STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). Complaint #: NJ176042, NJ177460, NJ181753, NJ182135, NJ182242, NJ182422, NJ183104, NJ183269, and NJ183713. Survey Dates: 03/03/25 - 03/06/25 Survey Census: 133 Sample Size: 30 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		4/16/25

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

Electronically Signed | 03/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
F 623	Continued From page 1 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 623	Continued From page 2 completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
F 623	Continued From page 3 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure the resident and/or the resident representative (RR) were given a transfer notice/discharge notice at the time the resident was transferred/discharged to the hospital for seven of seven residents (Residents (R) 180, R181, R21, R22, R42, R89, and R56) reviewed for hospitalization of 30 sample residents. This created the potential for the residents or their RR to have incomplete information, misunderstand the reason, and process for transfer or discharge, and the discharge appeal process. Findings include: 1. Review of R180's electronic medical record (EMR) titled "Face Sheet" located under the "Profile" tab indicated the resident was admitted to the facility on NJ Exec Order 26.4b1 Review of R180's EMR titled general "Progress Notes" located under the "Prog (Progress)" note tab, dated NJ Exec Order 26.4b, revealed the resident NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 with staff NJ Exec Order 26.4b1 at the nurse and US FOIA (b)(6)) and NJ Exec Order 26.4b1 to NJ Exec Orde a NJ Exec Order 26.4b1 at the US FOIA (b)(6) The resident was transported to the NJ Exec Order 26.4b1 for evaluation and treatment. Review of R180's EMR failed to contain evidence that a transfer notice was sent with the resident and/or to the RR. 2. Review of R181's EMR titled "Face Sheet"	F 623	I. Corrective Action: As residents # 180, 181, 21, 22, 42, 89 and 56 had already been transferred to the hospital and returned, the facility was unable to do an immediate corrective action. II. Identification of other residents or areas having the potential to be affected by this deficient practice. All residents transferred to the hospital have the potential to be affected by this deficient practice. III. Measures put into place to prevent the recurrence. Admissions, Business Office, Social Services, Nursing Administration staff was re-inserviced on sending transfer notice documentation to the patient/family upon discharge to the hospital. IV.. Monitoring corrective action The Business Office Manager or designee will audit all hospital transfers weekly to ensure letters have been issued. The audits will be completed and turned into the DON weekly for tracking and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
F 623	Continued From page 4 located under the "Profile" tab indicated the resident was admitted to the facility on [redacted]. Review of R181's EMR titled Practitioner Note "Progress Notes" located under the (Prog) tab, dated [redacted], indicated R181 [redacted] a [redacted] The resident was assessed and then transferred to the [redacted] for evaluation and treatment. Review of R181's EMR failed to contain evidence that a transfer notice was sent with the resident and/or to the RR. 3. Review of R21's "Census" tab located in the EMR revealed R21 was admitted on [redacted] Review of the discharge "Minimum Data Set (MDS) " with an Assessment Reference Date (ARD) of [redacted] located under the "MDS" tab of the EMR revealed R21 had a Discharge Return Anticipated MDS. Review of the "Prog Note [Progress Note]" tab in the EMR revealed a note, dated [redacted], that indicated R21 was sent to the hospital due to a [redacted]. Review of the EMR revealed no transfer notice for the hospitalization. 4. Review of R22's "Census" tab of the EMR revealed R22 was originally admitted on [redacted] Review of the discharge "MDS" tab of the EMR with an ARD of [redacted] revealed R22 had a Discharge Return Anticipated MDS.	F 623	trending. Outcomes will be reviewed at the monthly Quality Assurance Process Improvement Committee Meeting for three months or until the committee agrees the problem is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 623	Continued From page 5 Review of the "Prog Note" tab in the EMR revealed a skilled evaluation note, dated [redacted] that stated R22 was sent to the hospital due to [redacted]. Review of the EMR revealed no transfer notice for the hospitalization. 5. Review of R42's "Census" tab in the EMR revealed R42 was admitted on [redacted]. Review of the discharge "MDS" tab of the EMR with an ARD of [redacted] revealed R42 had Discharge Return Anticipated MDSs. Review of the discharge "MDS" tab of the EMR with an ARD of [redacted] revealed R42 had Discharge Return Anticipated MDS. Review of the "Prog Note" tab of the EMR revealed a note, dated [redacted], that stated R42 requested to go to the hospital due to not having a [redacted] Another note, dated [redacted], stated R42 was sent to the hospital due to [redacted]. Review of the EMR revealed no transfer notice for the hospitalizations. 6. Review of R89's "Census" tab of the EMR revealed R89 was admitted on [redacted] Review of the discharge "MDS" tab of the EMR with an ARD of [redacted], revealed a Discharge Return Anticipated MDS. Review of the "Prog Note" tab of the EMR revealed R89 was sent to the hospital for a	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
F 623	Continued From page 6	F 623		

NJ Exec Order 26.4b1 from the prior day.

