

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2026	
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
(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 #s: NJ 176409, NJ 181028, NJ 86576, NJ 2704937 Survey Date: 1/9/26 Census: 56 Sample: 15+ 2 closed records. 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			02/02/2026
F0689 SS = SQC-H	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Complaint #: 2704937; 414412 Based on observation, interview, and record review, it was determined that the facility failed to ensure a) NJ Exec Order 26.4b1 was provided to a NJ Exec Order 26.4b1 resident (Resident #7) identified as being at NJ Exec Order 26.4b1. Resident #7, NJ Exec Order 26.4b1, including three NJ Exec Order 26.4b1, that required transfer to the NJ Ex Order 26.4(b)(1) on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1, and on NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1.			F0689	Element 1 – Corrective Action Resident #7 was immediately provided with NJ Exec Order 26.4b1. The resident's NJ Exec Order 26.4b1 prevention care plan was revised to include supervision, and Certified Nursing Assistants assignment sheets were updated accordingly. NJ Exec Order 26.4b1 investigations were completed for the NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26.4b1 at 1:03 PM, NJ Exec Order 26.4b1 at 12:30 PM, NJ Exec Order 26.4b1 at 7:40 PM, NJ Exec Order 26.4b1 at 2:20 PM, and NJ Exec Order 26.4b1 at 8:06 PM. Resident #27's care plan was updated to include NJ Exec Order 26.4b1 requiring two staff members. Resident #70 was discharged in NJ Exec Order 26.4b1 and the facility cannot retroactively correct. However, the facility implanted the below corrections to avoid reoccurrence. Supervision in the activity room and the purple room was restructured to ensure that the purple room is monitored by an Activities Aide, Nursing Assistant, or nurse to provide supervision for residents at risk for falls. If supervision cannot be maintained in the purple room, residents will be relocated to the main activity room to ensure appropriate monitoring. Element 2 – Residents Potentially Affected		01/10/2026

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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F0689 SS = SQC-H	Continued from page 1 and to the which required b) ensure each was thoroughly investigated to prevent and c.) consistently initiate and implement new prevention interventions in response to to prevent further This deficient practice identified for 3 of 3 residents reviewed for (Resident #7, #27, and #70) and was evidenced by the following: A review of the facility's policy titled "Managing Falls and Fall Risk," dated/revised 3/2018, included the staff would identify interventions related to the resident's specific risks and causes to prevent the resident from falling and minimize complications from falling. Under Resident-Centered Approaches to Managing Falls and Fall Risk included; that the staff with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls...the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather many at once). When a fall reoccurred despite initial interventions, the staff would implement additional or different interventions or indicate why the current approach remained relevant. If underlying causes could not be readily identified or corrected, staff would try various interventions, based on assessment of the nature or category of "falling", until reduced or stopped, or until the reason for the continuation was identified as unavoidable. Under Monitoring of Subsequent Falls and Fall Risk included that the staff would monitor and document each resident's fall response to interventions intended to reduce falling or the risks of falling. For continued "falls" the staff would re-evaluate the situation and the appropriateness to continue or change current interventions and the attending physician would help the staff reconsider possible causes that may not have been identified. A review of the facility's "Falls- Clinical Protocol Policy," revised September 2012, and the "Falls Risk Assessment Policy," revised March 2018, were also reviewed. All three policies did not include supervision related to falls. 1. On 1/05/26 at 10:00 AM, the surveyor toured the nursing unit and observed Resident #7 seated in a wheelchair in the dayroom (Room #1). The resident had a peg board on the table and was trying to play with the board. The resident with the surveyor. The resident appeared	F0689	Continued from page 1 All residents requiring supervision have the potential to be affected by this deficient practice. The facility retained the services of an external nurse consultant to assist with the development and implementation of this Plan of Correction. An ad-hoc QAPI meeting was conducted on 1/09/26, during which a root cause analysis related to the deficiency was completed. The Director of Nursing conducted a facility-wide audit to identify residents who are cognitively impaired and have a high fall risk score. The care plans of those residents were reviewed to identify potentially affected residents. Immediate actions were taken, including updating care plans and implementing individualized interventions to ensure appropriate fall prevention strategies were in place. Enhanced monitoring was implemented for residents who are cognitively impaired with repeated falls and/or are identified as high risk for falls to ensure closer supervision as needed. Element 3 – Systematic changes Administrator and Director of nursing reviewed the Fall Prevention Policy and determined it follows state and federal guidelines. System changes implemented by the facility include requiring complete and timely incident documentation for all falls. An immediate root cause analysis protocol was implemented for all fall incidents utilizing a standardized investigation form. Director of Nursing and Nurse educator educated all nursing staff on 1/9/26 on all fall prevention strategies and safe repositioning techniques. Environmental modifications were implemented as indicated to reduce fall risks. Enhanced monitoring was established for residents identified as high risk for falls, particularly residents who are cognitively impaired or have a history of repeated falls. Supervision in the activity room and purple room was restructured to ensure appropriate monitoring of residents at risk for falls. The purple room will be supervised by an Activities Aide, Nursing Assistant, or nurse. If supervision cannot be maintained in the purple room, residents will be relocated to the main activity room to ensure continuous monitoring and resident safety. Bottom of Form DIRECTED EDUCATION: The following additional education was initiated with the Ad-Hoc QAPI and Root Cause Analysis done on 1/9/26 and reviewed by an external nurse consultant on 1/12/26:	01/10/2026

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F0689 SS = SQC-H	Continued from page 2 and [REDACTED] and there was no staff in attendance. On 1/05/26 at 11:00 AM, the surveyor observed Resident #7 in the dayroom (Room #1) seated at a table alone, along with seven other residents. There was no staff observed in attendance. At 11:20 AM, the surveyor observed a staff member coming from the other room (staff identified it as the "Purple Room"), and the staff member identified herself as the [REDACTED] US FOIA (b)(6). The [REDACTED] informed the surveyor she had to provide activities and monitor both rooms by herself, and she stated she "didn't have any help." The [REDACTED] informed the surveyor that the facility used two dayrooms where the Certified Nurse Aides (CNAs) brought the residents to after providing morning care, and the residents could attend activities in either Room #1 or the Purple Room. According to the [REDACTED] the facility assigned only one staff member to cover both activity rooms. There was no staff observed in the first room to supervise the residents, while the [REDACTED] had to monitor the residents in the Purple Room. On 1/06/26 at 11:15 AM, the surveyor observed Resident #7 seated alone at a table in Room #1. The resident appeared [REDACTED] and was observed [REDACTED] NJ Exec Order 26.4b1 and [REDACTED] in the wheelchair. The [REDACTED] was in the Purple Room and there was no clear, unobstructed path to visualize what was happening in Room #1. The surveyor interviewed the [REDACTED] and inquired who was responsible to supervise and provide activities to Room #1 while she was attending to the residents in the Purple Room. The [REDACTED] stated that currently she had "no help," and at times she had to transport some of the residents to the hairdresser, so she had to ask the nursing staff to keep an eye on both rooms. The [REDACTED] stated there were no staff physically assigned to monitor the activity area if she had to step out. The [REDACTED] asked the surveyor what the ratio should be for activities as she was aware that she could not provide activities and supervise both rooms. The surveyor referred her to the [REDACTED] US FOIA (b)(6). The surveyor then asked the [REDACTED] if she discussed her concerns with the [REDACTED] US FOIA (b)(6), and she stated, "yes." On 1/06/26 at 11:35 AM, the surveyor interviewed the [REDACTED] who cared for Resident #7. The [REDACTED] stated that Resident #7 required [REDACTED] NJ Exec Order 26.4b1 with care, was [REDACTED] NJ Exec Order 26.4b1, and [REDACTED] NJ Exec Order 26.4b1 to prevent [REDACTED] The [REDACTED] further stated that the resident was usually transferred to the dayroom after care for activities. On 1/06/26 at 11:45 AM, the surveyor interviewed	F0689	Continued from page 2 Falls management includes identification of high-risk fallers and implemented person centered interventions: Every fall requires a root cause analysis to develop a targeted intervention to prevent further falls. Rehab referrals are necessary to evaluate resident's physical capabilities and help with a root cause analysis. Care plan updates are required after every fall including a despite note if all interventions have been exhausted. Medication reviews should be completed when a cluster of falls occur. Psychiatry, psychology, or social work can assist if residents' falls are the result of non-compliant behavior. Enhanced monitoring means the resident requires greater supervision due to risk of falls and staff should have a general knowledge of where the resident is and the activity of the resident. Supervision means the resident is in the line of sight of staff Element 4 – Monitoring / QAPI Oversight The Director of Nursing or designee will conduct audits of 10% of residents identified as high risk for falls to ensure that residents with falls, repeated falls, and/or residents identified as high risk for falls have appropriate interventions in place and that those interventions are being implemented and maintained. Audits will be conducted weekly for four weeks and then monthly for three months. The results of these audits will be presented by the Director of Nursing or designee at the monthly QAPI meeting until May 2026. The Director of Nursing is responsible for oversight and implementation of this Plan of Correction	01/10/2026

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F0689 SS = SQC-H	Continued from page 3 Resident #7's US FOIA (b)(6) regarding resident NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that all the NJ Exec Order 26.4b1 were reviewed during morning meetings and the US FOIA (b)(6) updated the care plan. On 1/06/26 at 11:55 AM, the surveyor requested all of Resident #7's NJ Exec Order 26.4b1 investigations, their NJ Exec Order 26.4b1 risk assessments, and a timeline of their NJ Exec Order 26.4b1 from the US FOIA (b)(6). On 1/07/26 at 10:11 AM, the surveyor observed Resident #7 in Room #1 with six other residents and there was no staff in attendance. Resident #7 was observed NJ Exec Order 26.4b1 from the wheelchair and another resident (unsampled) asked the resident to NJ Exec Order 26.4b1. There was no staff in attendance. The surveyor walked to the next room, the Purple Room, and observed the US FOIA (b)(6) in the back of the Purple Room with her back facing the entrance door to the room, looking through papers. The US FOIA (b)(6) was unable to visualize the residents in Room #1 that was divided by a wall. At that time, the residents in Room #1 were left unattended. At 10:18 AM, the surveyor was about to exit the door, when the US FOIA (b)(6) came into the room and stated to the surveyor that she had to get something from the Purple Room. On 1/07/26 at 11:30 AM, the surveyor reviewed Resident #7's medical record which revealed the following: A review of the Admission Face Sheet (an admission summary), reflected that Resident #7 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 US FOIA (b)(6) A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, reflected that Resident #7 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 out of 15, which indicated a NJ Exec Order 26.4b1 US FOIA (b)(6) A review of Resident #7's Comprehensive Care Plan provided by the facility or NJ Exec Order 26.4b1 included a focus area initiated NJ Exec Order 26.4b1, that Resident #7 was at risk for NJ Exec Order 26.4b1. The goal was that Resident #7 will be NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 related NJ Exec Order 26.4b1 through the next review date NJ Exec Order 26.4b1 with a target date of NJ Exec Order 26.4b1	F0689		01/10/2026

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F0689 SS = SQC-H	Continued from page 4 The interventions included: NJ Exec Order 26.4b1, initiated The resident had a NJ Exec Order 26.4b1 to the bed to NJ Exec Order 26.4b1 and to NJ Exec Order 26.4b1 them from NJ Exec Order 26.4b1, initiated NJ Exec Order 26.4b1. The resident was NJ Exec Order 26.4b1 and has NJ Exec Order 26.4b1 and requires NJ Exec Order 26.4b1 to all requests for assistance, initiated NJ Exec Order 26.4b1. Maintain the bed in the NJ Exec Order 26.4b1, initiated NJ Exec Order 26.4b1. Evaluate the environment at the time of the resident's NJ Exec Order 26.4b1 and identify any factors that may have contributed to the NJ Exec Order 26.4b1 initiated NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 to screen/evaluate and/or treat as indicated, initiated NJ Exec Order 26.4b1. The resident was to be in the common area when out of bed, and NJ Exec Order 26.4b1 in the room in the wheelchair, initiated NJ Exec Order 26.4b1. Staff to bring resident out of the room after morning care to participate in activities of their choice, initiated NJ Exec Order 26.4b1. The resident needs NJ Exec Order 26.4b1 activities that minimize the potential for NJ Exec Order 26.4b1 while providing NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 initiated NJ Exec Order 26.4b1. On 1/07/26 at 11:40 AM, the following NJ Exec Order 26.4b1 Risk Evaluations were provided by the NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 Evaluation dated NJ Exec Order 26.4b1 reflected Resident #7 scored a NJ Exec Order 26.4b1 which indicated a NJ Exec Order 26.4b1 risk. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Risk Evaluation dated NJ Exec Order 26.4b1, reflected that the facility identified Resident #7 as a NJ Exec Order 26.4b1. Resident #7 received a score of NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 Risk Evaluation dated NJ Exec Order 26.4b1, reflected that the facility identified Resident #7 as a NJ Exec Order 26.4b1. Resident #7 received a score of NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 Risk Evaluation dated NJ Exec Order 26.4b1, reflected that the facility identified Resident #7 as a NJ Exec Order 26.4b1. Resident #7 received a score of NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 Risk Evaluation dated NJ Exec Order 26.4b1, reflected that the facility identified Resident #7 as a NJ Exec Order 26.4b1.	F0689		01/10/2026

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F0689 SS = SQC-H	Continued from page 5 Resident #7 scored a [REDACTED] [US FOIA (b) (7)(F)] The following incidents and [REDACTED] [NJ Exec Order 26.4b1] Evaluations were documented in the electronic Medical Record, and/or provided by the [REDACTED] [US FOIA (b) (7)(F)] and revealed the following: -On [REDACTED] [NJ Exec Order 26.4b1] at 1:03 PM, a Nursing [REDACTED] [NJ Exec Order 26.4b1] Note revealed Resident #7 was [REDACTED] [NJ Exec Order 26.4b1] on the floor by the housekeeping staff between the bathroom and the bed. There was no [REDACTED] [NJ Exec Order 26.4b1] investigation provided by the facility. -On [REDACTED] [NJ Exec Order 26.4b1] at 12:30 PM, a Nursing Progress Note revealed that the writer was called to room by the [REDACTED] [US FOIA (b) (7)(F)] and they observed the resident [REDACTED] [NJ Exec Order 26.4b1] in the room, next to the wheelchair on their [REDACTED] [NJ Exec Order 26.4b1]. The resident was [REDACTED] [NJ Exec Order 26.4b1] and Resident #7 was provided with [REDACTED] [NJ Exec Order 26.4b1] care and taken to the common area. There was no [REDACTED] [NJ Exec Order 26.4b1] investigation provided by the facility. -On [REDACTED] [NJ Exec Order 26.4b1] at 7:40 PM, a Nursing Progress Note revealed the resident [REDACTED] [NJ Exec Order 26.4b1] in the room and [REDACTED] [NJ Exec Order 26.4b1] a [REDACTED] [NJ Exec Order 26.4b1]. There was no [REDACTED] [NJ Exec Order 26.4b1] investigation provided by the facility. -On [REDACTED] [NJ Exec Order 26.4b1] at 2:20 PM, a Nursing Progress Note revealed the resident [REDACTED] [NJ Exec Order 26.4b1] on the [REDACTED] [NJ Exec Order 26.4b1] in the [REDACTED] [NJ Exec Order 26.4b1]. No investigation was provided for this [REDACTED] [NJ Exec Order 26.4b1]. The facility did not identify who was responsible to monitor the resident in the dayroom. -On [REDACTED] [NJ Exec Order 26.4b1] at 8:06 PM, a Nursing Progress Note revealed that the resident was [REDACTED] [NJ Exec Order 26.4b1] on the [REDACTED] [NJ Exec Order 26.4b1] in the doorway of the room and [REDACTED] [NJ Exec Order 26.4b1] a [REDACTED] [NJ Exec Order 26.4b1] to the [REDACTED] [NJ Exec Order 26.4b1]. There was no [REDACTED] [NJ Exec Order 26.4b1] investigation provided by the facility. -On [REDACTED] [NJ Exec Order 26.4b1] at 7:00 PM, a Nursing Progress Note revealed that the resident was [REDACTED] [NJ Exec Order 26.4b1] on the [REDACTED] [NJ Exec Order 26.4b1] in the room, and upon assessment, Resident #7 was noted with [REDACTED] [NJ Exec Order 26.4b1] to the [REDACTED] [NJ Exec Order 26.4b1]. A review of the corresponding [REDACTED] [NJ Exec Order 26.4b1] report dated [REDACTED] [NJ Exec Order 26.4b1], did not include a [REDACTED] [NJ Exec Order 26.4b1]. The Interdisciplinary Care (IDC) team indicated that, "The resident has been identified as [REDACTED] [NJ Exec Order 26.4b1] for [REDACTED] [NJ Exec Order 26.4b1]. All current interventions remain appropriate and in place. Additional interventions are not appropriate at this time. The goal for the resident is to prevent [REDACTED] [NJ Exec Order 26.4b1]." - On [REDACTED] [NJ Exec Order 26.4b1] at 9:06 AM, a Nursing Progress Note revealed that the resident was [REDACTED] [NJ Exec Order 26.4b1] on the [REDACTED] [NJ Exec Order 26.4b1] in the room, and that the [REDACTED] [US FOIA (b) (7)(F)] the resident on the [REDACTED] [NJ Exec Order 26.4b1] in the [REDACTED] [NJ Exec Order 26.4b1] on their [REDACTED] [NJ Exec Order 26.4b1]	F0689		01/10/2026

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F0689 SS = SQC-H	Continued from page 6 the bed. The resident was assisted to bed with [REDACTED] noted. [REDACTED] NJ Exec Order 26.4b1 were initiated. The corresponding [REDACTED] NJ Exec Order 26.4b1 investigation dated [REDACTED] revealed the aide reported the resident [REDACTED] the IDC team reviewed the [REDACTED] the resident [REDACTED] the resident was [REDACTED] and [REDACTED] NJ Exec Order 26.4b1...No revised interventions added to the Care Plan. -Or [REDACTED] at 10:15 PM, an Incident report dated [REDACTED] reflected that Resident #7 was [REDACTED] in the [REDACTED] between the bed and the bathroom's door. The recommendation was to [REDACTED] their bed in the [REDACTED] According to the staff, the resident was [REDACTED] NJ Exec Order 26.4b1. The IDC team notes [REDACTED] documented the resident remains [REDACTED] and with [REDACTED] NJ Exec Order 26.4b1. [REDACTED] NJ Exec Order 26.4b1. -On [REDACTED] at 9:11 PM, an Incident Report revealed Resident #7 [REDACTED] a [REDACTED] in the hallway during [REDACTED] The progress notes revealed that the resident was observed [REDACTED] in the hallway with [REDACTED] and [REDACTED] from [REDACTED] The resident stated, [REDACTED] and [REDACTED] my [REDACTED] The [REDACTED] assisted the resident into the wheelchair and the resident [REDACTED] The resident was transferred to the Emergency Department (ED) and was diagnosed with [REDACTED] to [REDACTED] and [REDACTED] NJ Exec Order 26.4b1 and [REDACTED] NJ Exec Order 26.4b1. The IDC team's recommendations were to educate staff on safely repositioning in the wheelchair. During the [REDACTED] to the room, there was no [REDACTED] According to the [REDACTED] statement, the resident's [REDACTED] got [REDACTED] NJ Exec Order 26.4b1, the resident [REDACTED] and [REDACTED] their [REDACTED] -Or [REDACTED] at 2:00 AM, an Incident Report revealed during rounds, a [REDACTED] the resident on the [REDACTED] The [REDACTED] and the IDC team met on the same day to discuss the [REDACTED] and there was no [REDACTED] indicated for the [REDACTED] per the resident's care plan intervention, and the care plan interventions were not reviewed or revised. -On [REDACTED] at 11:30 AM, an Incident Report revealed that a [REDACTED] alerted the nurse that Resident #7 was [REDACTED] on the [REDACTED] in the activity room with the wheelchair behind them. On [REDACTED] the IDC team reviewed the [REDACTED] and it was determined that Resident #7 would [REDACTED] NJ Exec Order 26.4b1" even when there would be a [REDACTED] NJ Exec Order 26.4b1 in front of them. During the [REDACTED] Resident #7 [REDACTED] and went to [REDACTED] and missed the chair and [REDACTED] on the [REDACTED]	F0689	01/10/2026

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F0689 SS = SQC-H	Continued from page 7 "The resident needs activities that minimize the potential for while providing and - On at 7:42 AM, following the of the, the reported to the nurse that Resident #7 had and was and was. The resident was transferred to the ED for evaluation and treatment. A review of the hospital records revealed a history of and ANJ Exec Order 26.4b1 NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 was performed on, which revealed a to the Resident #7 remained at the hospital from NJ Exec Order 26.4b1 The resident was also diagnosed with NJ Exec Order 26.4b1 -On at 4:03 PM, a late entry Incident Note revealed that Activity Staff reported that the resident was on the in the activity room. The resident was NJ Exec Order 26.4b1 above their with a NJ Exec Order 26.4b1 noted and on their NJ Exec Order 26.4b1. The resident was transferred to the NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 The resident NJ Exec Order 26.4b1 above the NJ Exec Order 26.4b1 to the or to the of the the resident was diagnosed with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 that required NJ Exec Order 26.4b1 The Incident Report dated revealed that on, the IDC team reviewed the and determined that Resident #7 attempted to and and "All current interventions remain appropriate and in place. Additional interventions are not appropriate at this time. The goal for the resident is to prevent from The IDC team did not address the failure to supervise the resident after it was documented NJ Exec Order 26.4b1 that the resident required NJ Exec Order 26.4b1 while in activities. A review of the "Screen/Referral Form" dated revealed the following: "After speaking with nursing staff and as well as observation of [the resident], [the resident] may at times demonstrate NJ Exec Order 26.4b1 however this is [the resident's] NJ Exec Order 26.4b1	F0689		01/10/2026

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F0689 SS = SQC-H	Continued from page 8 There has been [REDACTED] in ADLs or [REDACTED] No [REDACTED] indicated." The facility did not indicate what measures were put in place to address the [REDACTED]. On 1/08/26 at 9:53 AM, the surveyor interviewed the [REDACTED] regarding Resident #7's [REDACTED] at the facility including the [REDACTED] with [REDACTED]. The [REDACTED] stated that the staff "should have followed the care plan." When asked if Resident #7 had [REDACTED] the [REDACTED] stated, "No." The [REDACTED] added that Resident #7 was easily [REDACTED] and Resident #7 "attempted to [REDACTED] as this is their [REDACTED] someone has to remind [REDACTED]." On 1/09/26 at 11:39 AM, the surveyor interviewed and shared the above concerns with the [REDACTED] regarding staffing. The [REDACTED] stated, "the activity needs to be re-evaluated, currently staffing is lacking," and stated her expectations were to re-evaluate and provide a safe environment to all residents. When asked if her expectations were being met/considered, she stated that she was aware of the staffing issue, that the activity staff had to oversee residents in both rooms, and she did not have a plan yet to resolve the staffing issues and ensure the residents' needs were met. A review of the Activity Director Position Description revealed the following: The activity director is responsible for the development, implementation, and supervision of the full scope of the facility's recreation services. This includes providing an ongoing inclusive program that uses purposeful activities to improve and maintain the quality of life for residents. The Activity Director was to uphold and safeguard resident's rights, advocates for and on behalf of residents. 2. The surveyor reviewed the electronic medical record (EMR) which revealed a comprehensive Minimum Data Set (MDS), an assessment tool dated [REDACTED], which indicated Resident #70 had a Brief Interview for Mental Status (BIMS) score of [REDACTED] which indicated an [REDACTED] a further review of the MDS revealed Resident #70 required [REDACTED] for [REDACTED] and had diagnoses that included but were not limited to; [REDACTED]. A review of the individual comprehensive care plan (ICCP) included a focus area dated [REDACTED], for [REDACTED]. The focus area was updated to include a [REDACTED] with [REDACTED] or [REDACTED], a [REDACTED] with [REDACTED].	F0689		01/10/2026

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F0689 SS = SQC-H	Continued from page 9 on [REDACTED], a [REDACTED] with [REDACTED] on [REDACTED] a [REDACTED] with [REDACTED] on [REDACTED] and an actual [REDACTED] with [REDACTED] to their [REDACTED] and [REDACTED] on [REDACTED]. Interventions dated [REDACTED], included to review information on past [REDACTED] and attempt to determine cause of [REDACTED] record possible root causes; after remove any potential causes if possible; anticipate and meet the resident's needs; be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; the resident needs prompt response to all requests for assistance; educate the resident/family/caregivers about safety reminders and what to do if a [REDACTED] occurs; ensure that the resident is [REDACTED] NJ Exec Order 26.4b1; follow facility [REDACTED] protocol; maintain [REDACTED] NJ Exec Order 26.4b1 while in bed; offer and provide [REDACTED] NJ Exec Order 26.4b1 before and after meals, at bedtime and as needed. An intervention dated [REDACTED] was [REDACTED] NJ Exec Order 26.4b1 [REDACTED] evaluate and treat as ordered or as needed (PRN). An Intervention dated [REDACTED] was to encourage the resident to participate in activities that [REDACTED] NJ Exec Order 26.4b1 for [REDACTED] and [REDACTED] NJ Exec Order 26.4b1 interventions dated [REDACTED] were to continue as risk plan and offer activities that minimize the potential for [REDACTED] while providing [REDACTED] and [REDACTED] An intervention dated [REDACTED] was the resident currently needs [REDACTED] and will be seen by the [REDACTED] US FOIA (b)(6) on [REDACTED] Monitor closely at this time until new glasses are received. According to documentation reviewed, there were no new interventions for the [REDACTED] that occurred on [REDACTED] A review of the facility provided Accident/Incident reports did not indicate when the resident was [REDACTED] at time of the incident, [REDACTED] or [REDACTED] (if applicable), or if resident had participated in activities as per ICCP interventions. Effectiveness of interventions were not evaluated and a root cause of [REDACTED] not identified. A review of the facility provided [REDACTED] Risk Evaluation dated [REDACTED] indicated that Resident #70 scored a [REDACTED] NJ Exec Order 26.4b1 [REDACTED]. No additional [REDACTED] risk evaluations provided. On 1/09/26 at 10:55 AM, the survey team interviewed the [REDACTED] US FOIA (b)(6), who	F0689		01/10/2026

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	Continued from page 10 stated that when there was a [REDACTED] the nurse on duty did the incident report. The [REDACTED] continued that the Interdisciplinary care team (IDCT) met the next morning to look for the root cause of the [REDACTED] and interventions were put into place immediately, before investigation was complete. The [REDACTED] stated as a team, the [REDACTED] was reviewed to look at what happened, and the care plan was updated with intervention(s) to prevent further [REDACTED]. The [REDACTED] stated they contacted whoever was needed for the intervention (i.e. [REDACTED] was indicated). The [REDACTED] stated when the investigation was complete, we changed the interventions if needed. A review of the facility provided policy "Falls - Clinical Protocol," dated revised March 2018, which included: Assessment and Recognition...2. In addition, the nurse shall assess and document/report the following...h. Precipitating factors, details on how the fall occurred...5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations, etc...Cause Identification: 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall...2. If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes...Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling...2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation... 3. On 1/05/25 at 10:44 AM, the surveyor observed Resident #27 in the activities room, seated in a [REDACTED] wheelchair. [REDACTED] by the surveyor's voice. The surveyor reviewed the medical record for Resident #27. According to the resident's Admission Record,			

