow-up form from Resident #2's [NJ Exec Order 26] appointment, she stated that the resident did not have one because there was no follow-up appointment to schedule and that the [NJ Exec Order] office was to schedule Resident #2 for [NJ Exec Order 26.4b1]. The CS staff stated that she called the [NJ Exec Order 2] office weekly to set up appointments for all residents. She further stated that she does not have access to the EMR and that she keeps track of her attempts to schedule appointments on paper. When asked to provide the documented attempts for Resident #2, the CS stated stated that she did not save the paperwork. During a joint interview on 3/13/26 at 5:33 PM, with the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] both stated that the facility does not have a policy in place related to the scheduling of out-of-facility appointments for residents. The [U.S. FOIA (b)] stated that after an appointment, the Consult Sheet was reviewed by nursing and the CS to see when the resident was due for their next appointment. She stated that no form had been completed for Resident #2 because a follow-up appointment was not required, she stated that the [NJ Exec Order] office was to schedule the resident for [NJ Exec Order 26]. They both stated that they were aware that the CS was calling regularly but that the office had not provided a date. [U.S. FOIA (b)(6)] stated that the CS staff kept track of all of her attempts in her own personal log, and that this was the process that they had in place. When the surveyor informed them that the CS did not have a documented evidence of her attempts to schedule appointments, they provided no other information to the surveyor. The facility did not provide further information regarding action plans for when the CS staff is unable to schedule an appointment and no evidence of attempts to reach the [NJ Exec Order 26.4] office. A review of the facility's "Charting Documentation" policy effective 3/2020, indicated that, "The medical record should facilitate communication between the interdisciplinary team..." N.J.A.C. 8:39-27.1(a)	F0690		05/12/2026

New Jersey Department of Health

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S0000	Initial Comments Complaint #: 2684037, 2693874, 2718861 The facility was not in compliance with the standards in the New Jersey Administrative code, 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		05/12/2026
S0410	Mandatory Resident Rights CFR(s): 8:39-4.1(a)(8) (a) Each resident shall be entitled to the following rights: 8. To receive a written statement or admission agreement describing the services provided by the nursing home and the related charges. Such statement or admission agreement must be in compliance with all applicable State and Federal laws. This statement or agreement must also include the nursing home's policies for payment of fees, deposits, and refunds. The resident shall receive this statement or agreement prior to or at the time of admission, and afterward whenever there are any changes; This LICENSURE REQUIREMENT is NOT MET as evidenced by: COMPLAINT #2684037 Based on interviews and review of pertinent facility documentation on 3/13/26, it was determined that the facility failed to document and to properly inform residents about changes to [redacted] NJ Exec Order 26.4b1 ordering process.	S0410	What corrective action will be accomplished for those residents affected by the deficient practice? Resident #1, was identified to be affected by the deficient practice. Facility scanned procedural change notification into residents medical record. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Administrator provided education to department heads on April 20, 2026, on: proper notification and documentation of facility procedural changes to residents and families. The Administrator or Designee will review facility procedural changes weekly to ensure timely notification and documentation to residents and families as needed.	05/12/2026

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S0410	Continued from page 1 This deficient practice was identified for 1 of 1 resident (Resident #1) and affects all residents that were admitted to the facility after NJ Exec Order 26.4b1 who require NJ Exec Order 26 and was evidenced as follows: A review of Resident #1's Admission Record (AR) indicated that the resident was admitted with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 Further review of the AR indicated that Resident #1 was their NJ Exec Order 26.4b1. Review of Resident #1's quarterly Assessment Minimum Data Set (MDS,) an assessment tool used to facilitate the management of care, dated NJ Exec Order 2, indicated that Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ indicating that the resident was NJ Exec Order 26.4b1. Further review of the MDS revealed that the resident was frequently NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 and occasionally NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1. A review of Resident #1's medical record (MR) did not include documentation that a written statement or agreement was provided to the resident at the time of the change to NJ Exec Order 26.4b1 process. During an interview on 3/13/26 at 11:39 AM, Central Supply (CS) staff stated that the current facility owners consider NJ Exec Order 2 to be a "NJ Exec Ord product." CS staff stated that under the previous owners, the Unit Secretary (US) coordinated with residents' families for the NJ Exec Orde and ensured the purchase was made. She further stated that when the new owners took over, they decided that facility staff would no longer order NJ Exec Orde the products on behalf of residents, and that families were notified through a letter. When asked for each resident's letter and date sent, the CS staff stated that she did not keep copies of the letter and that she was not aware if residents were informed of this information at the time of admission. During an interview on 3/13/26 at 12:26 PM, the Licensed Nursing Home Administrator (LNHA), stated that it was not possible for the facility to offer every single NJ Exec Order 26.4b1 product. She further stated that when the new owner took over, she could not recall when they decided that the ordering of the NJ Exec Order 2 would no longer be processed by the facility and that the identified families were each sent a letter.	S0410	Continued from page 1 How will the corrective action be monitored to ensure the deficient practice will not recure? The Administrator and/or Designee will audit notification and documentation to residents and families on any facility procedural changes once a week for 30 days. The results of the audit will be reviewed during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 6,2026. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	05/12/2026