Review of the EMR revealed no transfer notice for the hospitalization.

During an interview on 03/05/25 at 3:30 PM, the US FOIA (b)(6)) stated she was still looking for the written transfer/discharge forms. The US FOIA (b) stated the facility notified the residents' family and the Long-Term Care Ombudsman regarding all hospital transfers.

During a subsequent interview on 03/06/25 at 12:46 PM, the US FOIA (b) stated the residents were not provided with a written transfer/discharge notice. The US FOIA (b)(6) was present during this interview.

7. Review of R56's "Admission Record" located in the EMR under the "Profile" tab revealed an initial admission date of NJ Exec Order 26.4b and a hospital stay from NJ Exec Order 26.4b1. R56 returned from the hospital with diagnoses which included NJ Exec Order 26.4b1 .

Review of R56's annual "MDS" with an ARD of 12/25/24 and located in the "MDS" tab of the EMR revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Exe out of 15, indicating the resident's NJ Exec Order 26.4b1 .

Review of R56's "Prog Note" tab of the EMR revealed an entry on NJ Exec Order 26.4b1 at 9:57 AM which stated, "The US FOIA (b)(6) , US FOIA (b)(6)], and [resident] were all in agreement that [resident] needed to go the ER [emergency room] for evaluation and treatment." A follow-up entry on NJ Exec Order 26.4b at 2:06 PM documented, "[Resident]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 623	Continued From page 7 admitted to [hospital] with [redacted]]." Review of R56's EMR and paper chart revealed no notice of transfer to the resident and resident's representative of the transfer to the hospital. During an interview on 03/03/25 at 3:29 PM, R56 stated he had been hospitalized for a [redacted]. R56 could not recall receiving any paperwork from the facility regarding the transfer to the hospital. During an interview on 03/06/25 at 10:36 AM, Licensed Practical Nurse (LPN) 4 stated the paperwork sent to the hospital with the resident included only information for the hospital, about the resident, printed from the EMR. During an interview on 03/06/25 at 12:49 PM, the [redacted] stated the transfer form "does not exist" for the facility, and the [redacted] stated, "the process existed but fell through the cracks." Review of the facility's policy titled, "Discharge and Transfer," dated 11/15/22, indicated " ...For unplanned, acute transfers for patients must be permitted to return to the Center. Prior to the transfer, the patient and patient representative will be notified verbally followed by written notification using the Notice of Hospital Transfer or state specific information ..." The facility policy failed to address the following aspects: 1. The transfer notice must be in writing and in the language that the resident and/or the representative understands. 2. The transfer notice must identify the location and the reasons for the transfer. 3. If the facility has a resident with an intellectual disability or related disability, the transfer notice	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 623	Continued From page 8 must include the name, mailing address, email address, and telephone number for the agency for the protection and advocacy of people with developmental disabilities. 4. If the facility has a resident with a mental disorder or a related disability, the transfer notice must include the name, mailing address, email address, and the telephone number for the protection and advocacy of people with mental illness. NJAC 8:39-4.1 (a) 32 NJAC 8:39-5.1(a)	F 623		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		4/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 645	Continued From page 9 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
F 645	Continued From page 10 intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to initiate a new NJ Exec Order 26.4b1 for one of three residents (Resident (R) 22) reviewed for NJ Exec Order 26.4b1 to reflect the admitting diagnosis of NJ Exec Order 26.4b1 of 30 sample residents. The failure to maintain a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 that reflected the current diagnosis of R22 had the potential to delay or limit necessary assistance should R22 experience a NJ Exec Order 26.4b1 that disrupted NJ Exec Order 26.4b1. Findings include: Review of R22's "Census" tab located in the electronic medical record (EMR) revealed R22 was originally admitted on NJ Exec Order 26.4b1. Review of the "Med Diag (Medical Diagnoses)" tab located in the EMR revealed R22 had a diagnosis of NJ Exec Order 26 disorder as of NJ Exec Order 26.4b1. Review of the "Care Plan (CP)" under the "Care Plan" tab of the EMR revealed R22 had a focus with interventions related to NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 initiated on NJ Exec Order 26.4b1. Review of R22's NJ Exec Order 26.4b1, dated NJ Exec Order 26.4b1 and provided by the US FOIA (b)(6) revealed R22 did not have NJ Exec Order 26.4b1 listed as an applicable diagnosis. NJ Exec Order 26.4b1 listed R22 as having NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 of any kind.	