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F0689 SS = SQC-H	Continued from page 11 Resident #27 was admitted to the facility with diagnoses that included but not limited to: NJ Exec Order 26.4b1 A review of the most recent quarterly MDS dated NJ Exec Order 26.4b1, reflected the resident had a BIMS score of NJ Exec Order 26.4b1 out of 15, which indicated the resident had a NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 reflected the Resident #27 did NJ Exec Order 26.4b1 related to the NJ Exec Order 26.4b1 of care. Section NJ Exec Order 26.4b1 Abilities, reflected Resident #27 was NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 A further review of the MDS under NJ Exec Order 26.4b1 revealed the resident had a NJ Exec Order 26.4b1 that resulted in NJ Exec Order 26.4b1 A review of the facility Risk Management Report (RMR) dated NJ Exec Order 26.4b1 at 6:45 PM, revealed Resident #27 had NJ Exec Order 26.4b1 while being NJ Exec Order 26.4b1 on their NJ Exec Order 26.4b1 by the US FOIA (b)(6). The report was prepared by the US FOIA (b)(6) who was alerted by the US FOIA (b)(6) The NJ Exec Order 26.4b1 also documented that the Resident #27's NJ Exec Order 26.4b1 while their NJ Exec Order 26.4b1. The RMR did not include Resident #27's signed statement but was described as aware of who they were and the situation. Further review of the RMR reflected that on NJ Exec Order 26.4b1, the interdisciplinary (IDCP) team met to discuss Resident #27's NJ Exec Order 26.4b1 and resulted in staff education of NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 A review if the individualized comprehensive care plan (CP) for Resident #27 under NJ Exec Order 26.4b1 did not include the incident that occurred on NJ Exec Order 26.4b1, and the CP was not updated after that NJ Exec Order 26.4b1 including that the NJ Exec Order 26.4b1 occurred and the intervention discussed of proper NJ Exec Order 26.4b1 Resident #27 required prior to being NJ Exec Order 26.4b1. On 1/09/26 at 10:15 AM, during an interview with	F0689		01/10/2026

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F0689 SS = SQC-H	Continued from page 12 the surveyor, the US FOIA (b)(6) stated that the US FOIA (b)(6) was responsible for updating the resident's CP. On 1/09/26 at 10:49 AM, during an interview with the surveyor, the US FOIA (b)(6) stated that the US FOIA (b)(6) was responsible for collecting the data for all incidents and accidents reported and that she as the US FOIA (b)(6) reviewed the information the US FOIA (b)(6) collected. The US FOIA (b)(6) stated that after a fall, the interdisciplinary team (included the US FOIA (b)(6), social services, rehabilitation services and activities) met as a team to review and placed interventions prior to the completion of investigation to prevent further US FOIA (b)(6). On 1/09/26 at 12:02 PM, in the presence of the survey team, the US FOIA (b)(6) the surveyor discussed the concerns regarding Resident #27's CP was not updated to include the intervention discussed during the IDCP meeting on US FOIA (b)(6), to US FOIA (b)(6). A review of the provided policy titled; "Managing Falls and Fall Risk" included that the staff would monitor and document each resident's response to interventions intended to reduce falling or risk of falling. No further information was provided. N.J.A.C. 8:39-27.1(a)	F0689		01/10/2026
F0607 SS = SQC-F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F0607	Element 1 – Corrective Action The US FOIA (b)(6) was counseled by the Administrator immediately for failing to follow the abuse policy by not completing the required background checks prior to employment. Background checks for current identified employees were completed with no negative findings; no change in employment status was required. Element 2 – Residents Potentially Affected All residents have the potential to be affected by this deficient practice. No specific residents were identified as affected. The Administrator and Human Resources Director reviewed all current employee files including contracted staff to ensure background	03/13/2026

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F0607 SS = SQC-F	Continued from page 13 §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, it was determined that the facility failed to have a system in place to ensure a) prior to hire, all employees were pre-screened to ensure that they had not been found guilty in a court of law of abuse, neglect, or misappropriation, or had findings entered into the state nurse aide registry or against a professional license, and b) a process was in place to maintain documentation to confirm an appropriate pre-screening had occurred for all contracted facility employees which including dietary and housekeeping. The deficient practice was identified for 28 of 55 (50%) employee files reviewed that were provided by the facility (99 out of 154 employee files were not able to be provided by the facility). The evidence was as follows: A review of facility policy "Abuse, Neglect, Exploitation and Misappropriation Prevention Program", revised April 2021 included: Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives: ... 4. Conduct employee background			F0607	Continued from page 13 checks were completed for all employees. Element 3 – Systemic Changes A new employee checklist will accompany each new hire file verifying that all background checks are completed. On 1/10/2026 the Administrator finished educating facility Department Heads on abuse prevention to include the requirement of having a completed background check prior to hire. Department heads will review incoming employee files for their specific department to validate background checks prior to orientation. This process applies to all facility employees, including contracted staff. Element 4 – Monitoring / QAPI Oversight The Human Resources Director or designee will conduct weekly audits of all new hires for 4 weeks and then monthly for 3 months to ensure background checks were completed prior to hire. The HR director will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC.		03/13/2026

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F0607 SS = SQC-F	Continued from page 14 checks and not knowingly employ or otherwise engage any individual who has: a. been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; b. had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c. a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment or residents or misappropriation of resident property. On 1/5/26 at 9:40 AM, the surveyor requested a list of all employees, including contracted employees, that had been hired since 6/28/24 (last recertification survey date) and included employee name, date of hire, title, and date of separation (if applicable) from the [REDACTED] US FOIA (b)(6). On 1/6/26 at 7:55 AM, the [REDACTED] provided the list of 154 employee names with their status, title, department, date of hire and termination date (if applicable). The surveyor requested the [REDACTED] to provide all of the corresponding new hire documentation, including medical information, for the 154 employee names on the list. Thirty-five of the employees were listed as working for the Dietary and Housekeeping Department which was contracted with the facility. On 1/07/26 at 9:00 AM, the [REDACTED] provided the surveyor with 55 out of a total of 154 employee files requested. A review for employee files revealed the following: Employee # 2 was hired on [REDACTED] NJ Exec Order 2, and a criminal background search was completed and dated [REDACTED] NJ Exec Order 2 (22 days after employee #2 began working). Employee # 3 was hired on [REDACTED] NJ Exec Order 2, and a criminal background search was completed and dated [REDACTED] NJ Exec Order 2 (61 days after employee #3 began working). Employee # 7 was hired on [REDACTED] NJ Exec Order 2 and there was no criminal background report report in the file. Employee # 8 was hired on [REDACTED] NJ Exec Order 2, and a criminal background search was completed and dated [REDACTED] NJ Exec Order 2 (98 days after employee #8 began working). Employee # 11 was hired on [REDACTED] NJ Exec Order 2 and there was no criminal background report in the file.	F0607				03/13/2026	

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F0607 SS = SQC-F	Continued from page 15 Employee # 12 was hired on [REDACTED] and a criminal background search was completed and dated [REDACTED] (89 days after employee #12 began working). Employee # 13 was hired on [REDACTED], and a criminal background search was completed and dated [REDACTED] (146 days after employee #13 began working). Employee # 14 was hired on [REDACTED], and a criminal background search was completed and dated [REDACTED] 112 days after employee #14 began working). Employee # 15 was hired on [REDACTED] and a criminal background search was completed and dated [REDACTED] (54 days after employee #15 began working). Employee # 17 was hired on [REDACTED], and a criminal background search was completed and dated [REDACTED] (55 days after employee #17 began working). Employee # 18 was hired on [REDACTED], and there was no criminal background report in the file. Employee # 19 was hired on [REDACTED], and a criminal background search was completed and dated [REDACTED] (230 days after employee #19 began working). Employee # 20 was hired on [REDACTED] and there was no criminal background report in the file. Employee # 22 was hired on [REDACTED], and a criminal background search was completed and dated [REDACTED] (216 days after employee #22 began working). Employee # 25 was hired on [REDACTED], and a criminal background search was completed and dated [REDACTED] (295 days after employee #25 began working). Employee # 28 was hired on [REDACTED], and a criminal background search was completed dated [REDACTED] (76 days after employee #28 began working). Employee # 31 was hired on [REDACTED], there was no criminal background report in the file. Employee # 32 was hired on [REDACTED] and a criminal background search was completed dated [REDACTED]	F0607		03/13/2026

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F0607 SS = SQC-F	Continued from page 16 (93 days after employee #32 began working). Employee # 37 was hired on [REDACTED], a criminal background search was completed and dated [REDACTED] (131 days after employee #37 began working). Employee # 38 was hired on [REDACTED] a criminal background search was completed and dated [REDACTED] (61 days after employee #38 began working). Employee # 39 was hired on [REDACTED], and there was no criminal background report in the file. Employee # 42 was hired on [REDACTED] a criminal background search was completed and dated [REDACTED] (76 days after employee #42 began working). Employee # 44 was hired on [REDACTED], a criminal background search was completed and dated [REDACTED] (Five days after employee #44 began working). Employee # 45 was hired on [REDACTED] a criminal background search was completed and dated [REDACTED] (36 days after employee #45 began working). Employee # 46 was hired on [REDACTED], a criminal background search was completed and dated [REDACTED] (88 days after employee #46 began working). Employee # 47 was hired on [REDACTED] a criminal background search was completed and dated [REDACTED] (50 days after employee #47 began working). Employee # 49 was hired on [REDACTED] a criminal background search was completed and dated [REDACTED] (59 days after employee #49 began working). Employee # 52 was hired on [REDACTED], a criminal background search was completed and dated [REDACTED] (162 days after employee #52 began working). Employee # 55 was hired on [REDACTED] a criminal background search was completed and dated [REDACTED] (54 days after employee #55 began working). On 1/07/26 at 12:27, PM, the HRD in the presence of the [REDACTED] (US FOIA (b)(6)), confirmed that they were unable to provide all requested employee files. The [REDACTED] (US FOIA) stated "we cannot find them." When asked how do you know that all the employees were not excluded to work based on a criminal back search, they were unable	F0607		03/13/2026

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F0607 SS = SQC-F	Continued from page 17 to answer. On 1/9/26 at 8:19 AM, the US FOIA (b)(6) provided a copy of the Master Dining Service Agreement (Contractor) executed on 12/20/23 and commencing on January 1, 2024, the Contractor would provide the services identified on Exhibit B. Exhibit B which revealed: Management and Labor Responsibilities: Background checks for employees, at its cost, as required by, and in compliance with applicable federal and stated law. The Client Responsibilities section revealed: Vaccines, other physical and medical exams and tests, and drug screenings not required by the applicable state and federal authorities. On 1/9/26 at 9:30 AM, the US FOIA (b)(6) provided a copy of an unsigned Dining Services Director/Account Manager Job Description which revealed under Job Function ... Maintains personnel files in a locked cabinet. On 01/09/26 at 10:02 AM, the US FOIA (b)(6) confirmed that the background checks that were provided were what was available and confirmed that all background checks and references were not completed for all employees prior to date of hire. The US FOIA (b)(6) stated, "I can't do references and background checks for employees that have been terminated". On 01/09/26 at 11:38 AM, the US FOIA (b)(6) confirmed that she had never received any of the 35 employee files requested from the Contractor and was unable to confirm if the required background checks were completed prior to hire. On 01/09/26 at 12:01 PM, during an exit conference held with the US FOIA (b)(6), no further information was provided. NJAC 8:39-9.3(b)	F0607				03/13/2026	
F0725 SS = F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F0725	Element 1 – Corrective Action Immediate actions were taken to address staffing and care concerns identified during the survey. Staffing practices were reviewed and adjustments made to address gaps in Certified Nursing Assistant coverage and care delivery. Resident-specific follow-up was completed for Residents #22, #74, #9, #7, and #27 as described in the survey findings, including documentation review and re-education. Element 2 – Residents Potentially Affected			02/20/2026	

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F0725 SS = F	Continued from page 18 and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure a) sufficient and competent staff were available to provide timely and NJ Exec Order 26.4b1 assistance for residents who were dependent on staff for Activities of Daily Living (ADL's) care, b) ensure staff were available to supervise residents identified as NJ Exec Order 26.4b1, c) competent to reposition a resident in bed so the resident did not NJ Exec Order 26.4b1 a NJ Exec Order 26.4b1 and d) ensure minimum Certified Nurse Aide staffing requirements were consistently met. The deficient practice was evidenced for 5 of 5 residents who attended a resident council meeting, 4 of 4 residents reviewed for ADLs (Resident #9, Resident #22, Resident #73, Resident #74) and 2 of 2 residents reviewed for accidents (Resident #7 and Resident #27) and affected all residents who resident at the facility. The evidence was as follows: The deficient practice was as follows: Refer to F610, F677 & F689 a) On 1/5/26 at 10:12 AM, during the initial tour of the facility, a NJ Exec Order 26.4b1 was permeated in	F0725	Continued from page 18 All residents requiring staff assistance with ADLs have the potential to be affected. A review of residents requiring extensive or total assistance, including those requiring supervision for fall risk and repositioning, was completed to ensure staffing assignments were sufficient. No additional residents were identified as affected. Element 3 – Systemic Changes A daily staffing verification process was implemented to confirm Certified Nursing Assistant staffing meets required ratios and resident acuity prior to each shift. Charge nurses will review assignments/acuity and notify the Administrator or Director of Nursing immediately when staffing concerns arise so corrective actions can be initiated. On 2/3/26 the Director of nursing finished educating Nurses and CNAs on timely incontinence care, shower assistance, feeding assistance, resident supervision for fall risk, and proper repositioning techniques Element 4 – Monitoring / QAPI Oversight The Administrator/designee will conduct audits of daily staffing levels. Audits will be completed for 1 nursing shift daily for one month and then weekly for 4 weeks and then monthly for 2 months. The Administrator/designee will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC.	02/20/2026

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F0725 SS = F	Continued from page 19 the hallway. The surveyor continued the tour and entered Resident #22's room. A [REDACTED] was noted in the room. The surveyor asked a [REDACTED] to assist with an [REDACTED]. Resident #22 had [REDACTED] and was [REDACTED] with [REDACTED] and [REDACTED]. The [REDACTED] exited the room and returned 10 minutes later. The surveyor asked CNA #1 to check if the resident was [REDACTED]. The surveyor observed Resident #22 wearing [REDACTED], the [REDACTED] was [REDACTED] with [REDACTED] and [REDACTED] with [REDACTED]. CNA #1 informed the surveyor that the 11:00 PM to 7:00 AM, staff provided care and left the [REDACTED] on the resident. The surveyor then asked CNA #1 to ask the charge nurse to come to the room. On 1/5/26 at 10:30 AM, the surveyor summoned the [REDACTED] to the [REDACTED] room and we both observed that the [REDACTED] were [REDACTED] with [REDACTED] and [REDACTED]. The [REDACTED] stated in the presence of CNA #1, that the resident should not have been wearing [REDACTED]. On 1/6/26 at 8:30 AM, the surveyor observed the resident in the bathroom, CNA #2 was in the room making the bed. During an interview with CNA#2, she stated that the resident was aware of their [REDACTED], the resident required [REDACTED] with [REDACTED] from the bed to the [REDACTED]. On 1/6/26 at 9:20 AM, the surveyor conducted an interview with Resident #22. The resident informed the surveyor that they did not request to [REDACTED]. The resident stated that they were aware when [REDACTED]. On 01/07/2026 10:10 AM, the surveyor interviewed the [REDACTED] regarding [REDACTED] care protocol. The [REDACTED] stated [REDACTED] care was to be provided every 2 hours and as needed. The [REDACTED] also stated that no resident should have [REDACTED] on, as the [REDACTED] could be affected. The [REDACTED] stated that she was made aware of the issue with the above resident, in-service education was done, she will provide the in-service education regarding [REDACTED] care. On 01/07/2026 at 12:16 PM, the surveyor interviewed again CNA #1 who cared for Resident #22 or [REDACTED]. The CNA admitted and contradicted the earlier statement provided to the surveyor and admitted that she placed the [REDACTED] on the resident. CNA #1 stated again that the resident was a [REDACTED] "it is much easier for the resident and staff. The surveyor then asked CNA #1 what	F0725		02/20/2026

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F0725 SS = F	Continued from page 20 should be done for a resident that was frequently NJ Exec Order 26.4b1 CNA #1 stated, NJ Exec Order 26.4b1 b. On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility Resident #74 stated NJ Exec Order 26.4b1 and the resident stated, NJ Exec Order 26.4b1 Resident #74 stated they wanted to be to [another facility name] and the US FOIA (b)(6) had been made aware. Resident #74 also reported that a NJ Exec Order 26.4b1 called NJ Exec Order 26.4b1 because the NJ Exec Order 26.4b1. Resident #74 stated they were worried because "it was after 10:00 AM and the staff did not NJ Exec Order 26.4b1 and Resident #74 stated that they were a NJ Exec Order 26.4b1 and they NJ Exec Order 26.4b1. Resident #74 also reported that they had not received a NJ Exec Order 26.4b1 since they were admitted to the facility. The resident stated that every time the resident asked for a NJ Exec Order 26.4b1 the staff stated the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 On 1/06/26 at 9:22 AM the surveyor requested the US FOIA (b)(6) provide documentation of the showers that were given to the residents. The surveyor reviewed the facilities NJ Exec Order 26.4b1 binder" for NJ Exec Order 26.4b1 : Comprehensive NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 There were none found for resident #74. In addition, there were no NJ Exec Order 26.4b1 assessments found in the medical record for resident #74. On 1/06/26 at 9:30 AM, the surveyor interviewed the US FOIA (b)(6) regarding the NJ Exec Order 26.4b1 for Resident #74. In the presence of the surveyor, the NJ Exec Order 26.4b1 reviewed the NJ Exec Order 26.4b1 binder" and was unable to find any NJ Exec Order 26.4b1 sheets for Resident #74. The US FOIA (b)(6) stated she would "look" for them. No further information was provided. On 1/06/26 at 12:15 PM Resident #74 stated "I used to get a NJ Exec Order 26.4b1 at the other facility. NJ Exec Order 26.4b1" On 1/06/26 at 12:43 PM, the surveyor interviewed the resident's US FOIA (b)(6) who stated that she had taken care of Resident #74. She stated that their NJ Exec Order 26.4b1 days were Wednesday and Sunday 7 AM- 3 PM. The resident's US FOIA (b)(6) stated that she always offered Resident #74 a NJ Exec Order 26.4b1 not a NJ Exec Order 26.4b1 CNA stated, NJ Exec Order 26.4b1 and don't like the NJ Exec Order 26.4b1 and if they NJ Exec Order 26.4b1 I would	F0725		02/20/2026

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F0725 SS = F	Continued from page 21 document [REDACTED] in the CNA documentation system. The surveyor then reviewed the CNA documentation system for [REDACTED] NJ Exec Order 26.4b1 CNA task [REDACTED] NJ Exec Order 26.4b1 revealed "Resident [REDACTED] NJ Exec Order 26.4b1 column was left blank every day since Resident #74's admission date which was approximately [REDACTED] NJ Exec Order 26.4b1 prior. On 01/08/26 at 10:44 AM, the [REDACTED] US FOIA (b) confirmed there were no [REDACTED] NJ Exec Order 26.4b1 available for Resident #74. She stated "I will look through the progress notes to see if they received the care." She further stated that the staff informed her that the Resident #74 [REDACTED] NJ Exec Order 26.4b1 a [REDACTED] NJ Exec Order 26.4b1 c. On 1/5/26 at 10:28 AM, during the initial tour, the surveyor observed Resident #9 in bed, and the surveyor inquired about the care provided at the facility. Resident #9 stated there had been multiple times that they had been [REDACTED] NJ Exec Order 26.4b1 in [REDACTED] NJ Exec Order 26.4b1 and [REDACTED] NJ Exec Order 26.4b1 for hours." Resident #9 also stated that one time they called [REDACTED] NJ Exec Order 26.4b1 due to not being provided with [REDACTED] NJ Exec Order 26.4b1 care and the [REDACTED] NJ Exec Order 26.4b1 responded to the facility. d. On 1/6/26 at 10:13 AM, two (2) surveyors interviewed Resident #27 regarding the care that they received. Resident #27 stated their name and was aware that they resided in a long-term care facility. Resident #27 also stated that they had anticipated a [REDACTED] NJ Exec Order 26.4b1 related to follow-up [REDACTED] NJ Exec Order 26.4b1 that was scheduled for [REDACTED] NJ Exec Order 26.4b1 and Resident #27 shared that they were [REDACTED] NJ Exec Order 26.4b1 to see their physician because of the [REDACTED] NJ Exec Order 26.4b1 NJ Exec Order 26.4b1." Resident #27 added that nobody from the facility came to get them [REDACTED] NJ Exec Order 26.4b1 and ready for their appointment on the morning of [REDACTED] NJ Exec Order 26.4b1 Upon request for incident reports the facility provided a Risk Management Report (RMR) dated [REDACTED] NJ Exec Order 26.4b1 at 6:45 PM which revealed Resident #27 had [REDACTED] NJ Exec Order 26.4b1 while being [REDACTED] NJ Exec Order 26.4b1 on their [REDACTED] NJ Exec Order 26.4b1, by the [REDACTED] US FOIA (b)(6). The report was prepared by the [REDACTED] US FOIA (b)(6) who was alerted by the [REDACTED] US FOIA (b)(6). The [REDACTED] US FOIA (b)(6) also documented that the Resident #27's [REDACTED] NJ Exec Order 26.4b1 while their [REDACTED] NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Further review of the RMR reflected that on [REDACTED] NJ Exec Order 26.4b1, the interdisciplinary (IDCP) team met to discuss Resident #27's [REDACTED] NJ Exec Order 26.4b1 and resulted in staff education of [REDACTED] NJ Exec Order 26.4b1	F0725		02/20/2026

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F0725 SS = F	Continued from page 22 the resident "in the of the bed before to or the other." e. On 1/7/26 at 9:00 AM, during morning care, Resident #7 informed the (US FOIA (b)(6)) they would like to have a instead of being in the bed. The did not provide a. The informed the resident that their was scheduled for the 3:00 PM to 11:00 PM shift on Thursday. During an interview with the she confirmed that Resident #73 had asked for a that morning, and she did not provide the as Resident #73 was scheduled to receive a on the 3:00 PM-11:00 PM shift. The did not relay the request for a with the nurse. According to a review of the electronic medical record, Resident #73 had been since On 1/7/26 at 9:30 AM, Resident #73 asked the surveyor if they could arrange for them to have a. The resident reported that they had not had a since. The surveyor exited the room and went to the nursing station to inquire regarding Resident #73's day. During an interview with the (US FOIA (b)(6)) she stated that Resident #73 was scheduled to have a on Monday during the 3:00 PM-11:00 PM shift. The CN reviewed the log and the progress notes in the presence of the surveyor and was unable to locate any documentation regarding whether Resident #73 was or had a on (NJ Exec Order 26.4b1) during the 3:00 PM-11:00 PM shift. On 1/7/26 at 9:45 AM, the confirmed that Resident #73 asked for a on but did not provide the due to the resident being scheduled for the 3:00 PM-11:00 PM shift. f. On 1/6/6 at 10:30 AM, the surveyor conducted a resident council meeting with six residents and 6 of 6 residents reported the following concerns: A delay in answering the call lights during the 3:00 PM-11:00 PM and the 11:00 PM-7:00 AM shift. The residents reported concerns with care and staffing on the weekends, which were "the worst" regarding short staffing. One resident reported they had not had a since (NJ Exec Order 26.4b1) and were only offered a, and 5 of 6 residents stated they would not be offered a on their scheduled day. The residents stated that staff would answer the lights and stated they would come back, and they never returned. Another resident stated	F0725		02/20/2026

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F0725 SS = F	Continued from page 23 they witnessed their roommate use the call bell and it took close to an hour for someone to respond. The surveyor discussed the above concerns with the US FOIA (b)(6) and no additional information was provided. g. On 1/5/26 at 12:30 PM, the facility provided a copy of the facility assessment (FA) which completed by the prior US FOIA (b)(6) on 2/10/25 and revealed under Staff training/education and competencies 3.6 Describe the staff training/education and competencies that are necessary to provide the level and tapes of support and care needed for your resident population ... It may be helpful to review specific references in the regulation regarding the facility assessment ... Consider the following training topics (this is not an inclusive list) ... A review of the Matrix for Provided (a required document that lists diagnoses for the resident population) that was provided by the US FOIA (b)(6) revealed facility residents had pressure ulcers, required nutritional support by a feeding tube, had falls, indwelling urinary catheters and one resident had a colostomy. On 01/09/26 at 8:43 AM, the surveyor asked the US FOIA (b)(6) to review the FA and show the surveyor the competencies and training requirements identified for the staff based on the resident population. The US FOIA (b)(6) stated, "I can't say I see it." On 01/09/26 at 11:20 AM, the surveyor interviewed the US FOIA (b)(6). The surveyor asked if the US F had a schedule on training that she completed for the staff. The US F stated that she did not have a schedule of training for the staff and confirmed that competencies were not completed. The US F provided a binder of education that was completed, and stated education was completed in relation to specific incidents that had occurred with residents. h. 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:	F0725		02/20/2026

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F0725 SS = F	Continued from page 24 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each 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. Staffing had been calculated for the following time frames and revealed the following: 1. For the 2 weeks of staffing prior to survey from 12/21/2025 to 01/03/2026, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -12/21/25 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -12/28/25 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs. -01/02/26 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. On 1/9/26 at 12:02 PM, the above concerns regarding incontinence care and showers were presented to the US FOIA (b)(6) at the pre-exit conference and additional information was requested. 01/09/26 at 8:43 AM, the surveyor asked the US FOIA (b)(6) how the facility ensured that the staffing met the needs of the residents. The US FOIA (b)(6) stated the staffing coordinator or nursing filled the positions when nursing staff had called out. When asked if the nursing department reported to the US FOIA (b)(6) if staffing was adequate, he stated "typically yes, but not all the time." The surveyor asked if the facility met the staffing requirements and he stated, "we try to." On 1/9/26 at 1:30 PM, during the exit conference, no additional information was provided. no additional information was provided.	F0725		02/20/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F0725 SS = F	Continued from page 25 A review of the facility's policy titled, "Activities of Daily Living (ADLs) Supporting" last revised 3/2018 revealed the following: Policy Statement Residents will be provided with care and services as appropriate to maintain or improve their ability carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. A review of "Resident Rights" as documented in the facility Admission Agreement revealed: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Self Determination: The resident has a right to be treated with respect and dignity, including, the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences ... Self-Determination: The resident has the right to and the facility must promote and facilitate resident self-determination through support of the resident choice. The resident has a right to choose activities, schedules (including sleeping and waking times) .. NJAC 8:39-27.1 (a)2(g)(h); 8:39-4.1	F0725				02/20/2026	
F0730 SS = F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review it was	F0730	Element 1 – Corrective Action Performance reviews were completed for Certified Nursing Assistant #1 through #5. Element 2 – Residents Potentially Affected All residents have the potential to be affected, however, no residents were identified as affected. The Director of Nursing conducted an audit of CNA employee files to verify completed performance evaluations were done.			02/20/2026	