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S0410	Continued from page 2 During a follow-up interview on 3/13/26 at 4:13 PM, the LNHA provided a list of the residents that were identified in [NJ Exec Order 26.4b1] as utilizing [NJ Exec Order 2] under previous arrangement. She stated that each family of the residents on the list were provided with a letter that included the process for how families were to order [NJ Exec Order 2] via a website and that she has no documented evidence. The facility provided a list with 26 residents names whom she said used [NJ Exec Order 26] She further stated that [NJ Exec Order 26.4b1] options were available but that [NJ Exec Order 2] were no longer one of the options. The LNHA stated that letters to the families were mailed in [NJ Exec Order 26.4b1] and that the expectation was that families should start ordering the [NJ Exec Order 26] upon receiving the letter. When asked if there was a written policy/protocol related to the process of ordering [NJ Exec Order 26], the LNHA stated that there was not. When asked if the new process was incorporated into the admission packet to inform new residents of the process, she stated that facility has not. There was no evidence in Resident #1's medical record about the change in [NJ Exec Order 2] process.	S0410		05/12/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 14 day shifts, 2 evening shifts, and 3 overnight shifts. The deficient practice was evidenced by the following: 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 as 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:	S0560	What corrective action will be accomplished for those residents affected by the deficient practice? No residents were identified. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? On April 20,2026, the Administrator provided re-education to the Staffing Coordinator and nurse management on the minimum staffing requirements by shift for certified nurse aides (direct care staff) by the Department of Health.	05/12/2026

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S0560	Continued from page 3 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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 02/22/2026-03/07/2026, the facility was deficient in CNA staffing for 14 of 14 day shifts as follows: -2/22/26 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -2/23/26 had 6 CNAs for 106 residents on the day shift, required at least 13 CNAs. -2/24/26 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -2/25/26 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -2/26/26 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -2/27/26 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -2/28/26 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -3/1/26 had 7 CNAs for 106 residents on the day shift, required at least 13 CNAs. -3/2/26 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs. -3/3/26 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -3/4/26 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -3/5/26 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. -3/6/26 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs.	S0560	Continued from page 3 The Administrator, Director of Nursing and Staffing Coordinator will meet weekly to review staffing levels for the week, open positions, and recruitment efforts. How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing and/or Designee will audit staffing forms to ensure the facility staffing meets once a week for 30 days. The results of the audit will be reviewed during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 6, 2026. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	05/12/2026

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S0560	Continued from page 4 -3/7/26 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. For the 2 weeks of staffing prior to survey from 02/22/2026-03/07/2026, the facility was deficient in CNA staffing for 2 of 14 evening shifts as follows: -2/23/26 had 10 total staff for 106 residents on the evening shift, required at least 11 total staff. -3/1/26 had 9 total staff for 106 residents on the evening shift, required at least 11 total staff. For the 2 weeks of staffing prior to survey from 02/22/2026-03/07/2026, the facility was deficient in CNA staffing for 3 of 14 overnight shifts as follows: -2/22/26 had 6 total staff for 106 residents on the overnight shift, required at least 8 total staff. -2/28/26 had 6 total staff for 106 residents on the overnight shift, required at least 8 total staff. -3/1/26 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff.	S0560		05/12/2026
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00	S1680	What corrective action will be accomplished for those residents affected by the deficient practice? No residents were identified. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? On April 20, 2026, the Administrator provided re-education to the Staffing Coordinator and Nurse Management on the minimum staffing requirements by shift for nurses by the Department of Health.	05/12/2026

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S1680	Continued from page 5 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 02/22/2026 and 03/8/2026, it was determined that the facility failed to provide at least minimum staffing levels for 5 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 02/22/26 Required Staffing Hours: 289.00 -02/22/26 had 272.00 actual staffing hours, for a difference of -17.00 hours. -02/23/26 had 280.00 actual staffing hours, for a difference of -9.00 hours. -02/28/26 had 264.00 actual staffing hours, for a difference of -25.00 hours. For the week of 03/1/26 Required Staffing Hours: 293.50 -03/1/26 had 232 actual staffing hours, for a difference of -61.50 hours. -03/7/26 had 272.00 actual staffing hours, for a difference of -21.50 hours.	S1680	Continued from page 5 The Administrator, Director of Nursing and Staffing Coordinator will meet weekly to review staffing levels for the week, open positions, and recruitment efforts. How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing and/or Designee will audit staffing forms to ensure the facility staffing meets once a week for 30 days. The results of the audit will be reviewed during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 6, 2026. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	05/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315176	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT MEDFORD	**185 TUCKERTON ROAD , MEDFORD, New Jersey, 08055**

(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 An offsite/desk review of the facility's Plan of Correction was conducted on 5/13/26 in relation to the 3/24/26 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		05/13/2026

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

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060313	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT MEDFORD	185 TUCKERTON ROAD , MEDFORD, New Jersey, 08055

(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
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 5/13/26 in relation to the 3/24/26 State of New Jersey Complaint 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		05/13/2026

Office of Primary Care and Health Systems Management

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