F 645	I. Corrective Action: Corrected NJ Exec Order 26.4b1 has been completed for resident #22 II. Identification of other residents or areas having the potential to be affected by this deficient practice. All residents admitted to or residing at the facility have the potential to be affected by this deficient practice. III. Measures put into place to prevent the recurrence. The US FOIA (b)(6), Social Workers and Nursing Administration staff have been in-serviced on the PASARR requirements on admission and updating. All PASARR□s for in-house patients have been reviewed to ensure accuracy. PASARR□s for new admissions will be reviewed by Social Services upon admission to ensure accuracy. IDT team will review PASARR at the quarterly care plan meetings to ensure it remains accurate. IV. Monitoring corrective action Social Worker or designee will submit the audits to the Director of Nursing weekly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 645	Continued From page 11 During an interview on 03/05/25 at 3:02 PM, the [redacted]) stated residents arrived with [redacted] from the hospitals they came from. She stated the [redacted] should be recent and checked for accuracy. She verified [redacted] for R22 was conducted in [redacted] and was not accurate. The [redacted] stated the [redacted] should have been redone if it did not reflect the current diagnoses of residents. During an interview on 03/06/25 at 10:01 AM, the [redacted]) stated they used the prior [redacted] and "History and Physical" from the previous facility [both dated [redacted] which did not contain a [redacted] diagnosis. She stated the discrepancy should have been caught at admission and a new [redacted] completed. She stated it was her "error." Review of the facility's policy titled, "SS105 Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patients," revised 02/16/24, [redacted] revealed "Center Social Worker or designated staff will assure that all patients with Mental Disorders (MD) and/or Intellectual Disability (ID) receive appropriate pre-admission screenings according to federal and/or state regulations." The policy continued "Social Services will coordinate and/or inform the appropriate agency to conduct the evaluation and obtain results if ... ...it is learned after admission that the Pre-Admission Screening and Resident Review (PASRR) was not completed or is incorrect."	F 645	The findings will be reviewed by the DON for tracking and trending. Outcomes will be reviewed at the monthly quality Assurance Process Improvement Committee Meeting for three months or until the committee agrees the problem is corrected.	
F 656 SS=D	NJAC 8:39-5.1(a) Develop/Implement Comprehensive Care Plan	F 656		4/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 656	Continued From page 12 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
F 656	Continued From page 13 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to develop a person-centered care plan related to NJ Exec Order 26 when a resident started receiving NJ Exec Order 26.4b1 for one of one resident (Resident (R)56) reviewed for NJ Exec Order 26 of 30 sample residents. This had the potential for the residents to have unmet care needs. Findings include: Review of R56's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed an initial admission date of NJ Exec Order 26.4b1 and a hospital stay from NJ Exec Order 26.4b to NJ Exec Order 26.4b1. R56 returned from the hospital with diagnoses which included NJ Exec Order 26.4b1 [redacted] Review of R56's EMR under the "Progress Notes" tab revealed a "General" note, dated NJ Exec Order 26.4b, "Hospital Update- ...Hospital is also setting up NJ Exec Order 26.4b1 following the NJ Exec Order 26.4b1 placement ..." Another "General" note, dated NJ Exec Order 26.4b NJ Exec Order 26, documented "Patient is currently on mon-wed-and Fri ..." Review of R56's "Order Summary Report" located	F 656	I. Corrective Action: The care plan for resident #56 has been updated. II. Identification of other residents or areas having the potential to be affected by this deficient practice. All residents receiving dialysis have the potential to be affected by this deficient practice. III. Measures put into place to prevent the recurrence. The IDT team has been in-serviced on ensuring care plans for dialysis patients include all dialysis information. The care plans for all dialysis patients have been reviewed and updated to include all necessary dialysis information. IV.. Monitoring corrective action Nurse managers will audit 1 dialysis care plan weekly to ensure that they have all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 656	Continued From page 14 in the EMR under the "Orders" tab, revealed orders dated [redacted] for: "Monitor [redacted] site for NJ Exec Order 26.4b1 ... Notify the physician and [redacted] center immediately with any urgent problems." Review of R56's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] and located in the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, indicating the resident's NJ Exec Order 26.4b1 R56 received [redacted] Review of R56's EMR under the "Care Plan" tab revealed the only mention of [redacted] was an intervention dated [redacted], "Staff will provide care and have [resident] ready to attend [redacted] on Mondays, Wednesdays, and Fridays as scheduled," under the focus area of [redacted], revised on [redacted] All other interventions under the focus were dated [redacted] prior to [redacted] starting upon R56's return from the hospital on [redacted] During a concurrent observation and interview on 03/03/25 at 3:21 PM, R56 was observed with a [redacted] over NJ Exec Order 26.4b1. R56 reported going out to [redacted] on a [redacted] that the facility arranged. R56 reported waking around 3:15 or 3:30 AM on [redacted], assisted by staff to get ready, and eating a light breakfast prior to leaving and a larger breakfast upon return. During an interview on 03/06/25 at 10:36 AM, Licensed Practical Nurse (LPN) 4 stated everything was in the "Care Plan" or '[redacted] for nurses and Certified Nurse Aides (CNAs) in detail	F 656	pertinent / correct information. The audits will be submitted to the Director of Nursing weekly for tracking and trending. Outcomes will be reviewed at the monthly quality Assurance Process Improvement Committee Meeting for 3 months or until the committee agrees the problem is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