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F0730 SS = F	Continued from page 26 determined that the facility failed to ensure that annual performance reviews were completed for Certified Nurse Aides (CNAs) and ensure that education was provided based on the outcome of the review. The deficient practice was evidenced for 5 of 5 CNA records reviewed and was evidenced by the following: requested CNA files. A performance review had not been completed for all five of five CNAs: CNA #1, Date of Hire (DOH) [REDACTED] NJ Exec Order 26.40 CNA #2, DOH [REDACTED] NJ Exec Order 26.40 CNA #3, DOH [REDACTED] NJ Exec Order 26.40 CNA #4, DOH [REDACTED] NJ Exec Order 26.40 CNA #5, DOH [REDACTED] NJ Exec Order 26.40 On 01/07/26 at 12:30 PM, the [REDACTED] US FOIA (b)(6) confirmed that she did not have the performance reviews. On 01/09/26 at 10:02 AM, the [REDACTED] US FOIA (b) stated that performance evaluations were the responsibility of the department heads where the employee worked. The [REDACTED] US FOIA (b) stated sometimes the department heads provided copies and sometimes they did not. Performance evaluations are completed by the manager of the department where the employee works. Admin is responsible for department heads are responsible. Sometimes they give them to me and sometimes the manager keeps them On 01/09/26 at 11:48 AM, the [REDACTED] US FOIA (b) confirmed no competencies were completed for any CNAs and there was no training based on performance evaluations. NJAC 8:39-43.17(b)	F0730	Continued from page 26 Element 3 – Systemic Changes A performance evaluation tracking system using the employee roster and hire dates was implemented to identify due dates and ensure timely completion. Annual evaluations will be completed annually. The Director of Nursing or designee is responsible for completing evaluations and maintaining the tracking system. Element 4 – Monitoring / QAPI Oversight The Director of Nursing or designee will conduct audits of 20% of CNA files to ensure that Annual evaluations were completed annually. Audits will be conducted monthly for three months. The results of these audits will be presented by the Director of Nursing or designee at the monthly QAPI meeting until May 2026. The Director of Nursing is responsible for oversight and implementation of this Plan of Correction.	02/20/2026
F0803 SS = F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F0803	Element 1 – Corrective Action Portion sizes for menu items were clarified, appropriate portion utensils were implemented, and standardized recipes with portions were provided to dietary staff to ensure meals are prepared and served as intended.	02/20/2026

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F0803 SS = F	Continued from page 27 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility failed to have a system in place to ensure menus were prepared using standard meal planning guides, and recipes were utilized with portion sizes to ensure menus were nutritionally adequate. This deficient practice was evidenced by the following: On 1/5/26 at 10:00 AM, the US FOIA (b)(6) provided a copy of the for week menu cycle and the surveyor requested the extensions/portion sized for all diets. On 01/06/26 at 12:03 PM, during the lunch preparation observation in the remote dining pantry, the surveyor observed staff utilize a 2- ounce scoop and prepared portions of cucumber salad that were placed in a plastic cup with a lid. When asked the staff how much the portion of the salad should be, she stated 4 ounces, and then showed the surveyor the blue handled ice cream type scoop which was a 2-ounce scoop. On 01/06/26 at 12:12 PM, the surveyor asked the US FOIA (b)(6) where the portion sizes were listed for staff to ensure that the proper	F0803	Continued from page 27 Element 2 – Residents Potentially Affected All residents have the potential to be affected, no specific residents were identified with this deficiency. A review of current menus and meal service practices was conducted by the Regional Dietary Director to verify portion sizes and preparation methods aligned with approved menus and nutritional guidelines. Element 3 – Systemic Changes On 1/12/26 the Administrator educated the US FOIA (b)(6) and dietary staff on maintaining approved menus, standardized recipes, and portion sizes in the kitchen for use during meal preparation and service. A standardized menu binder will be maintained in the kitchen containing approved menus, recipes, and portion sizes for all diets. Element 4 – Monitoring / QAPI Oversight The Food Service Director or designee will conduct audits of menus/recipes/portion size. Audits will be completed daily for two weeks, and then weekly for 4 weeks and then monthly for 3 months. The Food Service Director or designee will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC.			02/20/2026	

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F0803 SS = F	Continued from page 28 portions were served? The US FOIA stated it should be on the meal ticket, and reviewed a meal ticket and confirmed there were no portion sized listed. The US FOIA confirmed the portion sizes were not listed on the menu either. Portion sizes or meal extensions/portion sizes were not provided for the menus. On 01/06/26 at 12:36 PM, the surveyor interviewed the US FOIA (b)(6) about the menus and asked to show the surveyor the recipes used for the menu items. The US FOIA stated, "we don't have them". When asked who reviewed the menus for nutritional adequacy? The US FOIA stated that he and the US FOIA made the menus. When asked if the US FOIA (b)(6) reviewed the menus also, he stated he hasn't seen her as the US FOIA didn't work for the company. When asked about a nutritional analysis of the menus or a process used to develop the menus. He stated, "I don't have that." When asked if that would be important to have, he responded, "yes, for maintaining nutritional value of the menu". When asked how much cucumber salad was supposed to be served to the residents, he stated "it should be at least a 4 ounce portion". The surveyor shared the observations of 2 ounce portion of the cucumber salad. On 01/06/26 at 1:18 PM, the surveyor interviewed the US FOIA (b)(6) and asked if she worked with the kitchen on the menus? The US FOIA stated she did not work with the kitchen and when asked if portion sizes, recipes and a nutritional analysis were important to have regarding the menus? The US FOIA stated it was important to ensure the residents were adequately served and the menus met the dietary guidelines. NJAC 8:39-17.2(b); 17.4(3)	F0803		02/20/2026
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	F0812	Element 1 – Corrective Action Immediate inspection of the kitchen, food storage areas, and remote pantry was completed by the Food Service Director and Administrator. Expired foods were removed/discarded; foods without use-by dates were discarded or labeled per policy. Dish machine was taken out of service until repaired and vendor replaced broken temperature gauges and hot water booster components. Refrigerators with malfunctioning thermometers/damaged gaskets were repaired or scheduled for replacement. Wet dishes/equipment were rewashed and air dried. Kitchen and storage areas were cleaned/sanitized including shelves, racks, ceilings, and areas behind equipment. Staff were instructed by Regional Dietary Director on proper hand hygiene when transitioning	02/20/2026

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F0812 SS = F	Continued from page 29 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to ensure a) food was stored in a manner to ensure it was utilized by a safe use- by date, and b) the kitchen and remote service kitchen environment and equipment was maintained in a sanitary manner to prevent potential contamination from foreign substances and limit the potential for the development a food borne illness. This deficient practice was evidenced by the following: On 01/05/26 at 9:48 AM, the surveyor conducted an initial tour of the kitchen with the US FOIA (b)(6) and observed the following: -The EC utilized a hair net on his face which did not cover all of his facial hair above lip and on sides. -Staff was observed using the dish-machine to clean dishware/food preparation equipment and while the dish machine was functioning the surveyor observed that the wash gauge did not register a temperature. The surveyor observed a hot water booster directly under the dish machine. The surveyor alerted the US FOIA to the observation and the US FOIA stated, "we were not aware." When asked if the facility had a hot water booster, the US FOIA responded to the surveyor that he, "didn't know." The surveyor observed the temperature log for the dish machine that was affixed to the wall which listed a wash temperature and 5 out of 13 entries, did not have staff initials documented next to the temperatures. The surveyor then interviewed the staff (FSW) that was observed doing the dishes and asked how was a temperature documented if the gauge did not function? The FSW stated that he just found out this morning and "I did what I was told to do." Continued with US FOIA and observed: -The fan in the walk in refrigerator unit was soiled	F0812	Continued from page 29 between clean and dirty handling and on covering all hair including facial hair. Element 2 – Residents Potentially Affected All residents have the potential to be affected. The Food Service Director and Registered Dietitian conducted a complete audit of food storage areas to ensure use-by dates, removal of expired foods, functioning equipment, and sanitary conditions. No additional concerns were identified. Element 3 – Systemic Changes Food preparation policy was reviewed by Administrator and Regional Food Service Director and were in accordance to state and federal regulations. System changes were implemented to include daily food storage inspection checklist for food Service director. Established cleaning schedule for kitchen equipment and storage areas. Dish machine temperature log completed each meal service. Dishware/equipment must air dry. On 1/11/26 Regional Dietary Director educated The Food Service Director and dietary staff on hand hygiene, food labeling, sanitation procedures, dish machine temperature monitoring, and safe food handling per policy and regulations. Element 4 – Monitoring / QAPI Oversight The Food Service Director or designee will conduct weekly food safety and sanitation audits to include labeling/expiration, refrigerator/freezer temps, dish machine temperature logs, sanitation of areas/equipment, and staff compliance. Audits will be completed weekly x 4 weeks and then monthly for 3 months. The Administrator will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC.	02/20/2026

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F0812 SS = F	Continued from page 30 with embedded dust like debris which was also affixed to the ceiling. -A partially sealed bag of scallions located on a shelf, had no use by date and the ends were shriveled. -A bin of celery, a box of carrots and a box of onions had no use by date. When asked the [US FOIA (b)(6)] if there should be a use -by date, he stated "yes". -An opened box of 4 ounce yogurts had no use by date, and the yogurts and box was stamped "best by January 3rd, 2026" and the [US FOIA (b)(6)] stated they expired on Saturday and removed the box. At 10:06 AM, a [US FOIA (b)(6)] for the Management Company joined the tour. -The Dry storage area had food stored on metal racks which had visible debris affixed to the racks throughout the store room. The surveyor used a piece of paper to remove the debris and showed the [US FOIA (b)(6)]. The surveyor asked when the racks were last cleaned and he stated he did not know and confirmed the surveyor's observations. -Visible dark and crumb like debris were observed behind the cooking area including the stoves and ovens. - English muffins were located in a reach in freezer without a use by date. - The large and small blender were both stored upright and were wet inside. The [US FOIA (b)(6)] stated "nothing should be holding water". -The ceiling in the kitchen had visible splatters. -Underneath the metal shelf pass through by the food preparation area was heavily soiled with debris. On 1/5/26 at 10:29 AM, the surveyor observed the skilled nursing remote food service pantry with the [US FOIA (b)(6)] present, and observed the following: -One person was utilizing an under the counter dish machine to clean up the breakfast dishes. The same staff was removing clean dishes and placing dirty dishes into the machine without washing hands. When asked the [US FOIA (b)(6)] if one person was allowed to go from clean to dirty without washing hands, he stated, "no".	F0812				02/20/2026	

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F0812 SS = F	Continued from page 31 -The staff was observed with a rack of insulated bowls that were visibly wet and piled on top of one another, and the staff took each bowl and proceeded to wipe them with a rag on the inside. The surveyor asked if it was okay to use a rag to wipe the bowls and showed him the wet bowls piled up. The [REDACTED] stated the bowls should be "air dried" and stated only one staff was scheduled for dishes in the pantry. -The refrigerator in the pantry had an internal thermometer that did not register temperature and the [REDACTED] stated it was not working and needed to be removed. -The gaskets on the refrigerator were ripped in several areas and there was visible splatter and debris inside of the refrigerator. -The refrigerator contained 8 of the same 4-ounce expired yogurts that were observed in the main kitchen. The staff stated they brought the yogurts to the pantry from the main kitchen. On 1/5/26 at 2:14 PM, the surveyor received the requested report from the dish machine service company which detailed that all three temperature gauges for the dish machine and two fuses in the hot water booster were replaced due to "broken" temperature gauges. On 01/06/26 at 12:03 PM, the surveyor observed the meal service preparation in the pantry and observed a stack of 11 meal trays that staff confirmed were used to deliver meals to the rooms. The Food Preparation Policy, Revised 9/2017 revealed: 1. All staff will practice proper hand washing techniques and glove use. 2. Dining Services Staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological and chemical contamination. The Cold Foods Storage Policy, Revised 4/2018 revealed: 4. An accurate thermometer will be kept in each refrigerator ... NJAC 8:39-17.2(g)	F0812		02/20/2026	
F0836 SS = F	License/Comply w/ Fed/State/Local Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law.	F0836	Element 1 – Corrective Action The Facility Administrator contacted the consultant who assisted with CMS enrollment applications to confirm submission of the facility name change. Supporting documentation confirmed an application was submitted to CMS on February 27, 2025 requesting the name update; the facility is awaiting CMS correspondence confirming the update in	02/20/2026	

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F0836 SS = F	Continued from page 32 §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in the facility's name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and			F0836	Continued from page 32 enrollment records. The facility contacted the New Jersey Department of Health licensing office and obtained an updated license reflecting 5692 LLC d/b/a The Fountains at Atco. The facility is working to ensure alignment across CMS records, licensure, signage, and public-facing materials. Element 2 – Residents Potentially Affected All residents have the potential to be affected; however, no residents were identified as affected. This issue was administrative and did not impact resident care or services. Element 3 – Systemic Changes A Regulatory Change Checklist was implemented to ensure any future changes related to facility name, ownership, licensure, or CMS enrollment information are reported to CMS and applicable agencies within required timeframes. The checklist requires verification of notifications and receipt/maintenance of updated documents. Element 4 – Monitoring / QAPI Oversight The Administrator or designee will conduct periodic reviews of CMS enrollment records, state licensure documentation, and facility signage/public-facing materials to ensure consistency. Findings will be reviewed at monthly QAPI for six (6) months until 100% alignment/compliance is achieved and sustained.		02/20/2026

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F0836 SS = F	Continued from page 33 applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76..... (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location. (2) All other changes in enrollment must be reported within 90 days." Prior to the survey, the surveyor accessed the facility website which listed the facility name as "The Fountains at Atco" at the address listed for the registered name "Allegria at the Fountains." On 1/5/25 at 9:00 AM, upon arrival to the facility, the surveyors observed signage on the building which read "The Fountains at Atco." That name did not correspond with the CMS licensed, approved name and provider registered name "Allegria at the Fountains." On 1/5/25 at 9:05 AM, upon entering the facility, the surveyors observed signage on the wall which	F0836				02/20/2026	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F0836 SS = F	Continued from page 34 documented the License for 60 Long Term Care beds and was issued March 18, 2025 from the New Jersey Department of Health, and Expired November 30, 2025 which listed the facility name "The Fountains of Atco", which differed from the exterior signage. The Centers for Medicare and Medicaid Services (CMS), Clinical Laboratory Improvement Amendments certificate, identified the facility name as Allegria at the Fountains. On 1/12/26 the surveyor requested from the US FOIA (b)(6) any communication from CMS that confirms they have accepted the name change for the facility. The US FOIA (b)(6) provided a copy of an approval from the New Jersey Department of Health, Certificate of Need and Licensing dated 11/25/24, that approved the transfer of ownership and name change to the Fountains of Atco. The US FOIA (b)(6) did not provide information from CMS. No additional information regarding the facility's name change was provided to the survey team. NJAC 8:39-5.1 (a)	F0836				02/20/2026	
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity;	F0838	Element 1 – Corrective Action Upon notification, the Administrator, Director of Nursing, Medical Director, and department leadership reviewed the Facility Assessment. The Facility Assessment was revised to include staff competencies and training necessary to care for the resident population, including residents with pressure ulcers, feeding tubes, falls risk, indwelling urinary catheters, colostomies, and behavioral health needs. The revised assessment identifies required skills, competencies, and training. Element 2 – Residents Potentially Affected All residents have the potential to be affected by this deficient practice. The review ensured the facility has appropriate staff competencies, training, and resources to meet current resident needs. No residents were identified with this deficiency. Element 3 – Systemic Changes On 2/16/26 Regional Director in-serviced facility leadership US FOIA (b)(6), and			02/20/2026	

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F0838 SS = F	Continued from page 35 (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).			F0838	Continued from page 35 department heads on Facility Assessment requirements to include resident population acuity, required competencies, training requirements, resources/equipment/services, cultural/religious/psychosocial needs, and risk assessment. The Facility Assessment will be reviewed annually and when significant change occurs. Element 4 – Monitoring / QAPI Oversight The Administrator or designee will audit the facility assessment to ensure the Facility Assessment is reviewed annually and upon significant changes in resident population/services/staffing. Audits will be done monthly for three months. The administrator will report findings to monthly QAPI meeting until May 2026. Administrator is responsible for oversight of this POC.		02/20/2026

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F0838 SS = F	Continued from page 36 § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.	F0838				02/20/2026	

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F0838 SS = F	Continued from page 37 This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and document review it was determined that the facility failed to ensure the facility assessment addressed the skill sets, and competencies required by staff to provide care to the resident population. The deficient practice affected all residents and was evidenced by the following: On 1/5/26 at 12:30 PM, the facility provided a copy of the facility assessment (FA) which completed by the prior US FOIA (b)(6) on 2/10/25 and revealed under Staff training/education and competencies 3.6 Describe the staff training/education and competencies that are necessary to provide the level and tapes of support and care needed for your resident population ... It may be helpful to review specific references in the regulation regarding the facility assessment ... Consider the following training topics (this is not an inclusive list) ... A review of the Matrix for Provided (a required document that lists diagnoses for the resident population) that was provided by the US FOIA (b)(6) revealed facility residents had pressure ulcers, required nutritional support by a feeding tube, had falls, indwelling urinary catheters and one resident had a colostomy. On 01/09/26 at 8:39 AM, the surveyor interviewed the US FOIA (b)(6) regarding what was the purpose of the FA. The US FOIA (b)(6) stated it identified the care and services the facility offered and he stated it was completed prior to his arrival. When asked if he had reviewed it, he stated "I did not". On 01/09/26 at 8:43 AM, the surveyor asked the US FOIA (b)(6) to review the FA and show the surveyor the competencies and training requirements identified for the staff based on the resident population. The US FOIA (b)(6) stated, "I can't say I see it." NJAC 8:39-5.1(a)	F0838		02/20/2026
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmp CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the	F0865	Element 1 – Corrective Action The interdisciplinary team reviewed the facility's QAPI program and process. The QAPI plan was reviewed and updated by leadership including the Administrator, Director of Nursing, and Medical Director. Priority issues identified during the survey were added to the QAPI agenda, which included staffing supervision, missed appointments, resident care concerns, documentation/record availability.	02/20/2026

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F0865 SS = F	Continued from page 38 outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.			F0865	Continued from page 38 Element 2 – Residents Potentially Affected All residents have the potential to be affected. A review of facility incidents occurring within the previous 30 days was conducted by the Director of Nursing. The Director of Social Services conducted a review of all grievances and care concerns reported during the previous 30 days. The Administrator conducted a review of operational issues identified within the same 30-day period. These reviews were completed to identify trends, potential areas of concern, and any issues requiring further analysis through the facility's QAPI program and performance improvement initiatives. Element 3 – Systemic Changes On 2/16/26 Regional Director in-serviced facility leadership US FOIA (b)(6), and department heads on QAPI requirements. A standing agenda item "Significant Events Review" was added for each QAPI meeting to review and track events including incidents/accidents, 911 calls, missed appointments, staffing concerns, infection control, grievances, care delivery issues, Element 4 – Monitoring / QAPI Oversight The Administrator or designee will audit QAPI agendas, action plans, and follow-up documentation to ensure issues are addressed. Audits will be done monthly for three months. The Administrator will report findings to the monthly QAPI Committee, until May 2026. The administrator is responsible for oversight of this POC		02/20/2026

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F0865 SS = F	Continued from page 39 §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F0865				02/20/2026	

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F0865 SS = F	Continued from page 40 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility Quality Assurance and Performance Improvement (QAPI) committee failed to self-identify systems and processes that may negatively affect resident quality of care, quality of life and review significant events implement data driven QAPI program. The deficient practice affected all residents who resided at the facility and was evidenced by the following: Refer to 607F, 610E, 677E, 684E, 689H, 742D On 1/5/26 at 10:12 AM, the surveyor observed Resident #22 lying in bed in their room. There was a [REDACTED] in the room. The resident was [REDACTED] and informed the surveyor that he/she was [REDACTED]. The surveyor left the room and informed the [REDACTED] if he could assist with an [REDACTED] tour observation. The [REDACTED] exited the room and returned 10 minutes later. The surveyor asked CNA #1 to check if the resident was [REDACTED]. The surveyor observed Resident #22 wearing [REDACTED] which were [REDACTED] with [REDACTED] and [REDACTED] with [REDACTED]. On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility Resident #74 stated [REDACTED] and the resident stated, "I am a [REDACTED]. Resident #74 stated they wanted to be [REDACTED] to [another facility name] and the [REDACTED] had been made aware. Resident #74 also reported that a [REDACTED] ago they called [REDACTED] because the "staff did not [REDACTED]." A review of Resident #74's electronic medical record revealed the resident had a history of [REDACTED] that the facility had not identified. On 1/05/2026 at 10:28 AM, the surveyor observed Resident #9 lying in bed. Resident stated there have been multiple times that they have been [REDACTED] in [REDACTED] and [REDACTED] were also [REDACTED] for hours. Resident #9 also stated that one time they called [REDACTED] was and the [REDACTED] responded due to the staff not helping them. On 1/5/26 at 11:00 AM, the surveyor observed Resident #7 in the dayroom seated at a table alone, and seven other residents were in the room, and no staff observed in attendance. At 11:20 AM the surveyor observed a staff coming from the other room, the staff who identified herself as the [REDACTED].	F0865		02/20/2026

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F0865 SS = F	Continued from page 41 US FOIA (b)(6) informed the surveyor she had to provide activity and monitor both rooms as she does not have any help. The facility had 2 dayrooms where the US FOIA (b)(6) placed the residents after care for activity, (Room 1 and Room #2). According to the US FOIA (b)(6) the facility had one staff assigned to both activity rooms. There was no staff observed in the first room to supervise the residents while the US FOIA (b)(6) had to monitor the residents in Room # 2 (the purple room). On 1/5/26 at 12:30 PM, the facility provided a copy of the facility assessment (FA) which completed by the prior US FOIA (b)(6) on 2/10/25 and revealed under Staff training/education and competencies 3.6 Describe the staff training/education and competencies that are necessary to provide the level and tapes of support and care needed for your resident population ... It may be helpful to review specific references in the regulation regarding the facility assessment ... Consider the following training topics (this is not an inclusive list) ... A review of the Matrix for Provided (a required document that lists diagnoses for the resident population) that was provided by the Director of Nursing (DON) revealed facility residents had pressure ulcers, required nutritional support by a feeding tube, had falls, indwelling urinary catheters and one resident had a colostomy. On 1/6/26 at 10:13 AM, during an interview with two (2) surveyors, Resident #27 stated their name and was US FOIA (b)(6) that they US FOIA (b)(6) in a long-term care facility. Resident #27 also stated that they had anticipated their appointment the night before and was US FOIA (b)(6) to see their physician because of the NJ Exec Order 26.4b1 US FOIA (b)(6). Resident #27 added that nobody came to get them US FOIA (b)(6) and ready for their appointment on the morning of US FOIA (b)(6) and did not US FOIA (b)(6) the appointment. The resident stated that they felt US FOIA (b)(6) had US FOIA (b)(6) and US FOIA (b)(6) the resident used their US FOIA (b)(6) to indicate the US FOIA (b)(6) was from the US FOIA (b)(6) to show the US FOIA (b)(6) from their NJ Exec Order 26.4b1 US FOIA (b)(6). On 1/6/26 at 11:15 AM, the surveyor observed Resident #7 seated alone at a table. The resident NJ Exec Order 26.4b1 and was moving US FOIA (b)(6) and in the wheelchair. Resident #7 appeared US FOIA (b)(6). The US FOIA (b)(6) was in the next room and could not visualize what was going on in the first room.	F0865		02/20/2026

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F0865 SS = F	Continued from page 42 On 1/7/26 at 10:11 AM, the surveyor observed the resident in activity with 6 other residents, there was no staff in attendance. The resident [redacted] to another resident had to ask the resident to [redacted]. The surveyor walked to the next room and observed the Activity staff in the back of the purple room, with her back facing the entrance door to the room, looking through some papers. She could not visualize the residents. At 10:18 AM, the surveyor was about to exit the door to get a staff at the nursing station to assist Resident #7, when the Activity staff came to the room and stated she had to get something in the next room. She was not aware that the surveyor had been in the first room, as the room is divided by a wall, and she was in the back of the purple room. A review of the electronic medical records for Resident #7, along with facility provided documents identified the resident as being at [redacted] NJ Exec Order 26.4b1, was [redacted] required [redacted] and sustained [redacted] including [redacted] that required [redacted] to the [redacted] NJ Exec Order 26.4b1 for a [redacted] and [redacted] to the [redacted] NJ Exec Order 26.4b1 and [redacted] for a [redacted] NJ Exec Order 26.4b1 to the [redacted] and on [redacted] for a [redacted] NJ Exec Order 26.4b1 and [redacted] to the [redacted] which required [redacted] On 1/07/26 at 12:27, PM the [redacted] US FOIA (b)(6) present, confirmed that they were unable to provide all requested employee files, [redacted] US FOIA stated "we cannot find them." On 01/09/26 at 8:39 AM, the surveyor interviewed the [redacted] US FOIA (b) regarding what was the purpose of the FA. The [redacted] US FOIA (b) stated it identified the care and services the facility offered and he stated it was completed prior to his arrival. When asked if he had reviewed it, he stated "I did not". On 01/09/26 at 8:43 AM, the surveyor asked the [redacted] US FOIA (b) to review the Tacitly Assessment and show the surveyor the competencies and training requirements identified for the staff based on the resident population. The [redacted] US FOIA (b) stated, "I can't say I see it." The surveyor asked about the QAPI process and how would a QAPI plan be initiated? The [redacted] US FOIA (b) stated when department heads identified and issue in the department, they would complete audits. The [redacted] US FOIA (b) stated that the department head would bring the concern to the QAPI meeting they would discuss it at the QAPI meeting and develop audits to rectify the problem and the goal would be set at 100%. The [redacted] US FOIA (b) stated the problem must be identified, the	F0865		02/20/2026

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F0865 SS = F	Continued from page 43 measures in place for review, data must be collected for each QAPI. The surveyor asked the [US FOIA (b)] what the current QAPI plans were and he stated per the most recent QAPI meeting, held on 10/9/25, the current QAPI plans were: 1. Residents with weight loss completed by the [US FOIA (b)(6)]. 2. Pharmacy consultant report. 3. Antibiotic Stewardship. 4. Rehabilitation from the former rehabilitation company. 5. Number of grievances. 6. Dietary (not related to sanitation). 7. Radiology and Cardiology. 8. Wheelchair cleaning. When asked if there was a review of significant events, including when [NJ EXEC] was called by two residents, the employee files that were not available, and there was no QAPI plans related to staffing, related to failure to identify residents with [NJ EXEC] and for not having a system in place to ensure resident were sent to appropriate appointments, or appointment outside of the facility were rescheduled as needed. The [US FOIA (b)] stated he was unaware of "how bad" the employee files were and moving forward he would do more QAPI plans. NJAC 8:39-27.1(a)	F0865		02/20/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a	F0880	Element 1 – Corrective Action The [US FOIA (b)(6)] on 1/9/26 was counseled on P.L.2019 c.330 requirements, mandating vaccination for all employees including non-direct care, and only physician-documented medical exemptions on the required form will be accepted. The Infection Preventionist conducted vaccination clinics on multiple dates in January and February 2026. The Infection Preventionist reviewed and verified all medical exemption documentation. Employees refusing vaccination without valid exemption were removed from the schedule per policy and state requirements. Element 2 – Residents Potentially Affected	02/20/2026

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NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
(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	
F0880 SS = F	Continued from page 44 minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 44 All residents have the potential to be affected due to potential influenza transmission. No specific residents were identified as affected. Vaccination and exemption records were reviewed by Director of Nursing to ensure compliance for all employees working in the Skilled Nursing Facility. Element 3 – Systemic Changes The Influenza Vaccination Policy was reviewed and is in accordance to state regulation. On 2/4/26 Administrator completed education to facility Department Heads on the vaccination requirements. Element 4 – Monitoring / QAPI Oversight The Director of Nursing or designee will audit influenza vaccination records maintained by the Infection Preventionist weekly through March 2026. Director of Nursing will report findings to the monthly QAPI meeting, until April 2026. The director of nursing is responsible for oversight of this POC.			02/20/2026	

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F0880 SS = F	Continued from page 45 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, review of facility policies and review of pertinent facility documentation, it was determined that the facility failed to develop a system to prevent the spread of potential influenza (flu) by ensuring a process was in place to monitor employee flu vaccination to prevent potential transmission of influenza to residents. This deficient practice had the potential to affect all resident who resided at the facility and was evidenced by the following: Reference: Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings; Health Care Providers (HCP); April 28, 2025. On January 13, 2020, Governor Murphy signed P.L. 2019 c. 330 (codified at N.J.S.A. 26:2H-18.79 and referred to hereafter as "the Statute"). The Statute requires certain healthcare facilities to establish and implement an annual influenza vaccination program. The New Jersey Department of Health (Department) is required by the Statute to promulgate rules and designate a medical exemption form to be distributed to the covered healthcare facilities. This memo and the attached form are intended to assist general or special hospitals, nursing homes (long-term care facilities licensed pursuant to N.J.A.C. 8:39), and home health care agencies, collectively referred to as "facility" or "facilities," in understanding and meeting their obligations under the Statute, until the rules and the medical exemption form can be adopted through rulemaking. All facility employees are required to be vaccinated, including employees who are not responsible for direct patient care. Per diem and contract employees are to be considered facility employees and are required to be vaccinated. Facilities are required to review and confirm each medical exemption to ensure the exemption is consistent with standards enumerated by the Advisory Committee on Immunization Practices,	F0880				02/20/2026	

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F0880 SS = F	Continued from page 46 which can be found at: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html. Facilities must maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee. The Department will address through rulemaking proper procedures for submitting data to the Department. The facility must require any employee who does not receive an influenza vaccination to wear a surgical or procedural mask when in direct contact with patients and in common areas, as specified in facility policy, or to be removed from direct patient care responsibilities during influenza season. On 1/7/26 at 11:22 AM, the surveyor interviewed the US FOIA (b)(6) regarding the staff flu vaccine process, and she stated that there were many exemptions for the flu vaccine and those staff members must wear a mask during flu season. On 1/7/26 at 11:55 AM, the surveyor reviewed the facility provided documentation for staff flu vaccinations provided by the US FOIA (b)(6). The surveyor noted that 24 out of 75 employees (32%) were documented to have NJ Exec Order 26.4b1 the flu vaccine for the current flu season. No medical documentation was found for these NJ Exec Order 26.4b1. Many of the declination forms had no reason for refusal noted, other had various reasons including but not limited to NJ Exec Order 26.4b1. NJ. On 1/7/26 at 12:09 PM, the surveyor interviewed the US FOIA (b)(6), who stated she was unaware of employee flu vaccine NJ Exec Order 26.4b1 and would provide more information. On 1/08/2026 at 9:28 AM, the surveyor interviewed the US who stated she was not aware of the current guidance for the flu vaccine including the New Jersey statute of 2020. She stated that she reminded managers to ensure their employees are wearing masks and wearing them properly. When asked if she does any audits regarding wearing masks and wearing them correctly, she stated she has no audits, and "if I see a problem, I tell them".	F0880		02/20/2026

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F0880 SS = F	Continued from page 47 On 1/08/2026 at 9:53 AM, the surveyor interviewed the [REDACTED] who stated she was unaware any current guidance for the flu vaccine including the NJ state statute of 2020. No further information was provided by the facility. A review of facility provided policy " Influenza Vaccine", not dated included: Policy Statement All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or resident' legal representatives); for example, risk factors that have been identified for specific age groups or individuals with risk factors such as allergies or pregnancy. Policy Interpretation and Implementation 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless vaccine is medically contraindicated, or the resident or employee has already been immunized. 2. Employees hired or residents admitted between October 1st, and March 31st shall be offered the vaccine within 5 working days of the employee's job assignment or the resident's admission to the facility. 3. Employees will be offered the influenza vaccine at no charge, at a location onsite. 4. Prior to the vaccination, the resident or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record. 5. For those who receive the vaccine, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record.	F0880				02/20/2026	

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F0880 SS = F	Continued from page 48 7. If an employee refuses the vaccine for reasons other than medical contraindication, this shall be documented on the employee informed consent for influenza vaccine. 10. Residents and staff may obtain their influenza vaccines from their personal physicians. Documentation of previous vaccination should be provided to the facility. 11. Administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. N.J.A.C. 8:39-19.4(a)	F0880				02/20/2026	
F0940 SS = F	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to: This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, it was determined that the facility failed to develop and implement a staff training program and ensure staff were competent to provide care and services for the resident population as identified on the facility assessment. The deficient practice was evidenced by the following: On 1/5/26 at 12:30 PM, the facility provided a copy of the facility assessment (FA) which completed by the prior US FOIA (b)(6) on 2/10/25 and revealed under Staff training/education and competencies 3.6 Describe the staff training/education and competencies that are necessary to provide the level and tapes of support and care needed for your resident population ... It may be helpful to review specific references in the regulation regarding the facility assessment ... Consider the following training topics (this is not an inclusive list) ... A review of the Matrix for Provided (a required document that lists diagnoses for the resident population) that was provided by the	F0940	Element 1 – Corrective Action Administrator, Director of Nursing, and Assistant Director of Nursing reviewed the resident population and identified required clinical competencies. Which included residents requiring specialized care such as feeding tubes, indwelling urinary catheters, colostomies, pressure ulcers/wounds, and were reviewed for negative outcomes related to absence of documented competencies; no adverse outcomes were identified. Element 2 – Residents Potentially Affected All residents have the potential to be affected. The Director of Nursing reviewed the facility assessment and resident diagnosis matrix to identify required competencies for the resident population, including wound care, feeding tube management, catheter care, ostomy care, and infection prevention. No residents were identified as affected. Element 3 – Systemic Changes On 2/2/26 Administrator US FOIA (b)(6) or nursing of the education requirements. Specific competency training programs for nursing staff were developed based on resident acuity. The Assistant Director of Nursing developed and implemented a competency training schedule. Competencies apply to Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants. New nursing employees complete required competencies during orientation prior to working independently.			02/20/2026	

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F0940 SS = F	Continued from page 49 US FOIA (b)(6) revealed facility residents had NJ Exec Order 26.4b1 On 01/09/26 at 8:43 AM, the surveyor asked the US FOIA (b)(6) to review the FA and show the surveyor the competencies and training requirements identified for the staff based on the resident population. The US FOIA (b)(6) stated, "I can't say I see it." On 01/09/26 at 11:20 AM, the surveyor interviewed the US FOIA (b)(6). The surveyor asked if the US FOIA (b)(6) had a schedule on training that she completed for the staff. The US FOIA (b)(6) stated that she did not have a schedule of training for the staff and confirmed that competencies were not completed. The US FOIA (b)(6) provided a binder of education that was completed, and stated education was completed in relation to specific incidents that had occurred with residents. On 01/09/26 at 11:48 AM, the surveyor interviewed the US FOIA (b)(6) regarding any education or staff competencies that were completed for staff. The US FOIA (b)(6) stated she was aware that the 12 hours of Certified Nurse Aide (CNA) education had been completed, and there was no additional staff education or competencies based on the CNAs performance evaluation. NJAC-8:39-33.4	F0940	Continued from page 49 Element 4 – Monitoring / QAPI Oversight The Director of Nursing or designee will conduct monthly audits of employee education/competency files to ensure competencies are completed. Audits will be done for three months. The director of nursing will present the findings of the order at the monthly QAPI meeting until May 2026. The director of nursing is responsible for oversight of this POC	02/20/2026
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency,	F0610	Element 1 – Corrective Action Grievances were initiated for Resident #9 and Resident #74 related to reported concerns involving NJ Exec Order 26.4b1 care and NJ Exec Order 26.4b1. Findings were documented and reviewed by facility leadership. NJ Exec Order 26.4b1 related to the grievance was identified for Resident #9 or Resident #74. Element 2 – Residents Potentially Affected All residents have the potential to be affected by the deficient practice. The Social Services Director reviewed the grievance logs from the past 30 days. The Administrator reviewed the incident log to determine whether any grievances should have been initiated. No other residents were found to be affected.	02/20/2026

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F0610 SS = E	Continued from page 50 within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to ensure investigations were initiated to determine if potential [REDACTED] and [REDACTED] had occurred when residents who were [REDACTED] on staff to provide care, contacted [REDACTED] due to the facility not providing [REDACTED] care or [REDACTED] with [REDACTED]. This deficient practice was identified for 2 of 2 residents (Resident #9 and Resident #74) reviewed for [REDACTED] and [REDACTED] and was evidenced by the following: a. On 1/5/2026 at 10:28 AM, during the initial tour, the surveyor observed Resident #9 in bed, and the surveyor inquired about the care provided at the facility. Resident #9 stated there had been multiple times that they had been [REDACTED] Resident #9 also stated that one time they called [REDACTED] due to not being provided [REDACTED] care and the [REDACTED] responded to the facility. On 1/6/2026 at 8:58 AM, the surveyor interviewed Resident #9 again regarding the date the [REDACTED] call was made, and the resident was unable to recall. On 1/6/26 AT 11:10 am, the surveyor reviewed the electronic medical record (EMR) which revealed the following: A review of the Admission Face Sheet (an admission summary) reflected that Resident #9 was admitted to the facility with a diagnosis which included but was not limited to, [REDACTED]. Admission Minimum Data Set (MDS), an assessment tool, dated [REDACTED], which indicated Resident #9 had a Brief Interview for Mental Status (BIMS) score of [REDACTED] which indicated [REDACTED] and that the resident was [REDACTED] of [REDACTED] and [REDACTED]. A review of the individual comprehensive care plan (ICCP) included a focus area dated [REDACTED], that the resident was [REDACTED] of [REDACTED] and [REDACTED] with goals that the resident would remain [REDACTED] of [REDACTED] and [REDACTED]. A focus area dated [REDACTED] for [REDACTED] was also noted with an intervention that the resident needs [REDACTED] of [REDACTED] with [REDACTED].	F0610	Continued from page 50 Element 3 – Systemic Changes On February 2nd and 3rd, the Director of Nursing and Administrator conducted in-service for all nursing staff and department heads regarding the grievance process and the facility procedure when [REDACTED] arrive at the building due to a resident calling [REDACTED]. Notification procedures were posted at the nurses' stations to reinforce staff responsibilities and ensure that if [REDACTED] arrive due to a resident calling [REDACTED] or alleging potential abuse or neglect, the concern is promptly identified, investigated, documented, and reported in accordance with facility policy and regulatory requirements. Element 4 – Monitoring / QAPI Oversight The Social Worker/designee will conduct audits of incident reports, grievance logs, and investigation files to ensure any potential concerns are documented, investigated, and resolved per facility policy. Audits will be completed weekly x 4 weeks and then monthly for 3 months. The Social Worker will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC.	02/20/2026

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F0610 SS = E	Continued from page 51 There was no information related to calling [redacted] documented on the care plan. A review of the EMR from NJ Exec Order 26.4b1 did not reveal any progress notes or ICCP related to the resident making a call to [redacted]. On 1/06/2026 at 1:17 PM, the surveyor interviewed the US FOIA (b)(6) who stated Resident #9 called [redacted] about ten days ago. When asked if she would complete an investigation of any [redacted] calls made by residents? The US FOIA (b)(6) stated, "yes, they should be investigated". On 1/07/2026 at 2:37 PM, the survey team interviewed the US FOIA (b)(6) who stated that a resident complaining of not receiving care that was "so [redacted] that resident called [redacted] could be [redacted] of [redacted]. She also stated that this should be investigated and that she would absolutely investigate what happened and if it was [redacted] she would definitely report it (to the Department of Health). b. On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility Resident #74 stated NJ Exec Order 26.4b1 and the resident stated, "I am [redacted] Resident #74 stated they wanted to be [redacted] to a [another facility name] and the US FOIA (b)(6)) had been made aware. Resident #74 also reported that a [redacted] ago they called [redacted] because the "staff did not [redacted] breakfast." Resident #74 stated they were [redacted] because "it was after 10:00 AM and the staff did not [redacted] and Resident #74 stated that they were a [redacted] and they started [redacted]. On 1/06/2026, at 10:00 AM the surveyor reviewed the medical record for Resident #74 which revealed the following: According to the facility Admission Record, an admission summary, reflected that Resident #74 was admitted to the facility with diagnoses that included, NJ Exec Order 26.4b1 [redacted] [redacted]. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the	F0610		02/20/2026

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F0610 SS = E	Continued from page 52 resident was [REDACTED] NJ Exec Order 26.4b1, Section [REDACTED] NJ Exec was left blank. A review of the individual comprehensive care plan (ICCP) included a Focus area dated [REDACTED] NJ Exec Order [REDACTED] NJ Exec Order [REDACTED]. Goals included that the [REDACTED] NJ Exec Order 26.4b1 will be met through the next review date. A Intervention revealed the resident needs [REDACTED] NJ Exec Order 26.4b1 of [REDACTED] NJ with [REDACTED] NJ Exec Order [REDACTED]. A review of the Physician History and Physical note dated [REDACTED] NJ Exec Order 26.4b1 revealed that Resident #74 was "seen in bed talking to [REDACTED] NJ Exec and reporting not being [REDACTED] NJ Exec Order 26.4b1". On 1/06/26 at 11:34 AM, the surveyor interviewed the [REDACTED] US FOIA (b) regarding Resident #74's telephone call to [REDACTED] NJ Exec. The [REDACTED] US FOIA (b) stated if a resident had called [REDACTED] NJ Exec the incident should have been documented in the medical record and investigation should have been completed. The [REDACTED] US FOIA (b) confirmed she was not aware that Resident #74 called [REDACTED] NJ Exec and had no investigation to provide. On 1/07/2026 at 12:46 PM, the survey team interviewed the [REDACTED] US FOIA (b)(6) who stated he has been employed at this facility since [REDACTED] NJ Exec Order 26.4b1. He stated that he was the [REDACTED] NJ Exec Order 26.4b1 and he has received training with in-services and videos during orientation. He stated that he tried to go to morning meeting and he did not keep any notes from meetings. He stated that he was notified if [REDACTED] NJ Exec entered the facility. The [REDACTED] US FOIA (b) stated he is notified of [REDACTED] NJ Exec being called and if the [REDACTED] NJ Exec asked to speak with [REDACTED] US FOIA (b)(6). On certain days the DON would be the next person responsible, and he stated, there was a list that include the [REDACTED] US FOIA (b)(6) and other staff would be contacted to ensure someone was made aware that the [REDACTED] NJ Exec were in the facility. When asked, if resident was not being [REDACTED] NJ Exec or [REDACTED] NJ Exec with [REDACTED] NJ Exec to the point that the resident contacted [REDACTED] NJ Exec could that be potential [REDACTED] NJ Exec per the facility policy? The [REDACTED] US FOIA (b) stated "I would have to investigate" and that he was not sure if it was potential [REDACTED] NJ Exec. He further stated that he was not aware of [REDACTED] NJ Exec being called and that [REDACTED] NJ Exec Order 26.4b1 were contacted for either Resident #9 or Resident #74. When asked if he had been aware that resident [REDACTED] NJ Exec Order 26.4b1 of not being [REDACTED] NJ Exec Order 26.4b1 with [REDACTED] NJ Exec or not being [REDACTED] NJ Exec enough that the resident called [REDACTED] NJ Exec would that be investigated. The [REDACTED] US FOIA (b) stated, "yes."	F0610		02/20/2026

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F0610 SS = E	Continued from page 53 On 1/08/26, after surveyor inquiry, the [US FOIA (b)] provided the surveyor with a Grievance Report dated [NJ Exec Order 26.4]. A review of the Grievance Report revealed that Resident #74 reported that they became [NJ Exec Order 26.4b1] when they had not received their [NJ Exec Order 26.4] on [NJ Exec Order 26.4]. Resident #74 stated that they had a [NJ Exec Order 26.4b1] and called [NJ Exec Order 26.4b1]. No further information was provided by the facility. A review of facility policy "Abuse, Neglect, Exploitation and Misappropriation Prevention Program", revised April 2021 included: Policy Statement Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Policy Interpretation and Implementation The resident abuse, neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriating of property by anyone including, but not necessarily limited to: 2. Develop and implement policies and protocols to prevent and identify a. abuse or mistreatment of residents; b. neglect of residents; and/or c. theft, exploitation or misappropriation of resident property. 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. Review of facility provided policy "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating", revised September 2022, included: Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as			F0610			02/20/2026

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F0610 SS = E	Continued from page 54 required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Investigating Allegations: 1. All allegations are thoroughly investigated. The administrator initiates investigations. 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident. e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to who the accuse employee provides care or services; k. reviews all events leading up to the alleged incident; and l documents the investigation completely and thoroughly 11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator. NJAC 8:39-9.4(f)	F0610		02/20/2026
F0676 SS = E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's	F0676	Element 1 – Corrective Action For Resident# 27 a wall-mounted file holder was placed next to the resident's bed to hold the NJ Exec Order 26.4b1 Binder. The facility translation line	02/20/2026

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F0676 SS = E	Continued from page 55 needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: COMPLAINT #2704937 Based on observation, interview, and record review, it was determined that the facility failed to provide a NJ Exec Order 26.4b1 for a resident identified as having NJ Exec Order 26.4b1.	F0676	Continued from page 55 was reactivated, and staff were in-serviced on the use of the translation line, signage, and the location/use of NJ Exec Order 26.4b1 Binders. Clear signage related to the NJ Exec Order 26.4b1 line was placed in resident #27 room and at the nurses' station. Element 2 – Residents Potentially Affected All residents have the potential to be affected by this deficient practice. All residents were assessed for communication needs which included inability to make needs known, language barriers, cognitive barriers. The Therapy Department completed resident communication needs assessments. No additional residents were identified. Element 3 – Systemic Changes All nursing staff were in-serviced by the Facility Educator on resident communication needs. The Director of Nursing or designee will assess the communication needs of all new admissions and readmissions and will ensure that reassessment is completed at the time of the quarterly MDS assessment, or with any significant change in condition, and whenever there is a change in the resident's ability to communicate. Element 4 – Monitoring / QAPI Oversight The Director of Nursing/designee will conduct audits of care plans for new admissions, readmissions, and residents with significant change to ensure communication needs are identified and addressed. Audits will be completed weekly x 4 weeks and then monthly for 3 months. The Director of Nursing/designee will present the results of these audits at the monthly QAPI meeting until May 2026. The Director of Nursing is responsible for oversight of this POC.	02/20/2026

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F0676 SS = E	Continued from page 56 This deficient practice was identified for one (1) of one (1) resident (Resident #27) reviewed for [redacted] and [redacted] NJ Exec Order 26.4b1 and was evidenced by the following: Refer to 684E A review of the Complaint # [redacted] NJ Exec Order 26.4 reflected an [redacted] NJ Exec Order 26.4 event date on [redacted] NJ Exec Order 26.4 at 8:15 AM showed the family representative arrived at the hospital on that day at 8:00 AM that day, to meet the resident and was told that the facility cancelled the appointment. The family representative then arrived at the facility at 8:15 AM and spoke with Resident # 27 who spoke [redacted] NJ Exec Order 26.4b1. On 1/5/26 at 10:44 AM, the Certified Nursing Assistant (CNA #1) assigned to the resident that day entered Resident #27's room with the surveyor. At that time, the CNA #1 could not locate a [redacted] NJ Exec Order 26.4b1 and confirmed that a [redacted] NJ Exec Order 26.4b1 was not [redacted] NJ Exec Order 26.4b1 inside the resident's room. The surveyor reviewed the medical record for Resident #27. According to the resident's Admission Record (AR; or face sheet; admission summary) reflected the resident was admitted to the facility with diagnoses that included but not limited to: [redacted] NJ Exec Order 26.4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] NJ Exec Order 26.4 reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident had a [redacted] NJ Exec Order 26.4b1. Section [redacted] NJ Exec Order 26.4b1 reflected Resident #27's [redacted] NJ Exec Order 26.4b1 was [redacted] NJ Exec Order 26.4b1 redacted] and needed an [redacted] NJ Exec Order 26.4b1. A review of the individualized comprehensive care plan included a focus on [redacted] NJ Exec Order 26.4b1 that was initiated/revised on [redacted] NJ Exec Order 26.4b1. The interventions were	F0676		02/20/2026

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	Continued from page 57 dated/ revised on [REDACTED] included that there were staff that [REDACTED] the same [REDACTED] and were able to [REDACTED] The family of Resident #27 was also available via phone to [REDACTED] and the resident had a [REDACTED] in their room. On 1/6/26 at 1:42 PM, during an interview with the surveyor, CNA #2 stated that the family arrived on [REDACTED] to go with the resident in the transport to [REDACTED] help with [REDACTED] the resident "doesn't [REDACTED] you know . On 1/6/26 at 2:45 PM, during an interview with the surveyor, the [REDACTED] (US FOIA (b)(6)) stated he could not [REDACTED] the same [REDACTED] as Resident #27 and [REDACTED] with the resident by [REDACTED] and by looking at the resident. The [REDACTED] confirmed that he did not use a [REDACTED] , nor did the facility provide those services. On 1/7/26 at 11:03 AM, during an interview with the surveyor, the [REDACTED] (US FOIA (b)(6)) stated that they did not have a [REDACTED] or [REDACTED] in the facility. On 1/7/26 at 11:07 AM, in the presence of the [REDACTED] (US FOIA (b)(6)) and the surveyor, the [REDACTED] (US FOIA (b)(6)) provided binders to the surveyor that had [REDACTED] with [REDACTED] (US FOIA (b)(6)) The [REDACTED] (US FOIA (b)(6)) informed the surveyor that she found the binders for [REDACTED] (US FOIA (b)(6)) was found underneath the bedside table. At that time, the surveyor discussed the concern with the [REDACTED] (US FOIA (b)(6)) that the staff was not aware of and could not be located prior to surveyor inquiry. On 1/9/26 at 12:02 PM, during a meeting with the survey team the [REDACTED] (US FOIA (b)(6)) , the surveyor discussed the concern with the [REDACTED] (US FOIA (b)(6)) that the staff was not aware of. A review of the provided facility policy titled; Translation Services dated/revised on 1/2020 included that the facility maintained a contracted			

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F0676 SS = E	Continued from page 58 relationship with a translation service for language and sign language. Family members and friends shall not be relied upon to provide interpretation services for the resident unless explicitly requested by the resident. Family and friends used to interpret must have a written consent for disclosure of protected health information... No further information was provided. NJAC 8:39-27.1 (a)	F0676		02/20/2026
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure residents who were dependent on staff for Activities of Daily Living (ADLs) were provided with timely and appropriate care, and NJ Exec Order 26.4b1. The deficient practice was evidenced for 4 of 4 residents reviewed for ADLs (Resident #9, Resident #22, Resident #73, Resident #74) and was evidenced by the following: a) On 1/5/26 at 10:12 AM, during the initial tour of the facility, a NJ Exec Order 26.4b1 was in the hallway. The surveyor continued the tour and entered Resident #22's room. A NJ Exec Order 26.4b1 was noted in the room. The surveyor asked a US FOIA (b)(6) to assist with an NJ Exec Order 26.4b1 tour. Resident #22 had NJ Exec Order 26.4b1. The US FOIA (b)(6) exited the room and returned 10 minutes later. The surveyor asked CNA #1 to check if the resident was NJ Exec Order 26.4b1. The surveyor observed Resident #22 wearing NJ Exec Order 26.4b1. CNA #1 informed the surveyor that the 11:00 PM to 7:00 AM, staff provided care and left the NJ Exec Order 26.4b1 on the resident. The surveyor then asked CNA #1 to ask the US FOIA (b)(6) to come to the room. On 1/5/26 at 10:30 AM, the surveyor summoned the US FOIA (b)(6) to the	F0677	Element 1 – Corrective Action Resident #74 confirmed they preferred a NJ Exec Order 26.4b1 rather than a NJ Exec Order 26.4b1 the care plan was updated accordingly. Resident #22 was provided immediate care and NJ Exec Order 26.4b1 was assessed, and appropriate NJ Exec Order 26.4b1 supplies were provided. Resident #9 had NJ Exec Order 26.4b1 assessment done on NJ Exec Order 26.4b1 with no new findings. The resident's care plan and CNA assignment were reviewed to ensure appropriate and timely incontinence care was provided according to the resident's needs. Resident #9 was interviewed by the Social Services Director to address any concerns and ensure needs were met. Element 2 – Residents Potentially Affected All residents have the potential to be affected by this deficient practice. The Director of Nursing audited Nursing Assessments and MDS to identify resident's dependent on staff or requiring extensive assistance with ADLs. Residents were interviewed for shower/bathing preferences and care plans were updated accordingly. No additional residents were identified. Element 3 – Systemic Changes CNA assignment sheets were updated to identify residents requiring meal assistance and level of assistance, and residents preferring meals in-room vs dining room. A Shower Accountability Form was implemented requiring CNA notification to the nurse and signature when a resident refuses; the nurse verifies refusal, documents the reason, and signs. The nurse also verifies showers documented as given. The Facility Educator completed in-service education for all nursing staff by 2/3/26 regarding the Shower Accountability Form, honoring resident	02/20/2026

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	Continued from page 59 room and we both observed that the [REDACTED] the [REDACTED] stated in the presence of CAN #1, that the resident should not have [REDACTED] NJ Exec Order 26.4b1 On 1/6/26 at 8:30 AM, the surveyor observed the resident in the [REDACTED] CNA #2 was in the room making the bed. During an interview with CNA#2, she stated that the resident was [REDACTED] of [REDACTED] NJ Exec Order 26.4b1 the resident required [REDACTED] with [REDACTED] from the [REDACTED] to the [REDACTED] NJ Exec Order 26.4. On 1/6/26 at 9:20 AM, the surveyor conducted an interview with Resident #22. The resident informed the surveyor that they did not request to [REDACTED] NJ Exec Order 26.4b1. The resident stated that they were [REDACTED] when they had to use the [REDACTED] NJ Exec Order 26.4b1. On 01/07/2026 10:10 AM, the surveyor interviewed the [REDACTED] US FOIA (b)(6) regarding incontinence care protocol. The [REDACTED] stated [REDACTED] care was to be provided every 2 hours and as needed. The [REDACTED] also stated that no resident should have [REDACTED] as the [REDACTED] could be affected. The [REDACTED] stated that she was made aware of the issue with the above resident, in-service education was done, she will provide the in-service education regarding [REDACTED] care. On 01/07/2026 at 12:16 PM, the surveyor interviewed again CNA #1 who cared for Resident #22 on 1/5/26. The [REDACTED] admitted and contradicted the earlier statement provided to the surveyor and admitted that she placed the [REDACTED] on the resident. CNA #1 stated again that the resident was a [REDACTED] "it is much easier for the resident and staff. The surveyor then asked CNA #1 what should be done for a resident that was [REDACTED] CNA #1 stated, "NJ Exec Order 26.4b1 [REDACTED]" b. On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility Resident #74 stated [REDACTED] NJ Exec Order 26.4b1 and the resident stated, "I am [REDACTED] NJ Exec Order 26.4b1 Resident #74 stated they wanted to be [REDACTED] to [another facility name] and the [REDACTED] US FOIA (b)(6) had been made aware. Resident #74 also reported that a [REDACTED] NJ Exec Order 26.4b1 ago they called [REDACTED] NJ Exec Order 26.4b1 because the "staff did not [REDACTED] NJ Exec Order 26.4b1." Resident #74 stated they were [REDACTED] NJ Exec Order 26.4b1 because "it was after 10:00 AM and the staff did not [REDACTED] NJ Exec Order 26.4b1 and Resident #74 stated that they were a [REDACTED] NJ Exec Order 26.4b1 and they started [REDACTED] NJ Exec Order 26.4b1. Resident #74 also reported that they had not received a [REDACTED] NJ Exec Order 26.4b1 since [REDACTED] NJ Exec Order 26.4b1		Continued from page 59 preferences, maintaining resident dignity, providing timely incontinence care, responding promptly to call bells, and ensuring completeness of plan of care documentation. Element 4 – Monitoring / QAPI Oversight The Director of Nursing/designee will conduct audits to include review of care plan documentation, accountability logs, CNA assignment sheets, and random resident interviews. Audits will be completed weekly x 4 weeks and then monthly for 3 months. The Director of Nursing/designee will present the results of these audits at the monthly QAPI meeting until May 2026. The Director of Nursing is responsible for oversight of this POC.	

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F0677 SS = E	Continued from page 60 they were admitted to the facility. The resident stated that every time the resident asked for a [REDACTED] the staff stated the [REDACTED] was [REDACTED]. On 1/06/26 at 9:22 AM the surveyor requested the [REDACTED] US FOIA (b)(6) provide documentation of the showers that were given to the residents. The surveyor reviewed the facilities [REDACTED] binder" for [REDACTED] NJ Exec Order 26.4b1 [REDACTED] for [REDACTED] NJ Exec Order 26.4b1 and [REDACTED] NJ Exec Order 26. There were none found for resident #74. In addition, there were no [REDACTED] assessments found in the medical record for resident #74. On 1/06/26 at 9:30 AM, the surveyor interviewed the [REDACTED] US FOIA (b)(6)) regarding the [REDACTED] NJ Exec Order 26.4b1 [REDACTED] for Resident #74. In the presence of the surveyor, the [REDACTED] reviewed the [REDACTED] binder" and was unable to find any [REDACTED] sheets for Resident #74. The [REDACTED] US FOIA stated she would "look" for them. No further information was provided. On 1/06/26 at 12:15 PM Resident #74 stated "I used to get a [REDACTED] at the other facility. I would get out of [REDACTED] NJ Exec Order 26.4b1!" On 1/06/26 at 12:43 PM, the surveyor interviewed the resident's [REDACTED] US FOIA (b)(6) who stated that she had taken care of Resident #74. She stated that their [REDACTED] days were Wednesday and Sunday 7 AM- 3 PM. The resident's [REDACTED] US FOIA stated that she always offered Resident #74 a [REDACTED] NJ Exec Order 26 not a [REDACTED] US FOIA stated, "they [REDACTED] NJ Exec Order 26.4b1 and don't like the [REDACTED] NJ Exec Order 26.4b1 and if they [REDACTED] NJ Exec Order 26 I would document [REDACTED] US FOIA in the [REDACTED] documentation system. The surveyor then reviewed the [REDACTED] US FOIA documentation system for [REDACTED] NJ Exec Order 26.4b1 [REDACTED] US FOIA task [REDACTED] NJ Exec Order 26.4b1 revealed "Resident [REDACTED] NJ Exec Order 26 column was left blank every day since Resident #74's admission date which was approximately [REDACTED] NJ Exec Order 26.4b1 prior. On 01/08/26 at 10:44 AM, the [REDACTED] US FOIA confirmed there were no SRS available for Resident #74. She stated "I will look through the progress notes to see if they received the care." She further stated that the staff informed her that the Resident #74 [REDACTED] NJ Exec Order 26 a [REDACTED] NJ Exec Order 26	F0677		02/20/2026

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F0677 SS = E	Continued from page 61 c. On 1/5/26 at 10:28 AM, during the initial tour, the surveyor observed Resident #9 in bed, and the surveyor inquired about the care provided at the facility. Resident #9 stated there had been multiple times that they had been NJ Exec Order 26.4b1 Resident #9 also stated that one time they called NJ Exec Order 26.4b1 due to not being provided with NJ Exec Order 26.4b1 care and the NJ Exec Order 26.4b1 responded to the facility. On 1/9/26 at 12:02 PM, the above concerns regarding NJ Exec Order 26.4b1 care and NJ Exec Order 26.4b1 were presented to the US FOIA (b)(6) at the pre-exit conference and additional information were requested. On 1/9/26 at 1:30 PM, during the exit conference, no additional information was provided. no additional information was provided. A review of the facility's policy titled, "Activities of Daily Living (ADLs) Supporting last revised 3/2018 revealed the following: Policy Statement Residents will be provided with care and services as appropriate to maintain or improve their ability carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate NJAC 8:39-27.1 (a) 2 (g) (h)	F0677		02/20/2026
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility	F0684	Element 1 – Corrective Action Resident #27's appointment was immediately rescheduled for NJ Ex Order 26.4(b)(1). An earlier appointment was available by a different provider in February, but family wanted to keep the NJ Ex Order 26.4(b)(1) appointment.	02/20/2026

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F0684 SS = E	Continued from page 62 residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Complaint # NJ 2704937 Based on observation, interviews, and record review, it was determined that the facility failed to ensure that a system was developed and implemented that enabled residents to attend outside physician appointments in accordance with resident needs, goals for care, and professional stands of practice. This deficient practice was identified for one (1) of one (1) resident (Resident# 27) reviewed for Activities of Daily Living (ADL) and was evidenced by the following: On 1/5/26 at 10:51 AM, Resident #27 was observed asleep in the activities room and [REDACTED] NJ Exec Order 26.4b1 The surveyor reviewed the medical record for Resident #27. According to the resident's Admission Record (AR; or face sheet; admission summary) reflected the resident was admitted to the facility with diagnoses that included but not limited to: [REDACTED] NJ Exec Order 26.4b1 [REDACTED] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [REDACTED] NJ Exec Order 26.4b1 reflected the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED] out of 15, which indicated the resident had a [REDACTED] NJ Exec Order 26.4b1. Section [REDACTED] NJ Exec Order 26.4b1 reflected Resident #27's [REDACTED] NJ Exec Order 26.4b1 and needed an [REDACTED] NJ Exec Order 26.4b1. Further review of the MDS under, Section [REDACTED] NJ Exec Order 26.4b1 reflected the Resident #27 did not exhibit such as [REDACTED] NJ Exec Order 26.4b1 of care. Section [REDACTED] NJ Exec Order 26.4b1 reflected Resident #27 was [REDACTED] NJ Exec Order 26.4b1 for [REDACTED] NJ Exec Order 26.4b1 and [REDACTED] NJ Exec Order 26.4b1. A review of the physician's progress notes (PN)	F0684	Continued from page 62 Element 2 – Residents Potentially Affected All residents have the potential to be affected by this deficient practice. The Director of Nursing or designee conducted an audit of resident appointments scheduled in the two (2) weeks prior to the survey (1/9/26) to identify missed appointments, none were identified. Element 3 – Systemic Changes A large whiteboard calendar was placed in the nurses' station to document all resident appointments (physician, specialty, appointment time, transportation pick-up time). The Facility Educator completed in-service education for all nursing staff by 2/3/26 on use of the whiteboard and documentation requirements for scheduled and missed appointments including physician/specialty, reason missed, family notification, and primary physician notification. Element 4 – Monitoring / QAPI Oversight The Director of Nursing/designee will conduct audits by comparing the appointment calendar, whiteboard calendar, and consult sheets. Missed appointments will be reviewed for required documentation. Audits will be completed weekly x 4 weeks and then monthly for 3 months. The Director of Nursing/designee will present the results of these audits at the monthly QAPI meeting until May 2026. The Director of Nursing is responsible for oversight of this POC.	02/20/2026

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F0684 SS = E	Continued from page 63 revealed two entries made by the provider in the resident's electronic medical record (eMR) which were or NJ Exec Order 26.4b1 and reflected the following: The Physician PN dated NJ Exec Order 26 was the comprehensive overview of Resident #27's status and indicated the resident underwent a NJ Exec Order 26 after a NJ Exec Order 26 that caused NJ Exec Order 26 in NJ Exec Order 26.4b1. The Physician PN dated NJ Exec Order 26, included that the resident had NJ Exec Order 26.4b1 and to follow-up with NJ Exec Order 26.4b1. No Physician PN were found for NJ Exec Order 26 and NJ Exec Order 26. On 1/6/26 at 10:13 AM, during an interview with two (2) surveyors, Resident #27 stated their name and was NJ Exec Order 26 that they NJ Exec Order 26 in a long-term care facility. Resident #27 also stated that they had anticipated their appointment the night before NJ Exec Order 26.4b1 was NJ Exec Order 26 to see their physician because of the NJ Exec Order 26.4b1. Resident #27 added that nobody came to get them NJ Exec Order 26 and ready for their appointment on the morning of NJ Exec Order 26 and did not refuse the appointment. The resident stated that they felt NJ Exec Order 26 had NJ Exec Order 26.4b1, the resident used their NJ Exec Order 26 to indicate the NJ Exec Order 26 was from the NJ Exec Order 26. On 1/6/26 at 2:45 PM, during a meeting with three surveyors, the US FOIA (b)(6) stated that he had his own eMR where he documented the resident's PN and transferred into the facility's eMR. The US FOIA also stated that his office copied then pasted the information into the facility's eMR and that there must have been something that went wrong that occurred with transcribing the NJ Exec Order 26 PNs. The US FOIA stated he would look into the matter. At that time, the physician could not recall if he was informed by the facility of the missed appointment on NJ Exec Order 26. The US FOIA also stated that the resident's NJ Exec Order 26.4b1 could be related to the NJ Exec Order 26.4b1 and could be related to the reason why he referred the resident to the NJ Exec Order 26.4b1. The US FOIA stated he would upload and forward the information to the surveyor. A review of the provided Physician PN that was	F0684		02/20/2026

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F0684 SS = E	Continued from page 64 uploaded into the facility's eMR reflected the following: On [REDACTED] at 3:39 PM, (late entry) the Physician PN included the resident had [REDACTED] [REDACTED] [REDACTED] On [REDACTED] 3:25 PM, (late entry) the Physician PN included the resident had [REDACTED] [REDACTED] On [REDACTED] at 4:01PM, (late entry) the Physician PN included that the resident was seen as a follow-up of the missed appointment [after surveyor inquiry]. Resident #27 [REDACTED] of [REDACTED] and the physician recommended a follow-up with [REDACTED] On 1/7/26 at 11:07 AM, during a meeting with the US FOIA (b)(6) [REDACTED] surveyor inquired if the [REDACTED] was aware that there were no Physician PN on record prior to surveyor inquiry and discussed the concern that [REDACTED] health care staff were not able to view the physician notes. On 1/7/26 at 2:07 PM, a follow up interview was held at the [REDACTED] in which she confirmed that Resident #27 did not [REDACTED] to the physician appointment on [REDACTED] On 1/6/26 at 10:27 AM, during an interview with the surveyor, the US FOIA (b)(6) [REDACTED] stated that appointments were scheduled and then documented in the resident's progress note. On 1/6/26 at 11:01 AM, during an interview with the surveyor, the US FOIA (b)(6) [REDACTED] [REDACTED] stated the US FOIA (b)(6) [REDACTED] handled the scheduling and was not at work that day. The US FOIA (b)(6) [REDACTED] stated she also scheduled appointments for the residents and then it was written on the white bulletin board and in progress notes. According to the US FOIA (b)(6) [REDACTED] the [REDACTED] scheduled appointments were not kept for the record and had no additional information to provide. The US FOIA (b)(6) [REDACTED] stated that any appointments missed for any reason such as transportation, refusals or family member cancellation would be documented under the resident's progress notes. On 1/6/26 at 1:42 PM, during an interview with the surveyor, the US FOIA (b)(6) [REDACTED] stated she learned from the US FOIA (b)(6) [REDACTED] [REDACTED]	F0684	02/20/2026

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F0684 SS = E	Continued from page 65 of US FOIA (b)(6)) when a resident had an appointment so that she could get the resident ready for an appointment. The US FOIA recalled Resident #27 had missed an appointment last week and stated that she was not informed by anybody to get the resident US FOIA for that appointment. The US FOIA also did not recall the resident's name being listed on the appointment/white board. On 1/6/26 at 1:56 PM, the surveyor and the US FOIA (b)(6) reviewed the Resident #27's PN together. At that time, the US FOIA (b)(6) confirmed that there were no documented notes made by facility staff that the resident US FOIA to attend their appointment. The US FOIA (b)(6) also confirmed that the PN did not reflect the physician was made aware of the missed appointment, a rescheduled follow-up appointment with the US FOIA (b)(6) was not found prior to surveyor inquiry. On 1/9/26 at 12:02 PM, in the presence of the survey team, the US FOIA (b)(6) discussed the concern regarding with Resident #27 who had NJ Exec Order 26.4b1, was NJ Exec Order 26.4b1 on staff for NJ Exec Order 26.4b1 sing, was not NJ Exec Order 26.4b1 and prepared by staff to attend their US FOIA (b)(6) appointment that was recommended by the US FOIA (b)(6) since NJ Exec Order 26.4b1. Additionally, the surveyor discussed the concern that the facility failed to reschedule the appointment prior to surveyor inquiry and failed to inform the physician that the appointment he recommended was missed. A review of the facility provided policy titled; Charting and Documentation included the following information to be documented in the resident medical record: objective observation, treatment and services performed, events, incidents or accidents involving the resident...whether the resident refused the procedure/treatment, notification of family, physician, or other staff... The facility was unable to provide any policy regarding scheduling of resident appointments. NJAC 8:39-11.2(b); 27.1 (a)	F0684		02/20/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F0761	Element 1 – Corrective Action The Director of Nursing or designee immediately inspected all medication storage areas to ensure medications of discharged residents were removed. Medications belonging to discharged Residents #78,	02/20/2026

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F0761 SS = E	Continued from page 66 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to dispose of medications for one (1) of one (1) medication refrigerator and for one (1) of one (1) medication room inspected. The deficient practice was evidenced by the following: On 1/7/26 at 10:33 AM, in the presence of the US FOIA (b)(6) the surveyor inspected the medication refrigerator and observed the following: -Spikevax (Moderna COVID-19 Vaccine) the pharmacy label reflected, thawed on 10/10/25 and an expiration date of 12/10/25. -Discharged Resident #78's one (1) box of NJ Exec Order 26.4b1 Resident #78 was discharged on NJ Exec Order 26.4b1. -Discharged Resident #79's one NJ Exec Order 26.4b1 Resident #79 was discharged on NJ Exec Order 26.4b1.	F0761	Continued from page 66 #79, #52, and #81 were identified, removed, and discarded in accordance with the facility's medication disposal policy. NJ Exec Order 26.4b1 were identified. Element 2 – Residents Potentially Affected All residents have the potential to be affected. A review was conducted by the Director of Nursing on medication storage areas to ensure medications belonging to discharged residents had been removed and properly discarded in accordance with policy. No additional residents were identified as affected. Element 3 – Systemic Changes A medication refrigerator tracking log was implemented to document resident name, date placed, medication name, quantity, and nurse initials. Upon discharge, the log is checked, medications removed/disposed per policy, date recorded, and nurse initials documented. On 2/3/26 the Facility Educator finished educating licensed nurses on use of the log and requirement to remove/return/dispose medications upon discharge. Element 4 – Monitoring / QAPI Oversight The Director of Nursing or designee will conduct audits of medication storage to ensure proper medication storage requirements. Audits will be conducted weekly for 4 weeks and then monthly for three months. The results of these audits will be presented by the Director of Nursing or designee at the monthly QAPI meeting until May 2026. The Director of Nursing is responsible for oversight and implementation of this Plan of Correction.	02/20/2026

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F0761 SS = E	Continued from page 67 -Discharged Resident #52's one box (1) of [REDACTED] NJ Exec Order 26.4). Resident #52 was discharged on [REDACTED] NJ Exec Order 26.4. At that time, the [REDACTED] US FOIA (b)(6) that the nurses on the 11:00 PM to 7:00 AM shift and the consultant pharmacist checked for expired medications, and both should have removed the discharged resident's medications from active inventory. On 1/7/26 at 10:59 AM, the surveyor observed 8 boxed of [REDACTED] that belonged to [REDACTED] NJ Exec Order 26.4/Unsampled Resident #81 who [REDACTED] on [REDACTED] NJ Exec Order 26.4. At that time, the [REDACTED] US FOIA (b)(6) stated she would remove the items from active inventory A review of the most recent [REDACTED] US FOIA (b)(6) unit inspection dated [REDACTED] NJ Exec Order 26.4 reflected that there was no expired medication in the storage area. The facility's compliance rate for [REDACTED] NJ Exec Order 26.4b1 was 95.12%. On 1/7/26 at 11:03 AM, the surveyor discussed the concerns found during the inspection of the medication refrigerator and medication room. A review of the undated, provided facility policy titled; Medication Labeling and Storage included that the dispensing pharmacy is contacted for instruction regarding returning or destroying discontinued, outdated or deteriorated medications or biologicals. No further information was provided. NJAC 8:39- 29.4(a) (g)(h), 29.7(a)	F0761		02/20/2026
F0825 SS = E	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy,	F0825	Element 1 – Corrective Action [REDACTED] NJ Exec Order 26.4 services for Resident #74 were initiated on [REDACTED] NJ Exec Order 26.4, including [REDACTED] NJ Exec Order 26.4 evaluation and treatment per physician orders. Documentation reflects services were provided while authorization processes were addressed. Element 2 – Residents Potentially Affected	02/20/2026

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F0825 SS = E	Continued from page 68 and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to provided rehabilitation services per physician order to ensure a resident reached their ^{NJ Exec Order 26.4b1} and ^{NJ Exec Order 26.4b1}. The deficient practice was evidenced for 1 of 1 resident reviewed for ^{NJ Exec Order 26.4b1} services (Resident #74) and was evidenced by the following: On 01/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed and when asked how things were going at the facility, Resident #74 stated, ^{NJ ES} "Resident #74 stated they wanted to be ^{NJ Exec Order 26.4b1} to [another facility name]. Resident #74 also reported that a ^{NJ Exec Order 26.4b1} ago they called ^{NJ Exec} because the staff was not ^{NJ Exec Order 26} them with ^{NJ Exec Order 26.4b1} and was ^{NJ Exec Order 2} because they were ^{NJ Exec Order 26.4b1} ^{NJ Exec Order 26.4b1}. The resident also reported that they had not received ^{NJ Exec Order 26.4b1} since they were admitted because the facility was waiting for an authorization. On 1/6/25 at 11:00, the surveyor reviewed the medical record for Resident #74 which revealed the following: A hospital discharge summary, dated ^{NJ Exec Order 26} detailed Resident #74 was treated for ^{NJ Exec Order 26.4b1} ^{NJ Exec Order 2} treatment prior to ^{NJ Exec Order 2} and recommendations included: ^{NJ Exec Order 26.4b1}	F0825	Continued from page 68 Residents with physician orders for therapy services have the potential to be affected. A review of current residents with physician-ordered rehabilitation services was completed to verify timely initiation; no additional residents were identified as affected. Element 3 – Systemic Changes A therapy order tracking log was implemented to ensure ordered services are initiated promptly upon admission. All residents will be screened by the therapy department upon admission regardless of payer source or authorization status, and therapy evaluations initiated based on physician orders without delay. The Director of Rehabilitation reviews all new admissions to ensure therapy screenings/evaluations are completed. On 1/28/2026, the Administrator educated the incoming ^{US FOIA (b)(6)} (start date ^{NJ Exec Order 26}) on providing therapy screening/evaluation regardless of payer status. Element 4 – Monitoring / QAPI Oversight The Director of Rehabilitation or designee will conduct weekly audits of therapy orders and therapy screenings for all new admissions for four (4) weeks, then monthly for six (6) months. Results will be reported at monthly QAPI demonstrating all admissions were appropriately screened and ordered therapy initiated without delay until 100% compliance is achieved and sustained.	02/20/2026

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NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS		STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004		
(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
F0825 SS = E	Continued from page 69 NJ Exec Order 26.4b1 ...; Description of Further Services Needed: NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 during NJ Exec Order 26.4b1 and for at least NJ Exec Order 26.4b1. NJ Exec Order 26.4b1. Monitor for signs/symptoms NJ Exec Order 26.4b1. Discontinue NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1 if any NJ Exec Order 26.4b1 noted. NJ Exec Order 26.4b1; Please NJ Exec Order 26.4b1 The Physician Orders, active as of NJ Exec Order 26.4b1, were reviewed and an NJ Exec Order 26.4b1 Evaluation and Treat as indicated was ordered on NJ Exec Order 26.4b1. There was no NJ Exec Order 26.4b1 evaluation although the resident had a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were identified as further services. There were no orders related to the NJ Exec Order 26.4b1 There was no NJ Exec Order 26.4b1 documentation or assessment completed per the physician orders on NJ Exec Order 26.4b1 On 01/06/26 at 11:34 AM, the surveyor interviewed the US FOIA (b)(6) in the presence of the survey team. The surveyor asked about the NJ Exec Order 26.4b1 for Resident #74. The US FOIA (b)(6) stated that she spoke with Resident #74 the previous day regarding the need for the facility to get an authorization prior to providing NJ Exec Order 26.4b1 services. The US FOIA (b)(6) stated she asked for NJ Exec Order 26.4b1 to show her how to NJ Exec Order 26.4b1 Resident #74's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 so she "could do it when she was there." The US FOIA (b)(6) stated the resident doesn't NJ Exec Order 26.4b1 due to being NJ Exec Order 26.4b1. The US FOIA (b)(6) confirmed Resident #74 has not received any NJ Exec Order 26.4b1 since they were admitted on NJ Exec Order 26.4b1 and the US FOIA (b)(6) needed to follow- up to obtain authorization. On 01/06/26 at 12:15 PM, the surveyor asked Resident #74 about receiving NJ Exec Order 26.4b1 services and they stated, "I've been waiting for the authorization and stated they used a NJ Exec Order 26.4b1 wheelchair at the prior facility but was NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. Resident #74 stated that they got up NJ Exec Order 26.4b1 ago via a NJ Exec Order 26.4b1. On 01/06/26 at 1:17 PM, the surveyor asked the US FOIA (b)(6) if the facility accepted an admission would the facility wait until they received payment authorization prior to providing NJ Exec Order 26.4b1 services, despite having an order for NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that NJ Exec Order 26.4b1 should be	F0825		02/20/2026

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F0825 SS = E	Continued from page 70 performed and an evaluation and treatment for Resident #74 should have occurred regardless of payment source. The [US FOIA (b)] stated he was unaware that Resident #74 was not provided with [NJ Exec Order] services. NJAC 8:39-27.1(a)	F0825		02/20/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or	F0582	Element 1 – Corrective Action Resident #1 was provided with the appropriate SNF ABN and documentation was completed by the social worker. Element 2 – Residents Potentially Affected All residents have the potential to be affected by the deficient practice. Residents with recent Medicare coverage changes who remained in the facility were reviewed by the Director of Rehabilitation or designee to verify if ABN is appropriate and delivered timely. No additional residents were identified as affected by the deficient practice. Element 3 – Systemic Changes The Administrator re-educated the [US FOIA (b)(6)] on the timely issuance and documentation of SNF ABNs when applicable. A Medicare coverage change tracking log will be implemented to identify residents requiring a SNF ABN and to verify issuance and documentation prior to discontinuation of covered services. Element 4 – Monitoring / QAPI Oversight The Social Worker or designee will conduct monthly audits of Medicare coverage changes to ensure required notifications are issued and documented appropriately. Audits will be completed for 3 months. Social worker/designee will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC.	02/20/2026

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F0582 SS = D	Continued from page 71 reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide the required Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) for 1 of 2 residents (Resident #1) reviewed for NJ Exec Order 26.4b1 [REDACTED] and who remained in the facility. The deficient practice was evidenced by the following: On 1/7/26 at 10:06 AM, the surveyor observed Resident #1 in bed, NJ Exec Order 26.4b1. Resident #1 stated they received NJ Exec Order 26.4b1 services in the past that had stopped without explanation. On 1/8/26 at 9:00 AM, the surveyor reviewed the facility provided Beneficiary Protection Notification Review (BPNR) forms for two residents, Resident #1 and #30, who had a NJ Exec Order 26.4b1 coverage status and remained in the facility. A review of Resident #1's BPNR included the last covered day for NJ Exec Order 26.4b1 was on NJ Exec Order 26.4b1 and the explanation as to why the resident was not provided the SNF ABN was, "not NJ Exec Order 26.4b1 On 1/8/26 at 9:51 AM, during an interview with the surveyor, the US FOIA (b)(6) [REDACTED] stated that Resident #1 should have received the SNF ABN since they had NJ Exec Order 26.4b1 and chose to remain in the facility. The US FOIA [REDACTED] also stated that the notification was important for continuity of care and to ensure the resident and resident's family involvement with their choice to continue to receive care. At that time, the US FOIA [REDACTED] stated the facility did not have a policy for SNF ABN but would double check with leadership.	F0582				02/20/2026	

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F0582 SS = D	Continued from page 72 On 1/8/26 at 10:05 AM, during a meeting with the US FOIA (b)(6) , the surveyor requested for the SNF ABN policy and informed the US FOIA (b)(6) of the identified concern for Resident #1 who had not received the SNF ABN notification prior to discontinuation of service. A review of the provided policy titled; Notice Advance Beneficiary Notifications (ABN) dated 7/2019, included that an ABN is issued to transfer potential financial liability to the Medicare beneficiary in certain instances. Under timing, included that prior to the delivery of the item or service, provision of enough time for the beneficiary to make an informed decision on whether to receive the service or item in question and accept potential liability. No further information was provided. NJAC 8:39-4.1(a)(8)	F0582		02/20/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must	F0585	Element 1 – Corrective Action A grievance was initiated for Resident #27 related to the missed medical appointment. The concern was reviewed by Director of Nursing and Administrator, and follow-up actions were completed and documented in accordance with the facility grievance process. During the survey on 1/7/2026, the facility contacted Resident #27's NJ Exec Order 26-42 to inform them that the appointment had been rescheduled for NJ Exec Order 26-42 the family acknowledged. A follow-up care conference phone call with the NJ Exec Order 26-42 and NJ Exec Order 26-42 was held on 1/16/2026 with participation of the Administrator, Social Worker, and Director of Nursing to confirm the rescheduled appointment; the family acknowledged. Element 2 – Residents Potentially Affected All residents have the potential to be affected by the deficient practice. No additional residents were identified as affected. A review of recent complaints and concerns was conducted by the Director of Nursing and Administrator to verify grievances were appropriately identified, logged, and tracked in accordance with the facility grievance policy. Element 3 – Systemic Changes	02/20/2026

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F0585 SS = D	Continued from page 73 give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in			F0585	Continued from page 73 Facility Educator educated nursing staff on the grievance policy and process including proper notification. Administrator educated Social services director on Grievances to be, promptly identified, logged as grievances when applicable, and tracked through resolution. Element 4 – Monitoring / QAPI Oversight The Social Worker/designee will conduct audits of grievances to ensure concerns are consistently documented, investigated, and resolved per facility policy. Audits will be completed weekly x 4 weeks and then monthly for 3 months. The Social Worker will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC.		02/20/2026

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F0585 SS = D	Continued from page 74 accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: COMPLAINT # NJ 2704937 Based on observation, interview, and review of pertinent documents, the facility failed to ensure that the method for filing a grievance was consistent with the facility's practice and policy. This deficient practice was identified for one 1 of four 1 residents (Resident #27) reviewed for grievances and was evidenced by the following: Refer to 684E and 676E On 1/6/26 at 10:13 AM, two (2) surveyors interviewed Resident #27 regarding the care that they received. Resident #27 stated their name and was [REDACTED] that they [REDACTED] in a long-term care facility. Resident #27 also stated that they had anticipated a medical appointment related to follow-up [REDACTED] that was scheduled on [REDACTED] and Resident #27 shared that they were [REDACTED] to see their physician because of the [REDACTED] NJ Exec Order 26.4b1 [REDACTED]. Resident #27 added that nobody from the facility came to get them [REDACTED] and ready for their appointment on the morning of [REDACTED] Resident #27 confirmed that they did not [REDACTED] the appointment. The resident stated that they felt [REDACTED] had [REDACTED] NJ Exec Order 26.4b1 [REDACTED]. On 1/6/26 at 10:35 AM, during an interview with the surveyor, the [REDACTED] US FOIA (b)(6) [REDACTED] stated she was the grievance officer and tracked the grievances referred to her by the residents and staff.	F0585			02/20/2026

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F0585 SS = D	Continued from page 75 At that time the ^{US FOIA} provided the grievance log for NJ Exec Order 26.4b1. Further review of the Grievance Log (GL) and Grievance Report (GR) revealed there were no grievances logged and a grievance report was not initiated for Resident #27. On 1/6/26 at 11:01 AM, during an interview with the surveyor, the ^{US FOIA (b)(6)} stated the ^{US FOIA (b)(6)} handled the scheduling and was not at work that day. The ^{US FOIA (b)(6)} stated she also scheduled appointments for the residents and was written on the white board and progress notes. According to the ^{US FOIA (b)(6)} the NJ Exec Order 26.4b1 scheduled appointments were not kept on record. The ^{US FOIA (b)(6)} stated that any appointments missed for any reason such as transportation, refusals or family member cancellation would be documented in the resident's progress notes. On 1/6/26 at 11:21 AM, the surveyor reviewed the medical record for Resident #27 which revealed the following: According to the resident's Admission Record (AR; or face sheet; admission summary) reflected the resident was admitted to the facility with diagnoses that included but not limited to: NJ Exec Order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 reflected the resident had a Brief Interview for Mental Status (BIMS) score of ^{NI} out of 15, which indicated the resident had a NJ Exec Order 26.4b1. Section ^{NJ Exec Order 26.4b1} reflected the Resident #27 did not NJ Exec Order 26.4b1 such as ^{NJ Exec Order 26.4b1} of care. Section ^{NJ Exec Order 26.4b1} Abilities reflected Resident #27 was NJ Exec Order 26.4b1. On 1/6/26 at 1:42 PM, during an interview with the surveyor, the ^{US FOIA (b)(6)} stated she would learn from the ^{US FOIA (b)(6)} when a resident had an appointment	F0585		02/20/2026

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	Continued from page 76 so that she could get the resident ready for an appointment. The [US FOIA (b)(6)] stated she recalled Resident #27 had a missed an appointment last week and stated that she was "not informed by anyone to get the resident ready for that appointment." The [US FOIA (b)(6)] also stated she did not recall the resident's name on the appointment list which was written on the white board. The [US FOIA (b)(6)] stated that the Resident Representative (RR) came into the facility visibly [NJ Exec Order 26.4(b)] about the appointment that was missed and that the [US FOIA (b)(6)] had both been aware. On 1/6/26 at 1:50 PM, during an interview with the surveyor, the [US FOIA (b)(6)] stated she recalled Resident #27 missed their appointment [NJ Exec Order 26.4(b)], was in the hallway with the [US FOIA (b)(6)] passing trays when the RR arrived [NJ Exec Order 26.4b1] in the hallway. The [US FOIA (b)(6)] recalled the resident [US FOIA (b)(6)] to go to the appointment and confirmed she did not speak with the resident, or their family regarding the incident. At that time the [US FOIA (b)(6)] stated "I don't think a grievance was made". On 1/6/26 at 1:56 PM, the surveyor and the [US FOIA (b)(6)] reviewed the progress notes (PN) for Resident #27 together. The [US FOIA (b)(6)] acknowledged and confirmed that the PN did not reflect that the resident [NJ Exec Order 26.4(b)] to go to their appointment, a follow-up appointment was also not made, and that the physician was not made aware that Resident #27 had missed their appointment. On 1/6/26 at 2:01 PM, the [US FOIA (b)(6)] confirmed that she was not made aware that the resident had an appointment on [NJ Exec Order 26.4(b)] and only learned of the missed appointment when the RR arrived. The [US FOIA (b)(6)] stated the RR made her aware of the missed appointment and they were [NJ Exec Order 26.4(b)]. The [US FOIA (b)(6)] informed the RR that she would investigate the matter and stated she did not start a grievance, but started an investigation. At that time, the [US FOIA (b)(6)] stated a grievance was important to ensure issues were resolved, tracked, trended and brought back for discussion during the Quality Assurance and Performance Improvement (QAPI) meetings. A review of the investigation file provided by the DON contained one signed witness statement from the [US FOIA (b)(6)] assigned to Resident #27 on [NJ Exec Order 26.4(b)]. The statement documented that Resident #27 [NJ Exec Order 26.4(b)] to go to their appointment after transport arrived and the facility			

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F0585 SS = D	Continued from page 77 staff [REDACTED] the resident. The [REDACTED] also documented that she had [REDACTED] the resident to go. There was no witness statements from the [REDACTED] who cared for the resident on [REDACTED], from the resident, or from the RR who staff, including the [REDACTED] confirmed verbalized their concerns. A review of the provided trip order #[REDACTED] reflected the pick-up was for Resident #27 was on [REDACTED] at 8:55 AM and was then cancelled by the same [REDACTED] who documented the single signed statement. The reason for cancelling the transportation was documented as due to "appointment cancelled". On 1/9/26 at 12:02 PM, the surveyor discussed the concern regarding the missed appointment voiced by the resident, and the RR, with the survey team present, the [REDACTED] US FOIA (b)(6) [REDACTED]. The facility was unable to provide a resolution for Resident #27 and there was no grievance initiated. A review of the provided facility policy titled; Grievance/ Complaints, Filing included that residents and their representative have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated. The administrator and staff would make prompt efforts to resolve grievances...The resident or person filing the grievance and/or complaint and/or complain on behalf of the resident will be informed verbally and in writing of the findings of the investigation and the actions that will be taken to correct any identified problems. No further information was provided. NJAC 8:39-4.1(a)(35);13.2(c)	F0585		02/20/2026
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F0636	Element 1 – Corrective Action The Comprehensive Admission MDS for Resident #74 was completed, and documentation was finalized to reflect compliance with required assessment timeframes. Element 2 – Residents Potentially Affected	02/20/2026

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F0636 SS = D	Continued from page 78 §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment	F0636	Continued from page 78 All residents have the potential to be affected by the deficient practice. A review of current residents was conducted by the MDS Coordinator to verify that Admission and required periodic MDS assessments were completed within regulatory timeframes. No other residents were identified. Element 3 – Systemic Changes The Administrator educated the US FOIA (b)(6) on the requirement of completion of the admission and periodic Minimum Data Set assessments within required regulatory timeframes. An MDS due-date tracker/log will be maintained to monitor Admission and periodic MDS completion deadlines. Element 4 – Monitoring / QAPI Oversight The MDS Coordinator/designee will conduct audits of MDS assessment schedules and completion dates to ensure compliance with required timelines. Audits will be completed weekly x 4 weeks and then monthly for 3 months. The MDS Coordinator will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC.	02/20/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/09/2026
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F0636 SS = D	Continued from page 79 of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete the Admission Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1 resident (Resident #74) reviewed for timing of assessments and was evidenced by the following: On 1/05/26 a review of the electronic health record (EHR) reflects that resident #74 was admitted to the facility on [REDACTED] [NJ Exec Order 26.4b1]. The Comprehensive Admission MDS was noted to be "in progress". On 1/07/2026 at 10:56 AM, the surveyor interviewed the [REDACTED] [US FOIA (b)(6)], who stated she worked [REDACTED] [NJ Exec Order 26.4b1] and was rarely in the facility. She further stated that an Admission MDS must be completed by day 14 (of the resident's stay in facility). The [REDACTED] [US FOIA (b)(6)] stated "I know that I am behind" She explained that was [REDACTED] [NJ Exec Order 26.4b1] for this facility and that she worked at another facility [REDACTED] [NJ Exec Order 26.4b1] which was causing her difficulty in keeping up with the work. She further explained that she was doing the best she could to follow the CMS regulation. She also stated "I prioritize the Medicare assessments (typically these are the revenue generating assessments), so they get done first that's why his didn't get done. That's how it works." According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2025, page 2-17, the Comprehensive Admission assessment must be completed no later than admission date + 13 calendar days [REDACTED] [NJ Exec Order 26.4b1] for Resident #74). NJAC 8:39-11.2 (e)	F0636		02/20/2026

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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, review of medical records, other facility documentation, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 1 resident reviewed (Resident #74). This deficient practice was evidenced by the following: On 1/05/26 a review of the electronic health record			F0641	Element 1 – Corrective Action The Admission MDS for Resident #74 was reviewed by the MDS Coordinator, corrected as indicated, and re-certified to ensure accuracy of assessment information and completion dates in accordance with RAI requirements. Element 2 – Residents Potentially Affected All residents have the potential to be affected by the deficient practice. A review of recent MDS assessments was conducted by the MDS Coordinator to verify accuracy, completion dates, and required signatures. No additional residents were identified. Element 3 – Systemic Changes The Administrator provided education to the [REDACTED] regarding requirements for accurate completion and certification of MDS assessments in accordance with RAI guidelines. A MDS completion checklist will be implemented prior to submission to verify all sections are complete, dates align appropriately, and required signatures are obtained before final certification. Element 4 – Monitoring / QAPI Oversight The MDS Coordinator/designee will conduct audits of MDS assessment schedules and completion dates to ensure compliance with required timelines. Audits will be completed weekly x 4 weeks and then monthly for 3 months. The MDS Coordinator will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC.		02/20/2026

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F0641 SS = D	Continued from page 81 (EHR) reflects that resident #74 was admitted to the facility on [REDACTED] NJ Exec Order [REDACTED]. The Comprehensive Admission MDS was noted to be "in progress". On 1/07/2026 at 10:56 AM, the surveyor interviewed the [REDACTED] US FOIA (b)(6) [REDACTED], who stated she worked remote and was rarely in the facility. She further stated that an Admission MDS must be completed by day 14 (of the resident's stay in facility). The [REDACTED] US FOIA (b)(6) [REDACTED] stated "I know that I am behind" She explained that was [REDACTED] NJ Exec Order 26.4b1 [REDACTED] or this facility and that she worked at another facility [REDACTED] NJ Exec Order [REDACTED] which was causing her difficulty in keeping up with the work. She further explained that she was doing the best she could to follow the CMS regulation. She also stated "I prioritize the Medicare assessments (typically these are the revenue generating assessments), so they get done first that's why his didn't get done. That's how it works." On 1/8/25, the surveyor noted the MDS to be "complete". Review of section Z0400B revealed that section F was completed by the [REDACTED] US FOIA (b)(6) [REDACTED] on 12/26/25, Z0040C revealed that section K was completed by the [REDACTED] US FOIA (b)(6) [REDACTED] on 12/27/25, and Z0400D revealed that sections A, B, GG, H, I, J, L, M, N, O, and P were completed by the [REDACTED] US FOIA (b)(6) [REDACTED] on 1/7/06. Review of Section Z0500 revealed the [REDACTED] US FOIA (b)(6) [REDACTED]'s signature and date of 12/21/25, verifying that the MDS assessment was completed 12/21/25. Review of facility provided "Batch #162" (the validation report for MDS transmission to CMS) indicated that Resident #74's Admission MDS was transmitted and accepted on [REDACTED] NJ Exec Order [REDACTED]. According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2025, page Z-5 – Z-8, the importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for: The development of an individualized care plan The Medicare Prospective Payment System Medicaid reimbursement programs Quality monitoring activities, such as the quality measure reports	F0641		02/20/2026

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F0641 SS = D	Continued from page 82 The data-driven survey and certification process The quality measures used for public reporting Research and policy development Coding Instructions All staff who completed any part of the MDS must enter their signatures, titles, sections of portions(s) of the section(s) they completed, and the date completed. Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information. Z0500 Signature of RN Assessment Coordinator Verifying Assessment Completion Federal regulations require the RN assessment coordinator to sign and thereby certify that the assessment is complete. For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date must be equal to the latest date at Z0400 or later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members. N.J.A.C 8:39-11.1	F0641		02/20/2026
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: Based on observation, interview and record review, it was determined that the facility failed to ensure	F0695	Element 1 – Corrective Action Resident #73 was immediately assessed for adverse consequences related to missed ^{NJ Exec Order 26.4} treatments, ^{NJ Exec Order 26.4b1}. The resident's physician was notified. The facility had ordered eight (8) new ^{NJ Exec Order 26.4} machines on January 5, 2026. Upon delivery the resident received the ordered ^{NJ Exec Order 26.4} treatments per the doctor's order, beginning January 7th, 2026. Element 2 – Residents Potentially Affected All residents have the potential to be affected. The Director of Nursing or designee audited recent admissions to verify presence of ordered/needed equipment, no additional residents were identified as	02/20/2026

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F0695 SS = D	Continued from page 84 On 1/5/26 at 1:30 PM, the surveyor interviewed the US FOIA (b)(6) assigned to the unit. The US FOIA (b)(6) informed the surveyor that the US FOIA (b)(6) machines were stored in the supply room. The surveyor followed the US FOIA (b)(6) to the supply room of the unit, there were no US FOIA (b)(6) machines. The US FOIA (b)(6) then stated that there was a storage room on the 3rd floor the US FOIA (b)(6) machines were stored also on the 3rd floor. On 1/6/25 at 9:15 AM, the surveyor interviewed the central supply staff and requested an inventory of the facility's US FOIA (b)(6) machine. The Central supply staff escorted the surveyor to the 3d floor central supply, there were no US FOIA (b)(6) machines. The staff informed the surveyor that the facility had 5 US FOIA (b)(6) machines, all were already assigned to other residents. The central supply staff informed the surveyor that she was made aware of the concern on 1/5/26 and she received authorization from the US FOIA (b)(6) to order 8 US FOIA (b)(6) machines would arrive possibly today. The surveyor requested and received the invoice dated 1/5/26 for the US FOIA (b)(6). On 1/6/26 at 9:30 AM, a review of the Progress Notes with the US FOIA (b)(6) confirmed that the nebulizer treatment was not administered because the facility did not have a US FOIA (b)(6) machine. When inquired regarding the admission process, the US FOIA (b)(6) will inform the nursing department of the admission and the medical equipment needed prior to admission. She informed the surveyor that she was on vacation and just returned to work. She reviewed the orders at home and was not aware that the facility did not have a US FOIA (b)(6) machine available for the resident. The US FOIA (b)(6) further stated that the admission Nurse was responsible for the assessment and ensure the physician orders were followed. On 1/7/26 at 10:15 AM, the surveyor reviewed the Medication Administration Record (MAR) and observed that the NJ Exec Order 26.4b1 at 6:00 PM, 1/5 at 12:00 AM, and 6:00 AM, or US FOIA (b)(6) at 06:00 AM. The surveyor reviewed the Medication Administration Record with the US FOIA (b)(6) she stated, there was no US FOIA (b)(6) machine available although the nurses initiated the MAR that the medication was administered or US FOIA (b)(6) at 12:00 PM and 6:00 PM US FOIA (b)(6) at 12:00 PM and 6:00 PM and US FOIA (b)(6) at 12:00 AM 6:00 AM, 12:00 PM and 6:00 PM.	F0695		02/20/2026

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F0695 SS = D	Continued from page 85 On 1/6/26 at 11:30 AM, the surveyor interviewed the US FOIA (b)(6) regarding the admission protocol. She stated the Liaison Management reviewed the hospital record, uploaded the information into the facility computerized system and reviewed the medical record with the nursing staff. The nursing staff was to review and ensure all medical equipment needed were available. On 1/8/26 at 8:45 AM, the surveyor interviewed the US FOIA (b)(6) regarding Resident #73 not receiving their NJ Exec Order 26.4b1 treatment as ordered by the physician, the US FOIA (b)(6) informed the surveyor that she was not made aware of the admission nor that the resident did not receive their treatment. The US FOIA (b)(6) was to provide the admission policy for review, none was provided. On 1/9/26 at 12:30 during the pre-exit conference the US FOIA (b)(6) confirmed that he authorized the purchase for the NJ Exec Order 26.4b1 machine but he was not aware of the issue. NJAC 8:39 -6.1(b)	F0695		02/20/2026
F0742 SS = D	Treatment/Srvcs Mental/Psychosocial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure a resident with history of NJ Exec Order 26.4b1 received the appropriate treatments and services, when on NJ Exec Order 26.4b1, the resident (Resident #74) became NJ Exec Order 26.4b1 when they had not received their NJ Exec Order 26.4b1 timely. The resident reported that they had a NJ Exec Order 26.4b1 and called NJ Exec Order 26.4b1 emergency services since they were NJ Exec Order 26.4b1 and received NJ Exec Order 26.4b1. This deficient practice	F0742	Element 1 – Corrective Action Resident #74's clinical and NJ Exec Order 26.4b1 needs were reviewed. A diagnosis of NJ Exec Order 26.4b1 was added to the diagnosis list and the care plan updated with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 Resident #74 was evaluated by the NJ Exec Order 26.4b1 Advanced Practice Nurse on NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 The resident was also evaluated by NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. Resident #74 has since been discharged and transferred to a NJ Exec Order 26.4b1 and relevant medical NJ Exec Order 26.4b1 information was included in discharge documentation. Element 2 – Residents Potentially Affected All residents have the potential to be affected. The Director of Nursing or designee conducted an audit of residents with behavioral symptoms, depression/anxiety indicators, recent grief/adjustment issues, refusal patterns, or psychosocial triggers to ensure diagnoses and psychosocial conditions are appropriately identified, documented, and care planned via admission documentation, MDS, nursing notes, incident reports, and psychotropic use. No additional residents were	02/20/2026

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F0742 SS = D	Continued from page 86 was identified for one 1 of 1 resident (Resident #74) reviewed for [REDACTED] and was evidenced by the following: Refer F 610 On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility, Resident #74 stated [REDACTED] and that [REDACTED]. Resident #74 stated they wanted to be transferred to [another facility name] and the [REDACTED] (US FOIA (b)(6)) had been made aware. Resident #74 also reported that a [REDACTED] ago they called [REDACTED] because the "staff did not [REDACTED] breakfast." Resident #74 stated they were [REDACTED] because "it was after 10:00 AM, and the staff did not [REDACTED]" and Resident #74 stated that they were a [REDACTED] and they started feeling [REDACTED] On 1/06/26 at 10:00 AM, the surveyor reviewed the medical record for Resident #74 which revealed the following: According to the resident's facility Admission Record, an admission summary, reflected that Resident #74 was admitted to the facility with diagnoses that included but were not limited to; [REDACTED] NJ Exec Order 26.4b1 [REDACTED] [REDACTED]. The resident's facility Admission Record did not include the diagnosis of [REDACTED] A review of the resident's hospital record included a [REDACTED] Note, documented by the clinical [REDACTED] (US FOIA (b)(6)) from the hospital, dated [REDACTED]. The progress notes revealed Resident #74's past medical history included a history of [REDACTED] NJ Exec Order 26.4b1 [REDACTED]. The Visit Summary revealed: [REDACTED]. Impressions revealed: ... rule out [REDACTED] with [REDACTED] and [REDACTED]. The plan included individual [REDACTED] to further address adjustment to [REDACTED] and post discharge follow-up for reassessment of [REDACTED] status.	F0742	Continued from page 86 identified as affected. Element 3 – Systemic Changes A Comprehensive Trauma Screening Assessment was implemented to be completed upon admission and with significant change. The interdisciplinary team completes the screening and ensures needs are incorporated into care plans. On 2/3/26 the Facility Educator finished educating nursing staff on PTSD awareness, trauma-informed care, behavioral interventions, and documentation. Element 4 – Monitoring / QAPI Oversight The Director of Nursing or designee will audit new admissions, readmissions, and residents with significant change for completion of the Comprehensive Trauma Screening Assessment to ensure that diagnoses and psychosocial conditions are appropriately identified, and documented. Audits will be conducted weekly for 4 weeks and then monthly for three months. The results of these audits will be presented by the Director of Nursing or designee at the monthly QAPI meeting until May 2026. The Director of Nursing is responsible for oversight and implementation of this Plan of Correction.	02/20/2026

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F0742 SS = D	Continued from page 87 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [REDACTED], reflected the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED] out of 15, which indicated the resident was [REDACTED]. In Section [REDACTED], [REDACTED] reflected that an interview was conducted and the resident was assessed. In the [REDACTED] prior to the assessment, the resident had reported [REDACTED] on 12-14 days (nearly every day), and the resident reported [REDACTED] about themselves or that they were a [REDACTED] or have let [REDACTED]. A review of Section I., Active Diagnoses was left blank. A review of the individualized comprehensive care plan (ICCP) did not include a focus area, interventions, or goals related to the resident's diagnosed history of [REDACTED]. A review of the initial [REDACTED] Evaluation dated [REDACTED], included that the resident reported feeling [REDACTED] about their condition but [REDACTED]. "Resident #74" continued their current dose of [REDACTED] for [REDACTED] and a [REDACTED] was not recommended. The assessment plan included supportive and individualized [REDACTED] interventions, [REDACTED] measures, [REDACTED], [REDACTED] and [REDACTED]. The [REDACTED] evaluation did not include the diagnosis of [REDACTED]. There were no [REDACTED] consultations (consults) included in the medical record. A review of the Social Service History and Initial Assessment dated [REDACTED], revealed in Section [REDACTED] question [REDACTED] Does the patient have a [REDACTED] diagnosis other than [REDACTED] the responses were; a. [REDACTED] 4a. specify: [REDACTED]. The diagnosis of [REDACTED] was not included on the Social Service History and Initial Assessment. A review of the Social Services Notes from [REDACTED], did not reflect the provisions of [REDACTED] health services related to [REDACTED].	F0742		02/20/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0742 SS = D	Continued from page 88 A review of the Physician History and Physical note dated [REDACTED] revealed that Resident #74 was "seen in bed talking to [REDACTED] and reporting not being [REDACTED]." [REDACTED] On 1/06/26 at 11:14 AM, the surveyor interviewed the [REDACTED] (US FOIA (b)(6)) regarding Resident #74's diagnosis of [REDACTED] (US FOIA (b)(6)). The [REDACTED] (US FOIA (b)(6)) stated Resident #74 was one of the facility's [REDACTED] (US FOIA (b)(6)) and that she was not aware of a diagnosis of [REDACTED] (US FOIA (b)(6)) and that, "I have to double check." The [REDACTED] (US FOIA (b)(6)) stated that the Admissions department screened new admissions and notified [REDACTED] (US FOIA (b)(6)) via email about the resident's [REDACTED] (US FOIA (b)(6)) conditions. The [REDACTED] (US FOIA (b)(6)) further stated if a resident had a history of [REDACTED] (US FOIA (b)(6)) she would have consulted the facility's [REDACTED] (US FOIA (b)(6)). The [REDACTED] (US FOIA (b)(6)) stated she would have only developed an individualized plan of care for a resident with [REDACTED] (US FOIA (b)(6)) if their [REDACTED] (US FOIA (b)(6)) were an issue. The [REDACTED] (US FOIA (b)(6)) stated it was important to know if a resident had [REDACTED] (US FOIA (b)(6)) because we needed to know if there was a [REDACTED] (US FOIA (b)(6)) that may have caused the resident to re [REDACTED] (US FOIA (b)(6)). The [REDACTED] (US FOIA (b)(6)) stated if a resident had a diagnosis of [REDACTED] (US FOIA (b)(6)) it should have been documented in the [REDACTED] (US FOIA (b)(6)) History and Initial Assessment. On 1/06/26 at 12:01 PM, the [REDACTED] (US FOIA (b)(6)) approached the surveyor to inform them that she found a note from the facility's [REDACTED] (US FOIA (b)(6)) that referenced a [REDACTED] (US FOIA (b)(6)) diagnosis. The [REDACTED] (US FOIA (b)(6)) acknowledged that the [REDACTED] (US FOIA (b)(6)) diagnosis should have been listed on Resident #74's diagnosis list; [REDACTED] (US FOIA (b)(6)) should have been included in the [REDACTED] (US FOIA (b)(6)) Initial Assessment; and there should have been an individualized plan of care developed. On 1/06/26 at 11:34 AM, the surveyor interviewed the [REDACTED] (US FOIA (b)(6)) regarding Resident #74's call made to [REDACTED] (US FOIA (b)(6)) on [REDACTED] (US FOIA (b)(6)). The [REDACTED] (US FOIA (b)(6)) stated if the resident had called [REDACTED] (US FOIA (b)(6)) the incident should have been documented in the medical record and investigation should have been completed. The [REDACTED] (US FOIA (b)(6)) stated she was not aware that Resident #74 called [REDACTED] (US FOIA (b)(6)), and no investigation was initiated or completed. On 1/06/26 at 1:01 PM, the surveyor re-interviewed the [REDACTED] (US FOIA (b)(6)) who stated that it was important to know the if a resident had a diagnosis of [REDACTED] (US FOIA (b)(6)) because	F0742		02/20/2026

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F0742 SS = D	Continued from page 89 they may need [REDACTED] help. The [REDACTED] continued if a resident had a diagnosis of [REDACTED] and had not been provided with services, it was a "bad thing." The [REDACTED] added that the diagnosis should also have been coded on the MDS and added to the diagnosis list. On 1/07/26 at 9:03 AM, the [REDACTED] informed the surveyor that a care plan for [REDACTED] was now initiated, approximately [REDACTED] after admission, and more than [REDACTED] after the resident called [REDACTED] for not being [REDACTED] their [REDACTED] timely while on [REDACTED] for [REDACTED] which resulted in the resident having an untreated [REDACTED]." On 1/08/26, the [REDACTED] provided the surveyor with a "Grievance Report" dated 1/07/26. A review of the "Grievance Report" revealed that Resident #74 reported that they became [REDACTED] when they had not received their [REDACTED] on [REDACTED]. Resident #74 stated that they had a [REDACTED] and called [REDACTED]. No further information was provided by the facility. NJAC 8:39-27.1(a); 28.1(c)	F0742		02/20/2026
F0755 SS = D	Pharmacy Svcs/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-	F0755	Element 1 – Corrective Action [REDACTED] found at the bedside of Resident #74 were immediately removed and properly discarded per facility policy. Resident #74 was assessed by the physician on [REDACTED] to ensure [REDACTED]. For Resident #77, the resident received the [REDACTED] in each [REDACTED] as ordered. Element 2 – Residents Potentially Affected All residents have the potential to be affected. Director of nursing conducted a review to ensure medications were properly administered, stored, and documented according to physician orders and facility policy. No additional residents were identified as affected. Element 3 – Systemic Changes On 2/3/26 the facility educator finished educating all	02/20/2026

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F0755 SS = D	Continued from page 90 §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 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 observation, interview, and record review, it was determined that the facility failed (a).to ensure that a medication was administered according to the physician orders (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified for (one) 1 of three (3) residents (Resident#77), administered by one (1) of two (2) nurses, observed during medication administration and (b). 1of 1 resident (Resident #74) reviewed for [REDACTED] and 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." a. On 1/6/26 at 9:08 AM, the surveyor observed [REDACTED] who was assigned to	F0755	Continued from page 90 nursing staff on proper medication administration, medication storage requirements, and documentation of medication administration and refusals, including following physician orders and medication administration protocols. Element 4 – Monitoring / QAPI Oversight The Director of Nursing or designee will conduct monthly medication pass observation audits of two nurses per shift to ensure compliance with proper medication administration practices, medication storage requirements, and accurate documentation. These audits will be conducted monthly for a period of three months. The results of the audits will be reviewed and presented by the Director of Nursing or designee at the facility's monthly QAPI meeting through May 2026. The Director of Nursing is responsible for the implementation and oversight of this Plan of Correction.			02/20/2026	

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F0755 SS = D	Continued from page 91 the NJ Exec Order 26.4b1, prepared medications for Resident #77. The medications included a physician's order (PO) for NJ Exec Order 26.4b1 two (2) sprays in each NJ Exec Order 26.4b1 one time day for NJ Exec Order 26.4b1. The PO was started on NJ Exec Order 26.4b1. On 1/6/26 at 9:24 AM, the US FOIA stated she was ready to administer the medications to Resident #77, turned and entered the resident's room. On 1/6/26 at 9:25 AM, the surveyor observed Resident #77 awake, NJ Exec Order 26.4b1. On 1/6/26 at 9:29 AM, the surveyor observed the US FOIA administer one NJ Exec Order 26.4b1 into Resident #77 NJ Exec Order 26.4b1 and provided the resident NJ Exec Order 26.4b1. On 1/6/26 at 9:33 AM, the US FOIA and the surveyor exited the resident's room, and the US FOIA began to clean her devices. On 1/6/26 at 9:35 AM, the surveyor observed the US FOIA signed the electronic Medication Administration Record (eMAR) and placed the NJ Exec Order 26.4b1 back into the medication cart. At that time, the surveyor and the US FOIA reviewed the eMAR together. The US FOIA confirmed and acknowledged that she should have administered NJ Exec Order 26.4b1 into each NJ Exec Order 26.4b1 instead of the one (1) NJ Exec Order 26.4b1. On 1/9/26 at 12:02 PM, during a meeting with the survey team, the US FOIA (b)(6) US FOIA, the surveyor discussed the concern with the US FOIA who failed to administer Resident #77's NJ Exec Order 26.4b1 as prescribed. b. On 1/05/26 at 10:18 AM the surveyor observed NJ Exec Order 26.4b1 with packages cut open on the bedside table in Resident #74's room. Resident #74 stated the nurse was going to administer the NJ Exec Order 26.4b1, but they did not want them NJ Exec Order 26.4b1 at that time. Resident #74 stated they got NJ Exec Order 26.4b1 to their NJ Exec Order 26.4b1. When the surveyor inquired when this occurred, Resident #74 stated "it was about NJ Exec Order 26.4b1 ago." There were no other residents seen in the vicinity of Resident #74's room. On 1/06/26 at 11:10 AM The surveyor reviewed the	F0755		02/20/2026

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	Continued from page 92 medical record for Resident #74. According to the facility Admission Record, an admission summary, reflected that Resident #74 was admitted to the facility with diagnoses that included, NJ Exec Order 26.4b1 The facility admission record did not include the diagnosis of NJ Exec Order 26.4b1. The hospital record included a NJ Exec Order 26.4b1 Note documented by the clinical US FOIA (b)(6) from the hospital dated NJ Exec Order 26.4b1. The progress notes revealed Resident #74's past medical history included a history of NJ Exec Order 26.4b1. The Visit Summary revealed: mildly NJ Exec Order 26.4b1. Impressions revealed: ... rule out NJ Exec Order 26.4b1. The plan included individual NJ Exec Order 26.4b1 to further address adjustment to NJ Exec Order 26.4b1 and post discharge follow-up for reassessment of NJ Exec Order 26.4b1. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 reflected the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 out of 15, which indicated the resident was NJ Exec Order 26.4b1. A review of the Medication Administration Record (MAR) for NJ Exec Order 26.4b1 revealed the physician's order for NJ Exec Order 26.4b1 one time a day for NJ Exec Order 26.4b1 was not signed on NJ Exec Order 26.4b1 at 9:00 AM, the MAR was blank. On 1/05/26 at 10:33 The surveyor interviewed the US FOIA (b)(6) who stated she did not leave NJ Exec Order 26.4b1 on the bedside table in Resident's #74 room, in addition she stated that she "has not been in the resident's room today." The US FOIA (b)(6) stated, "it could have been the night nurse." When asked if the medications should have been left at the bedside table the US FOIA (b)(6) stated, "of course not the medications should not be left at the bedside, they should be kept locked up." The Nurse directed the surveyor to US FOIA (b)(6)			

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F0755 SS = D	Continued from page 93 On 1/05/26 at 10:36 AM The ^{US FOIA} accompanied the surveyor to Resident #74's room, the ^{US FOIA} confirmed that the ^{NJ Exec Order 26.4b1} were cut open and left on the bedside table. The ^{US FOIA} stated if the resident ^{NJ Exec Order 26.4b1} them, they should have been thrown away. The ^{US FOIA} asked the resident if it was the night nurse who left the medication on the bedside table, and Resident #74 stated no, they were ^{NJ Exec Order 26.4b1}. The ^{US FOIA (b)(6)} threw the ^{NJ Exec Order 26.4b1} in the garbage in the resident's room and said she would inservice the staff. On 1/06/26 at 9:15 AM The surveyor interviewed the ^{US FOIA (b)(6)} who stated on ^{NJ Exec Order 26.4b1}, the day shift nurse called out "she took over the cart and worked 7AM-3 PM." The ^{US FOIA (b)(6)} stated that Resident #74 received all medications administered by ^{NJ Exec Order 26.4b1} at 9:00 AM, but Resident #74 did not receive treatments including ^{NJ Exec Order 26.4b1}. She did not recall taking out the ^{NJ Exec Order 26.4b1}. The ^{US FOIA (b)(6)} stated if the resident had ^{NJ Exec Order 26.4b1}, the ^{NJ Exec Order 26.4b1} should have been documented on the Treatment Administration Record (TAR). The ^{US FOIA (b)(6)} acknowledged that the ^{NJ Exec Order 26.4b1} should not have been left on the bedside table in the resident's room. A review of the provided facility policy, titled; Administering Medications dated/revised April 2019 included medications are administered in a safe, timely manner and as prescribed. No further information was provided. NJAC 8:39-29.2(d), 2	F0755		02/20/2026

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S0000	Initial Comments Complaint #s: NJ 176409, NJ 181028, NJ 86576, NJ 2704937 Survey Date: 1/9/26 Census: 56 Sample: 15+ 2 closed records. 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			02/02/2026	
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 interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for 3 of 14-day shifts as mandated by the state of New Jersey. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 12/21/2025 and ending 01/03/2025 for the Standard survey on 01/08/2025, revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements. The facility was deficient in CNA staffing for residents on 3 of 14-day shifts as follows:		S0560	Element 1 – Corrective Action Administrator, Director of Nursing, and Staffing Coordinator reviewed staffing assignments for 12/21/2025, 12/28/2025, and 01/02/2026. A review of resident records, incident reports, and nursing documentation for those shifts was conducted to determine adverse outcomes, none were identified. Scheduling procedures were reinforced to ensure compliance with New Jersey minimum staffing requirements for Certified Nursing Assistants on day shift. Element 2 – Residents Potentially Affected All residents have the potential to be affected. The Administrator and Director of Nursing reviewed staffing reports for the prior four weeks to verify compliance with NJ minimum ratios, no additional dates were identified. No residents were identified as affected by this deficiency. Element 3 – Systemic Changes		02/20/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S0560	Continued from page 1 -12/21/25 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -12/28/25 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs. -01/02/26 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. On 01/07/26 at 10:19 AM, during an interview with a surveyor, the Staffing Director (SD) stated he worked in the facility for three (3) months, and that his goal was to meet Center for Medicare and Medicaid Services' staffing requirements. The SD stated the agency was used minimally and the facility's unit clerk who was a Certified Nursing Assistant (CNA) covered unstaffed shifts (call outs). The SD also stated that the facility administration was supportive of him and was able to do what was needed to fulfill staffing needs. The SD stated he was aware of the required staffing ratios, tried to meet the ratios, "but then there are call outs." A review of the undated, facility provided policy titled; Sufficient and Competent Nursing Staffing included that the facility provided sufficient number of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Minimum staffing requirements...are adhered to when determining staff ratios...	S0560	Continued from page 1 A daily staffing ratio tracking log was implemented to document census and minimum required Certified Nursing Assistant staffing by shift per NJ regulations. If call-outs occur and staffing falls below required ratios, replacement procedures are initiated immediately. On 02/04/26 Staffing Coordinator was re-educated by the Administrator on NJ ratio requirements and facility staffing policy. Element 4 – Monitoring / QAPI Oversight The Administrator/designee will conduct audits of daily staffing levels. Audits will be completed for 1 nursing shift daily for one month and then weekly for 4 weeks and then monthly for 2 months. The Administrator/designee will present the results of these audits at the monthly QAPI meeting until May 2026. The Administrator is responsible for oversight of this POC	02/20/2026
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	S1405	Element 1 – Corrective Action The Director of Nursing reviewed current employee files and ensured all physicals were completed for active employees. Element 2 – Residents Potentially Affected All residents have the potential to be affected. The Director of Nursing reviewed current employee health documentation files to ensure required physicals are completed within two weeks prior to the first day of employment or upon employment, or If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. No residents	02/20/2026

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S1405	Continued from page 2 Based on interview, and review of other facility documentation, it was determined that the facility failed to have a system in place to ensure that employees received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment. This deficient practice was identified for 48 of 55 employee files reviewed, 99 out of 154 employee files were missing and was evidenced by the following: On 1/5/26 at 9:40 AM, the surveyor requested from the Human Resources Director (HRD) a list of all employees that were hired since last survey, including name, date of hire, title, and including contracted employees. On 1/6/26 at 7:55 AM, the HRD provided the list of employees, status, position, department, date hired and termination date. The surveyor asked the HRD to provide all the new hire files, including medical information for the names provided for the 154 names on the list. On 1/07/26 at 12:27, PM the HRD with the Licensed Nursing Home Administrator (LNHA) present, confirmed that they were unable to provide all requested employee files, HRD stated "we cannot find them." On 1/07/26 at 9:00 AM, The surveyor reviewed the 55 employee files that were provided out of a total of 154 employee files of the recently hired and terminated employees. Employee # 2 was hired on NJ Exec Order 26; the Physical Exam Form was signed by a License Practical Nurse (LPN) on NJ Exec Order 26. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 3 was hired on NJ Exec Order 26 the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 4 was hired on NJ Exec Order 26 the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced			S1405	Continued from page 2 were identified as affected with this deficiency. Element 3 – Systemic Changes A New Hire Medical Clearance Checklist was implemented requiring a completed health history and physical exam performed by a physician, advanced practice nurse, or licensed physician assistant within required timeframes, signed/dated appropriately, and verified prior to independent work. On 02/04/26 The Director of Nursing re-educated Human Resources and nursing leadership on employee health screening requirements and clearance verification prior to starting work. Human Resources was also educated on using the checklist during onboarding and on ensuring compliance with employee physicals. Element 4 – Monitoring / QAPI Oversight The Human Resources Director or designee will audit 25% of new hire files using the checklist. Audits will be completed weekly for 4 weeks and then monthly for 3 months. HR director will report results to the monthly QAPI Committee until may 2026. The administrator is responsible for this POC.		02/20/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060419		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2026	
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
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S1405	Continued from page 3 Practice Nurse, or a Licensed Physician Assistant. Employee # 5 was hired on [REDACTED] NJ Exec Order [REDACTED]; the Physical Exam Form was signed by a License Practical Nurse (LPN) on [REDACTED] NJ Exec Order [REDACTED]. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 6 was hired on [REDACTED] NJ Exec Order [REDACTED] the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 7 was hired on [REDACTED] NJ Exec Order [REDACTED] the Physical Exam Form was signed by a License Practical Nurse (LPN) on [REDACTED] NJ Exec Order [REDACTED]. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 8 was hired on [REDACTED] NJ Exec Order [REDACTED]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 11 was [REDACTED] NJ Exec Order [REDACTED] 26.4b) or [REDACTED] NJ Exec Order [REDACTED] the Physical Exam Form's date and signature was blank. Employee # 12 was hired on [REDACTED] NJ Exec Order [REDACTED] the Physical Exam Form's date and signature was blank. Employee # 13 was hired on [REDACTED] NJ Exec Order [REDACTED]; the Physical Exam Form's date and signature was blank. Employee # 14 was hired on [REDACTED] NJ Exec Order [REDACTED] there was no information available. Employee # 15 was hired on [REDACTED] NJ Exec Order [REDACTED]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 16 was [REDACTED] NJ Exec Order [REDACTED] 26.4b) on [REDACTED] NJ Exec Order [REDACTED]; there was no information available. Employee # 17 was hired on [REDACTED] NJ Exec Order [REDACTED] the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 18 was [REDACTED] NJ Exec Order [REDACTED] 26.4b) on [REDACTED] NJ Exec Order [REDACTED]; there was no information available.	S1405				02/20/2026	

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S1405	Continued from page 4 Employee # 19 was hired on [REDACTED] the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 20 was [REDACTED] on [REDACTED]; there was no information available. Employee # 21 was [REDACTED] on [REDACTED] there was no information available. Employee # 22 was hired on [REDACTED] the Physical Exam Form's date and physician signature was blank. Employee # 23 was [REDACTED] on [REDACTED]; the Physical Exam Form's date and physician signature was blank. Employee # 24 was hired on [REDACTED]; the Physical Exam Form was signed by a License Practical Nurse (LPN) on [REDACTED]. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 25 was hired on [REDACTED] the Physical Exam Form was signed by a License Practical Nurse (LPN) with no date. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 27 was hired on [REDACTED]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 28 was hired on [REDACTED]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 29 was [REDACTED] on [REDACTED]; there was no information available. Employee # 30 there was no information available. Employee # 31 was [REDACTED] on [REDACTED]; there was no information available. Employee # 32 was hired on [REDACTED]; there was no information available.	S1405		02/20/2026

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S1405		Continued from page 5 Employee # 34 was hired on [redacted]; the Physical Exam Form was signed by a License Practical Nurse (LPN) on [redacted]. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 35 was [redacted] or [redacted] there was no information available. Employee # 36 was hired on [redacted] the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 37 was hired on [redacted] there was no information available. Employee # 38 was hired on [redacted]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 39 was [redacted] on [redacted]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 40 was [redacted] or [redacted]; there was no information available. Employee # 41 was hired on [redacted]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 42 was [redacted] or [redacted]; there was no information available. Employee # 43 was [redacted] on [redacted]; there was no information available. Employee # 44 was [redacted] on [redacted]; there was no information available. Employee # 45 was hired on [redacted]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 46 was hired on [redacted]; the Physical		S1405			

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S1405	Continued from page 6 Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 47 was hired on [REDACTED]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 48 was hired on [REDACTED]; there was no information available Employee # 49 was hired on [REDACTED]; the Physical Exam Form was not signed, and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 50 there was no information available Employee # 51 was [REDACTED] or [REDACTED]; the Physical Exam Form was signed by a License Practical Nurse (LPN). There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 52 was hired on [REDACTED]; the Physical Exam Form was signed by a License Practical Nurse (LPN) and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 54 there was no information available. Employee # 55 was hired on [REDACTED]; the Physical Exam Form was not signed, and the date was blank. There was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. On 1/09/26 at 10:29 AM, the surveyor interviewed the Health Wellness Nurse (HWN) LPN who stated she is responsible for completing the health assessment which includes blood pressures and past medical history for newly hired employees. She further stated, after she completes the health assessment the information is given back to the HRD and the Physician signs off on them. She stated "I do not follow up and I was not aware that the Physician should have been completing them. I have always been completing the health assessment, but it must be signed off by the RN and/or MD."	S1405				02/20/2026	

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S1405	Continued from page 7 On 1/09/26 at 11:30 AM, the surveyor interviewed the facility's Medical Director regarding the completion of health assessments for newly hired employees. He stated that he is required to perform a health assessment if the employee did not have one completed outside the facility. He said the facility would "usually" let him know if health assessments needed to be done. He could not recall when he was last notified or the last time when he completed a health assessment. The facility did not have a policy for newly hired employees. No further information was provided. NJ 8:39-19.5(a.)	S1405				02/20/2026	
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. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documentation it was determined that the facility failed to have a process in place to ensure newly hired employees completed the required [NJ Exec Order 28.461] upon hire. The deficient practice was identified for 40 of 55 employee files reviewed, 99 out of 154 employee files were missing and was evidenced by the	S1410	Element 1 – Corrective Action The Director of Nursing reviewed current employee files and ensured all PPD's were completed for active employees. Element 2 – Residents Potentially Affected All residents have the potential to be affected. The Director of Nursing reviewed current employee health documentation files to ensure required PPD's are completed prior to or upon employment. No residents were identified as affected with this deficiency. Element 3 – Systemic Changes A New Hire Medical Clearance Checklist was implemented requiring a completed step 1 PPD prior to starting to work and completing a step 2 within the required timeframe. On 02/04/26 The Director of Nursing re-educated Human Resources and nursing leadership on employee health screening requirements including PPD requirements. Human Resources was also educated on using the checklist during onboarding and on ensuring compliance with employee PPD's. Element 4 – Monitoring / QAPI Oversight The Human Resources Director or designee will audit 25% of new hire files using the checklist. Audits will be completed weekly for 4 weeks and then monthly for 3 months. HR director will report			02/20/2026	

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S1410	Continued from page 8 following: On 1/5/26 at 9:40 AM, the surveyor requested from the Human Resources Director (HRD) a list of all employees that were hired since last survey, including name, date of hire, title, and including contracted employees. On 1/6/26 at 7:55 AM, the HRD provided the list of employees, status, position, department, date hired and termination date. The surveyor asked the HRD to provide all the new hire files, including medical information for the names provided for the 154 names on the list. On 1/07/26 at 12:27, PM the HRD with the Licensed Nursing Home Administrator (LNHA) present, confirmed that they were unable to provide all requested employee files, HRD stated "we cannot find them." On 1/07/26 at 9:00 AM, The surveyor reviewed the 55 employee files for [REDACTED] screening upon hire that were provided out of a total of 154 employee files of the recently hired and terminated employees. The review for [REDACTED] screening upon hire employees revealed the following: Employee # 2 was hired on [REDACTED] and had a NJ Exec Order 26.4b1 test completed on [REDACTED]. There was no documentation of a NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 test or an alternative [REDACTED] screening was completed upon hire. Employee # 3 was hired on [REDACTED]. There was no documentation in the file to indicate that a [REDACTED] was completed upon hire. Employee # 5 was hired on [REDACTED] and had a NJ Exec Order 26.4b1 test completed on [REDACTED]. There was no documentation of a NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 6 was hired on [REDACTED] and had a NJ Exec Order 26.4b1 test completed on [REDACTED]. There was no documentation of a NJ Exec Order 26.4b1 being completed. There was no additional documentation in the file to indicate	S1410	Continued from page 8 results to the monthly QAPI Committee until May 2026. The administrator is responsible for this POC.	02/20/2026

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S1410	Continued from page 9 that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 7 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 test completed on NJ Exec Order 26.4b1. There was no documentation of a NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 was completed upon hire. Employee # 11 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 test completed on NJ Exec Order 26.4b1. There was no documentation of a NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 12 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 test completed on NJ Exec Order 26.4b1. There was no documentation of a NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 13 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 test completed on NJ Exec Order 26.4b1. There was no documentation of a second NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 was completed upon hire. Employee # 14 was hired on NJ Exec Order 26.4b1. There was no documentation in the file to indicate that a NJ Exec Order 26.4b1 was completed upon hire. Employee # 15 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 test completed on NJ Exec Order 26.4b1. There was no documentation of a second NJ Exec Order 26.4b1 being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 was completed upon hire. Employee # 16 was hired on NJ Exec Order 26.4b1. There was no documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 17 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 test completed on NJ Exec Order 26.4b1. There was no documentation of a second	S1410		02/20/2026

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S1410	Continued from page 10 NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 18 was hired on NJ Exec Order 26.4b1. There was no documentation in the file to indicate that a NJ Exec Order 26.4b1 was completed upon hire. Employee # 20 was hired on NJ Exec Order 26.4b1. There was no documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 21 was hired on NJ Exec Order 26.4b1. There was no documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 22 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1. There was no documentation of a NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 23 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 test completed on NJ Exec Order 26.4b1. There was no documentation of a NJ Exec Order 26.4b1 being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 24 was hired on NJ Exec Order 26.4b1. There was no documentation in the file to indicate that a NJ Exec Order 26.4b1 was completed upon hire. Employee # 25 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 test completed on NJ Exec Order 26.4b1. There was no documentation of a NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 28 was hired on NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1. There was no documentation of a NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a NJ Exec Order 26.4b1 screening was completed upon hire.	S1410		02/20/2026

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S1410	Continued from page 11 Employee # 29 was hired on [REDACTED] NJ Exec Order 26. There was no documentation in the file to indicate that a [REDACTED] NJ Exec Order 26 screening was completed upon hire. Employee # 30's hire date was not documented. There was no documentation in the file to indicate that a [REDACTED] NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 31 was hired on [REDACTED] NJ Exec Order 26. There was no documentation in the file to indicate that a [REDACTED] NJ Exec Order 26 screening was completed upon hire. Employee # 32 was hired on [REDACTED] NJ Exec Order 26. There was no documentation in the file to indicate that a [REDACTED] NJ Exec Order 26 screening was completed upon hire. Employee # 34 was hired on [REDACTED] NJ Exec Order 26.4b1 had a [REDACTED] NJ Exec Order 26.4b1 test completed on [REDACTED] NJ Exec Order 26.4b1 was no documentation of a [REDACTED] NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a [REDACTED] NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 35 was hired on [REDACTED] NJ Exec Order 26. There was no documentation in the file to indicate that a [REDACTED] NJ Exec Order 26 screening was completed upon hire. Employee # 37 was hired on [REDACTED] NJ Exec Order 26 and had a [REDACTED] NJ Exec Order 26.4b1 test. There was no documentation of a [REDACTED] NJ Exec Order 26.4b1 test being completed. There was no additional documentation in the file to indicate that a [REDACTED] NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 38 was hired on [REDACTED] NJ Exec Order 26 and had a [REDACTED] NJ Exec Order 26.4b1 test. There was no documentation of a second [REDACTED] NJ Exec Order 26.4b1 being completed. There was no additional documentation in the file to indicate that a [REDACTED] NJ Exec Order 26.4b1 screening was completed upon hire. Employee # 42 was hired on [REDACTED] NJ Exec Order 26. There was no documentation in the file to indicate that a [REDACTED] NJ Exec Order 26 screening was completed upon hire. Employee # 43 was hired on [REDACTED] NJ Exec Order 26. There was no	S1410		02/20/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004	
(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
S1410	Continued from page 12 documentation in the file to indicate that a [NJ Exec Order 26.4b1] was completed upon hire. Employee # 44 was hired on [NJ Exec Order 26.4b1]. There was no documentation in the file to indicate that a [NJ Exec Order 26.4b1] was completed upon hire. Employee # 45 was hired on [NJ Exec Order 26.4b1] and had a [NJ Exec Order 26.4b1] test completed on [NJ Exec Order 26.4b1]. There was no documentation of a [NJ Exec Order 26.4b1] test being completed. There was no additional documentation in the file to indicate that a [NJ Exec Order 26.4b1] screening was completed upon hire. Employee # 46 was hired on [NJ Exec Order 26.4b1]. There was no documentation in the file to indicate that a [NJ Exec Order 26.4b1] screening was completed upon hire. Employee # 48 was hired on [NJ Exec Order 26.4b1]. There was no documentation in the file to indicate that a [NJ Exec Order 26.4b1] screening was completed upon hire. Employee # 49 was hired on [NJ Exec Order 26.4b1] and had a [NJ Exec Order 26.4b1] completed on [NJ Exec Order 26.4b1]. There was no documentation of a second [NJ Exec Order 26.4b1] being completed. There was no additional documentation in the file to indicate that a [NJ Exec Order 26.4b1] was completed upon hire. Employee # 51's hire date was not documented. There was no documentation in the file to indicate that a [NJ Exec Order 26.4b1] test or an alternative [NJ Exec Order 26.4b1] screening was completed upon hire. Employee # 52 was hired on [NJ Exec Order 26.4b1] and had a [NJ Exec Order 26.4b1] test completed on [NJ Exec Order 26.4b1]. There was no documentation of a [NJ Exec Order 26.4b1] test being completed. There was no additional documentation in the file to indicate that a [NJ Exec Order 26.4b1] screening was completed upon hire. Employee # 53's hire date was not documented. There was no documentation in the file to indicate that a [NJ Exec Order 26.4b1] screening was completed upon hire. Employee # 54's hire date was not documented. There was no documentation in the file to indicate that a [NJ Exec Order 26.4b1] screening was completed upon hire.	S1410		02/20/2026

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NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004	
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S1410	Continued from page 13 screening was completed upon hire. Employee # 55 was hired on [REDACTED] and had a NJ Exec Order 26.4b1 completed on [REDACTED]. There was no documentation of a [REDACTED] [REDACTED] test being completed. There was no additional documentation in the file to indicate any other [REDACTED] or alternative [REDACTED] was completed. On 1/09/26 at 10:29 AM, the surveyor interviewed the Health Wellness Nurse (HWN) Licensed Practical Nurse (LPN) who stated she is responsible for administering NJ Ex Order 26.4(b)(1) for all new employees hired at the facility unless they have had a [REDACTED] gold test or [REDACTED]. The HWN stated after she administers the first step [REDACTED] the information is given to HRD and then HRD sets up the next appointment for the employee to receive the second [REDACTED]. HWN further stated that the HRD emails her the date and time the employee is scheduled to receive the [REDACTED]. The surveyor requested to review an example of one of the email follow ups that were sent to her from the HRD. The Wellness Nurse was unable to provide an email and stated, "I do know they have been slacking off on that." The surveyor asked if she ever followed up with HRD regarding outstanding employee who require a [REDACTED] and the HWN replied "I do not follow up I have never been responsible for that." The facility did not have a policy for newly hired employees. No further information was provided. NJ 8:39-19.5(b.)	S1410		02/20/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
(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 Revisit Date: 3/12/26 Survey Date: 1/9/26 Census: 51 Sample Size: 3 The facility was found to be not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.		F0000			03/18/2026	
F0607 SS = E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of		F0607	Element 1 – Corrective Action for Affected Individuals All employees identified in the deficient practice (Employee #4, #5, #6, #8, #9, and #11) currently have completed criminal background checks on file. Review of these background checks confirmed that there were no findings prohibiting employment, and all employees remain eligible for continued employment. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were re-educated by the Regional Consultant on Friday, March 13, 2026, on the requirements of criminal background checks and ensuring that no staff member begins working prior to completion of a criminal background check. Element 2 – Identification of Other Individuals at Risk All residents have the potential to be affected. All employees, hired after January 10, 2026, were reviewed by Human resource director on March 13th 2026 to ensure that criminal background checks were completed and maintained in their personnel files. No additional concerns were identified. No residents were identified with this deficiency.		03/13/2026	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004	
(X4) ID PREFIX TAG F0607 SS = E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F0607	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 03/13/2026
	Continued from page 1 the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, it was determined that the facility failed to consistently complete a pre-screening (criminal background check) for all employees, prior to hire, to ensure they had not been found guilty in a court of law of abuse, neglect, or misappropriation. The deficient practice was identified for 6 of 12 (50%) employee files reviewed for employees hired after [REDACTED] and was evidenced by the following: On 3/12/26 at 9:14 AM, during an interview with the surveyor, the [REDACTED] (US FOIA (b)(6)) stated that she had received education regarding the hiring process that included prescreening of applicants prior to the date of hire. The [REDACTED] also stated that the employee files had been audited for completeness monthly, and that those that were hired from [REDACTED] were "100 % in compliance." At that time the surveyor requested a list of all employees, including contracted employees, who had been hired since [REDACTED] (completion date) and included employee name, date of hire, title, and date of separation (if applicable). A review of the facility provided employee files revealed the following: Employee #4 was hired on [REDACTED] and the criminal background search was ordered and completed on [REDACTED] (6 days after the date of hire). Employee # 5 was hired on [REDACTED], and the criminal background search was ordered on [REDACTED] and completed on [REDACTED] (12 days after the date of hire). Employee # 6 was hired on [REDACTED], and the criminal background search was ordered and completed on [REDACTED] (one day after the date of hire). Employee # 8 was hired on [REDACTED] and the criminal background search was ordered and completed on [REDACTED] (11 days after the date of hire).		Continued from page 1 Element 3 – Systemic Changes / Measures Put in Place The facility has implemented the following systemic changes to ensure compliance: Pre-Employment Requirement Enforcement: Effective immediately, criminal background checks must be completed and verified prior to any employee starting work. Payroll Control Process: Employees will not be entered into payroll or granted timeclock access until Human Resources provides confirmation that a criminal background check has been completed. HR Process Standardization: Human Resources has implemented a mandatory pre-employment verification process ensuring background checks are ordered, completed, and documented prior to hire/start date. Orientation Control: No employee will be permitted to attend orientation until the criminal background check was completed. All department heads received an education that they cant hire anyone prior to having a criminal background check completed. Element 4 – Monitoring / Quality Assurance (QAPI) The Human Resources Director or designee will conduct audits of all new hires to ensure background checks were completed prior to hire. Audits will be done Weekly audits for 4 weeks, Bi-weekly audits for 2 months, Monthly audits for 2 months, for a total of 5 months. The HR director will present the results of these audits at the monthly QAPI meeting until August 2026. The Administrator is responsible for oversight of this POC.	

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F0607 SS = E	Continued from page 2 Employee # 9 was hired on [REDACTED] NJ Exec Order [REDACTED], and the criminal background search was ordered and completed on [REDACTED] NJ Exec Order [REDACTED] (15 days after the date of hire). Employee # 11 was hired on [REDACTED] NJ Exec Order [REDACTED] and the criminal background search was ordered and completed on [REDACTED] NJ Exec Order [REDACTED] (20 days after the date of hire). On 3/12/26 at 1:35 PM, during a follow-up interview with the surveyor, the [REDACTED] US FOIA [REDACTED] stated that the criminal background checks were ordered prior to the date of hire. On 3/12/26 at 2:35 PM, in the presence of the survey team, the [REDACTED] US FOIA (b)(6) [REDACTED] the surveyor discussed the concerns regarding 6 of the 12 employee files reviewed that did not reflect documented evidence that the criminal background checks were completed by the facility prior to the date of hire. At that time, the [REDACTED] US FOIA (b)(6) [REDACTED] stated that he audited the employee files and confirmed that he had failed to notice that 6 of the 12 staff were hired prior to the completion of the criminal background check. A review of the undated facility provided policy titled: Human Resources included: All employees hired must complete required pre-employment documentation, verification procedures and health screenings prior to beginning employment... under section Personnel File Maintenance reflected that the Human Resources Department will maintain personnel files containing all required documentation. NJAC 8:39-9.3(b)			F0607			03/13/2026

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NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
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S0000	Initial Comments Revisit Date: 3/12/26 Survey Date: 1/9/26 Census: 51 Sample Size: 3 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			03/18/2026

Office of Primary Care and Health Systems Management

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2026	
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F0000	INITIAL COMMENTS Census: 51 Sample Size: 3 An on-stie revisit was conducted on 03/12/2026 to verify the facility's Plan of Correction for the 01/09/2026 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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New Jersey Department of Health

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S0000	Initial Comments Census: 51 Sample Size: 3 An on-stie revisit was conducted on 03/12/2026 to verify the facility's Plan of Correction in relation to the 01/09/2026 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 01/09/2026
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K0000 Bldg. 01	INITIAL COMMENTS The NJDOH conducted a Life Safety Code survey on 01/05/26 and 01/06/26. The facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Allegria at the Fountains is a one-story, Type II unprotected building. The 301 to 312 wing leads into the assisted living wing of the facility. The interior diesel 125 KW generator powers approximately 70% of the building per the Maintenance Director. The building utilizes an electric fire pump to support the fire sprinkler system. The facility has 60 LTC licensed beds and currently is occupying 56 at entrance.	K0000		02/02/2026
K0271 SS = F Bldg. 01	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 01/05/2026, in the presence of the US FOIA (b)(6), it was determined that the facility failed to provide a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and maintained free of obstructions in accordance with NFPA 101: 2012 edition, Sections 19.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0271	Element 1 – Corrective Action: The egress walkway for Emergency Door N5 was repaired to create a leveled surface for safe passage during emergency evacuation. Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice. A facility-wide inspection of exit discharge paths and walkways was completed to identify any additional uneven or unsafe surfaces. Element 3 – Systemic Changes: The Administrator educated the US FOIA (b)(6) on 1/26/2026 on Exit discharge, egress walkways, and uneven walking surfaces. The facility will maintain all exit discharge pathways in a safe, unobstructed condition by implementing an ongoing preventive maintenance approach, including prompt work order creation and repair when hazards are identified. Element 4 – Monitoring: The Maintenance Director or designee will conduct	02/27/2026

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004	
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K0271 SS = F Bldg. 01	Continued from page 1 An observation at 12:45 PM revealed the egress walkway from emergency exit door N5 had 2 separate points along its route where it had been pushed up causing a rounded bulge from one edge of the walk to the other. This created an unlevel surface for passage in the event of an emergency. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/06/2026 at 1:30 PM. NJAC 8:39-31.2(e)	K0271	Continued from page 1 monthly audits to ensure the ground remains leveled and safe at Emergency Door N5 and that no additional exit discharge hazards exist. The QAPI Committee will review audit results monthly for 6 months and determine if continued monitoring is required until 100% compliance is achieved and sustained.	02/27/2026
K0281 SS = F Bldg. 01	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Repeat Deficiency Based on observations, interview and documentation review on 01/05/2026 in the presence of the US FOIA (b)(6), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101: 2012 edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 12:30 PM revealed there were 3 light switches located in 200-Wing Lounge, North Lounge and South Lounge that turned off all lighting, leaving no illumination for emergency egress in the event of a power loss. In an interview at the time, the US FOIA (b)(6) confirmed the observations.	K0281	Element 1 – Corrective Action: The three light switches located in the 200 Wing Lounge, North Lounge, and South Lounge were repaired to ensure illumination is available for emergency egress 24 hours per day. Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice. Element 3 – Systemic Changes: On 1/27/2026, the Administrator provided in-service education to the US FOIA (b)(6) regarding illumination of means of egress and the 24-hour emergency lighting requirement. Element 4 – Monitoring / QAPI Oversight: The Maintenance Director or designee will conduct monthly audits of egress lighting to ensure proper illumination. Audits will be done monthly for 3 months. Maintenance Director will report findings to the monthly QAPI committee, until May 2026	02/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 01/09/2026	
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
(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	
K0281 SS = F Bldg. 01	Continued from page 2 The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/06/2026 at 1:30 PM. This deficient practice was also cited on the previous Recertification survey, dated 06/28/2024. NJAC 8:39-31.2(e)	K0281				02/20/2026	
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on documentation review and interview on 01/06/2026, in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that cooking equipment was protected in accordance with NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review on 01/06/2026 revealed the	K0324	Element 1 – Corrective Action: The back shelf of side #1 was removed per the inspection report recommendation. For side #2, The fire sprinkler vendor changed the sprinkler Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice. Element 3 – Systemic Changes: On 1/27/2026, the Administrator provided in-service education to the US FOIA (b)(6) regarding NFPA 96 kitchen hood and fire protection requirements related to kitchen hood systems and sprinkler coverage. Element 4 – Monitoring / QAPI Oversight: The Maintenance Director or designee will conduct monthly audits of the kitchen hood and cooking line to ensure NFPA compliance. Audits will be done monthly for 3 months. Maintenance Director will report findings to the monthly QAPI committee, until May 2026.			03/20/2026	

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K0324 SS = F Bldg. 01	Continued from page 3 Main Kitchen suppression system inspection report, dated 10/02/2025. The inspection report was marked as 'System inspected with deficiencies present'. The report noted that the system was a double-sided hood with side #1 having a range with a "back shelf on it and must have the back shelf removed or re-piped for LPR nozzles". "Side 2 had a 36x30 tilt skillet being protected by (2) F nozzles and needs 2 additional nozzles". A documentation review of the local Fire Prevention Division revealed that the Township Fire Marshall had inspected the facility on 12/08/2025 and provided the facility with a Notice of Violations and Order to Correct for the Kitchen Hood Repair. The facility was given an Abate by 01/12/2026. In an interview at the time, the US FOIA (b)(6) was asked if the facility had corrected the violations. The US FOIA (b)(6) stated that they had not. The US FOIA (b)(6) was asked if the facility could provide a contract showing the work was in process. The US FOIA (b)(6) was unable to do so. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 7/18/2025 at 1:30 PM. NJAC 8:39-31.1(c) - 31.2(e) NFPA 96	K0324		03/20/2026
K0341 SS = F Bldg. 01	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.	K0341	Element 1 – Corrective Action: A smoke detector was installed in the IT room to protect the Fire Alarm Control Unit and Fire Alarm Signal Communicator. Installation was completed by the facility's fire alarm vendor on 2/3/2026 and documented. Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice. Element 3 – Systemic Changes: On 1/27/2026, the Administrator provided in-service education to the US FOIA (b)(6) regarding Fire	02/20/2026

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K0341 SS = F Bldg. 01	Continued from page 4 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 01/05/2026, in the presence of the US FOIA (b)(6) , it was determined the facility failed to ensure that automatic smoke detection was provided at all Fire Alarm Control Unit's (FACU), in accordance with NFPA 101: 2012 Edition, Sections 19.3.4.1, 9.6.1.8 and NFPA 72: 2010 Edition, Section 10.15. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at approximately 11:35 AM, of the IT Room, revealed the room was not an occupied room and was not equipped with a smoke detector to protect the Fire Alarm Control Unit and fire alarm signal communicator. In an interview at the time, the US FOI confirmed the observation. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code Exit conference on 01/06/2026 at 1:30 PM. N.J.A.C. 8:39-31.2 (e) NFPA 72	K0341	Continued from page 4 Alarm System Installation & Smoke Detector requirements in the IT room and designated areas related to NFPA 72. Element 4 – Monitoring / QAPI Oversight: The Maintenance Director or designee will conduct monthly audits of the IT room smoke detector to ensure it remains present and functional. Audits will be done monthly for 3 months. Maintenance Director will report findings to the monthly QAPI committee, until May 2026.	02/20/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K0353	element 1- The facility contracted with a new licensed sprinkler vendor on 2/3/26. A 5-year Internal Inspection and a three-year air inspection were completed. Both gauges that were over five-years old were replaced. Any repairs noted as necessary in the new inspection reports were scheduled for repair. Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice. Element 3 – Systemic Changes: On 1/27/2026, the Administrator provided in-service education to the US FOIA (b)(6) regarding Sprinkler System - Maintenance and Testing requirements related to NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.	03/23/2026

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K0353 SS = F Bldg. 01	Continued from page 5 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on documentation review and interviews on 01/06/2026, in the presence the US FOIA (b)(6), it was determined that the facility failed to ensure that the fire sprinkler systems were Inspected, Tested and Maintained (ITM) in accordance with NFPA 25:2011 Edition, Section, 5.1.1.2. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 01/06/2026 revealed a "Work Acknowledgement " performed by the facility's Fire Protection Service. The document was dated 11/11/2025-11/12/2025 / 11/13/2025-11/14/2025 / 11/20/2025-11/21/2025 and 11/24/2025-11/25/2025. The report indicated it was "Repair Results" for the facility's sprinkler system. Documentation showed the 5-year FDC hydro inspection had "no sign of a 5-year Internal Inspection and no sign of a three-year air inspection. Both gauges are over five-years old and should be replaced one water gauge and one air gauge System #2". This had been discovered originally on 05/20/2025 during a Quarterly Sprinkler Inspection and again on 08/18/2025 during the Annual Sprinkler Inspection. Documentation indicated that the 5-year Internal and 3-year pressure tests were performed on the Wet system and the Dry System and both were found Unsatisfactory. In an interview at the time, the US FOIA (b)(6) confirmed the documentation review. The US FOIA (b)(6) was asked if the systems had been repaired and passed since the report, US FOIA (b)(6) stated the Facility had not yet made the repairs to the sprinkler systems. The facility's US FOIA (b)(6) was informed of the	K0353	Continued from page 5 Element 4 – Monitoring / QAPI Oversight: The Maintenance Director or designee will conduct monthly audits of the sprinkler inspection reports, to ensure NFPA 25, Water-based Fire Protection Systems compliance. Audits will be done monthly for 3 months. Maintenance Director will report findings to the monthly QAPI committee, until May 2026.	03/23/2026

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K0353 SS = F Bldg. 01	Continued from page 6 deficient practice at the Life Safety Code exit conference on 01/06/2026 at 1:30 PM. NJAC 8:39-31.2(e), 31.1(c) NFPA 25	K0353		03/23/2026
K0511 SS = F Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 1/05/2026, in the presence of the [US FOIA (b)(6)] it was determined that the facility failed to ensure that electrical equipment had approved wiring and electrical outlets in accordance with NFPA 70, 2011 Edition, Section 19.5.1.1, 9.1.1 and 9.1.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:56 AM revealed a modified plug being used to power the Main Kitchens oven. The cord was pinched along the outer sheath of electrical wire and offered no strain relief at the cord connection. In an interview at the time the [US FOIA] confirmed the observation. The facility's [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 01/06/2026 at 1:30 PM. NJAC 8:39-31.2(e), 31.1(c)	K0511	Element 1 – Corrective Action: The plug and cord for the kitchen oven was removed and replaced with a properly rated plug and cord. Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice. Element 3 – Systemic Changes: On 1/27/2026, the Administrator provided in-service education to the [US FOIA (b)(6)] regarding National Electric Code requirements related to electrical wiring and equipment with NFPA 70. Element 4 – Monitoring / QAPI Oversight: The Maintenance Director or designee will conduct monthly audits of kitchen equipment to ensure NFPA 70, National Electric Code compliance. Audits will be done monthly for 3 months. Maintenance Director will report findings to the monthly QAPI committee, until May 2026.	02/20/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K0761	Element 1 – Corrective Action: The right-hand door by the Wellness Hall was repaired using fire-rated caulk and metal to restore fire integrity.	02/20/2026

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K0761 SS = F Bldg. 01	Continued from page 7 Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 01/05/2026, in the presence of the US FOIA (b)(6), it was determined that the facility failed to ensure fire door assemblies were maintained in proper working condition in accordance with NFPA 101: 2012 Edition, Section 19.3 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:40 AM revealed a pair of fire doors leading from the Wellness Hall to the Skilled Nursing Facility. The right-hand door had 9 penetrations in the top left corner consistent with screw holes. In an interview at the time, the US FOI confirmed the observation and stated that Maintenance had "just removed a closer form the door" and had not yet "repaired the holes in the door". The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/06/2026 at 1:30 PM. NJAC 8:39-31.2(e) NFPA 80	K0761	Continued from page 7 Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice. Element 3 – Systemic Changes: On 1/27/2026, the Administrator provided in-service education to the US FOIA (b)(6) regarding Maintenance, Inspection & Testing – Doors related to Fire Door integrity and that it complies with NFPA 101. Element 4 – Monitoring / QAPI Oversight: The Maintenance Director or designee will conduct monthly audits of fire doors to ensure NFPA 101, compliance. Audits will be done monthly for 3 months. Maintenance Director will report findings to the monthly QAPI committee, until May 2026.	02/20/2026			

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K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observations, interview and record review on 01/05/2026 and 01/06/2026, in the presence of the US FOIA (b)(6) it was determined the facility failed to ensure non-hospital grade outlets in patient care rooms were tested annually in accordance with NFPA 99: 2012 Edition, Section 6.3.3, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during the Life Safety tour of the facility on 01/05/2026 revealed a mixture of hospital-grade and non-hospital-grade receptacles at patient bed locations. A documentation review on 01/06/2026 revealed that an annual inspection for grounding, polarity, and blade tension was not provided. In an interview, the US FOIA (b)(6) was asked if the facility performed Maintenance and Testing of hospital-grade and non-hospital grade receptacles, the US FOIA (b)(6) confirmed that the facility had not performed any such testing.	K0914	Element 1 – Corrective Action: All non-hospital grade receptacles in patient care rooms were tested for proper functionality in accordance with NFPA 99: 2012 Edition, Section 6.3.3, 6.3.3.2.1 to 6.3.3.2.4. Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice. Element 3 – Systemic Changes: On 1/27/2026, the Administrator provided in-service education to the U.S. FOIA (b) (6) regarding Electrical Systems - Maintenance and Testing requirements related to NFPA 70 National Electric Code, NFPA 99, Maintenance & testing – Receptacle type identification. Element 4 – Monitoring / QAPI Oversight: The Maintenance Director or designee will conduct monthly audits of resident room receptacles to ensure NFPA 99, compliance. Audits will be done monthly for 3 months. Maintenance Director will report findings to the monthly QAPI committee, until May 2026.	02/20/2026

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K0914 SS = F Bldg. 01	Continued from page 9 The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/06/2026 at 1:30 PM. NJAC 8:39-31.2(e) NFPA 99	K0914		02/20/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenance CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on documentation review and interview on 01/06/2026, in the presence of the US FOIA (b)(6) , it was determined that the facility failed to ensure that patient care related electrical equipment (PCREE) was inspected, tested and maintained (ITM) in accordance with NFPA 99:2012 Edition, Chapter 10. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0921	Element 1 – Corrective Action: Inspection, testing, and maintenance (ITM) were completed on 1/28/2026 for all Patient Care Related Electrical Equipment (PCREE). Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice. Element 3 – Systemic Changes: On 01/27/2026, the Administrator provided in-service education to the US FOIA (b)(6) on requirements for testing & maintenance requirements for PCREE per NFPA 99. Element 4 – Monitoring / QAPI Oversight: The Maintenance Director or designee will conduct monthly audits of Patient Care Related Electrical Equipment (PCREE) to ensure NFPA 99 compliance. Audits will be done monthly for 3 months. Maintenance Director will report findings to the monthly QAPI committee, until May 2026.	02/20/2026

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K0921 SS = F Bldg. 01	Continued from page 10 A record review on 01/06/2026 revealed that records of ITM performed in accordance with NFPA 99, Chapter 10, covering but not limited to physical integrity, resistance testing, leakage/touch current and evaluations following any repairs or modifications of PCREE could not be produced. In an interview at the time, the US FOI confirmed the record review. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/06/2026 at 1:30 PM. NJAC 8:39-31.2(e) NFPA 99	K0921				02/20/2026	

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations from 1/05/2026 through 1/06/2026. The facility was found to be in NON-COMPLIANCE with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.		E0000			02/02/2026	
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an		E0004	Element 1 – Corrective Action: The facility completed the review of the Emergency Preparedness Plan (EPP) on 1/29/2026. The review included collaboration with the Administrator, Director of Nursing, Maintenance Director, and Department Heads to ensure all required components of the Emergency Preparedness Plan were present and compliant with regulatory requirements. Staff participating in the review signed verification acknowledging their participation. Element 2 – Residents Potentially Affected: All residents have the potential to be affected by the deficient practice. Element 3 – Systemic Changes: On 1/29/2026, an in-service education was conducted by the Administrator and Maintenance Director for all department heads. The training included requirements for development and evaluation of the Emergency Preparedness Plan, interdisciplinary collaboration requirements, documentation expectations, and regulatory expectations for annual review. An in-service attendance record with staff signatures was completed and maintained by the facility. Element 4 – Monitoring / QAPI Oversight: The Administrator or designee will conduct audits of the Emergency Preparedness Plan. Audits will be done Monthly for 3 months. Administrator will present these findings to the monthly QAPI Committee, until May 2026.		02/20/2026	

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2026	
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
(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	
E0004 SS = F	Continued from page 1 emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Based on documentation review and interview on 01/06/2026 in the presence of the U.S. FOIA (b)(6) and the US FOIA (b)(6), it was determined that the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with Appendix Z, Requirements for Long Term Care (LTC) facilities. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review at 11:30 AM revealed that the facilities Emergency Preparedness Plan (EPP) did not include a signed signature page including key members of the staff indicating an annual review of the EPP. In an interview at 1:00 PM, the facilities US FOIA (b)(6) confirmed the deficient practice. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/06/2026 at 1:30 PM. NJAC 8:39-31.2(e)	E0004				02/20/2026	
E0009 SS = F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a) (4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and	E0009	Element 1 – Corrective Action: The facility scheduled collaboration on 1/29/26 with local and county emergency preparedness officials and to extend invitation to OEM to review the facility's Emergency Preparedness Plan and coordinate a tabletop exercise. Element 2 – Residents Potentially Affected: All residents have the potential to be affected by this deficient practice.			02/20/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2026	
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
(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
E0009 SS = F	Continued from page 2 maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is NOT MET as evidenced by: Based on documentation review and interviews on 01/06/2026, in the presence of the U.S. FOIA (b)(6) and US FOIA (b)(6), it was determined that the facility failed to ensure the emergency preparedness plan included collaboration and cooperative planning with the local or county Office of Emergency Management (OEM) in accordance with the Code of Federal Regulations (CFR) 483.73 LTC facilities. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review at 11:30 AM revealed there was no record of the emergency preparedness plan collaboration and cooperative planning or annual review including the local or county OEM. In an interview at the time, the US FOIA (b)(6) was asked if a copy of the EPP had been delivered to the local or county authorities for review. He was uncertain if the previous U.S. FOIA (b)(6) had done so and was unable to provide any evidence of it having been delivered. In an interview, the US FOIA (b)(6) confirmed the document review at that time.			E0009	Continued from page 2 Element 3 – Systemic Changes: On 1/27/2026, the Administrator and Maintenance Director provided in-service education to department heads regarding coordination requirements with local, county, and state emergency preparedness agencies and the use of a collaboration log. Element 4 – Monitoring / QAPI Oversight: The Administrator or designee will conduct audits of the Emergency Preparedness Plan including EOM collaboration. Audits will be done Monthly for 3 months. Administrator will present these findings to the monthly QAPI Committee, until May 2026.		02/20/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2026	
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
(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
E0009 SS = F	Continued from page 3 The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/06/2026 at 1:30 PM. NJAC 8:39-31.2(e), 31.6(f), 31.6(h), 31.6(i)1			E0009			02/20/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/12/2026	
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
(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
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 4/12/2026 in relation to the 1/9/2026 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			04/12/2026

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/12/2026	
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS				STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD , ATCO, New Jersey, 08004			
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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 4/12/2026 in relation to the 1/9/2026 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			04/12/2026	

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