F 656	Continued From page 15 of what to look for when caring for [NJ Exec Order 26.] residents. During an interview on 03/06/25 at 11:08 AM, the [US FOIA (b)(6)], Registered Nurse (RN) 1 stated the unit managers were responsible for updating the care plans. RN1 stated the care plans were updated with "MDS" assessments and with any changes. RN1 stated the [NJ Exec Order 26.] care plan should include anything needed to encourage, teach, or watch for. RN1 stated R56 was [NJ Exec Order 26.4b1], so [NJ Exec Order 26.4b1]" RN1 reported R56's "Care Plan" could definitely be updated and more comprehensive to include more information on how to care for [NJ Exec Order 26.4b1], etc. During an interview on 03/06/25 at 12:53 PM, the [US FOIA (b)(6)]) stated care plans were expected to include residents' specific [NJ Exec Order 26.] information: where/when, type [NJ Exec Order 26.], program, any [NJ Exec Order 26.4b1]. The [US FOIA (b)] stated she expected more than the days of [NJ Exec Order 26.] [NJ Exec Order 26.] to be added to the care plan when started. Review of the facility provided, "Dialysis Services Agreement," dated 03/05/25, revealed "When a Center [skilled nursing facility] resident with renal disease requiring dialysis is authorized by Center [licensed provider of dialysis services] to receives services from Provider, Provider and Center shall jointly develop and agree upon the Center resident's care plan appropriate for management of end stage renal disease and pertinent to Services. Provider shall retain overall professional management responsibility for implementing and monitoring Services in accordance with the Center resident's care plan.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 656	Continued From page 16 Center shall be responsible for implementing non-Services portions of the Center resident's care plan, including but not limited to nutritional needs, ... and monitoring aspects of the patient's condition and care pertinent to the nature of end stage renal disease." Review of the facility's policy titled, "Person-Centered Care Plan," revised 10/24/22, revealed "A comprehensive person-centered care plan must be developed for each patient and must describe the following: services that are to be furnished; ... The care plan must be customized to each individual patient's preferences and needs ... Care plans will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals ..." NJAC 8:39-11.2(e) thru (i) NJAC 8:39-27.1(a)	F 656		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 881		4/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
F 881	Continued From page 17 Based on interview, record review, and facility policy review, the facility failed to establish an NJ Exec Order 26.4b1 program to include protocols to monitor extended NJ Exec Order 26.4b1 use for one of two residents (Resident (R) 35) reviewed for NJ Exec Order 26.4b1 of 30 sample residents. This failure had the potential to affect resident safety related to NJ Exec Order 26.4b1 usage. Findings include: Review of a Centers for Disease Control and Prevention (CDC) website titled, "Core Elements of Antibiotic Stewardship for Nursing Homes," dated 03/18/24 and located at https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html, indicated " ...Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Clinician response to antibiotic use feedback (e.g., acceptance) may help determine whether feedback is effective in changing prescribing behaviors ..." Review of R35's electronic medical records (EMR) titled "Face Sheet" located under the "Profile" tab indicated the resident was admitted to the facility on NJ Exec Order 26.4b1. Review of R35's EMR titled physician "Orders" located under the "Orders" tab, dated NJ Exec Order 26.4b1, indicated the resident was ordered NJ Exec Order 26.4b1 [redacted] to be administered twice a	F 881	Corrective Action: Resident #35 was seen by NJ Ex Order 26.4b1 [redacted] provider and medication was discontinued. II. Identification of other residents or areas having the potential to be affected by this deficient practice. All residents receiving prophylactic antibiotics have the potential to be affected by this deficient practice. III. Measures put into place to prevent the recurrence. Unit managers were in-serviced on follow up and documentation required for extended use of antibiotics. Infection preventionist was in-serviced on surveillance of extended antibiotic usage. IV.. Monitoring corrective action Infection preventionist will run an audit report weekly to assess patients requiring long term usage of antibiotics and ensure accurate surveillance. The Medical Director will review the list of residents requiring long term use of antibiotic therapy monthly to ensure best practices are being followed. The audits will be submitted to the Director of Nursing weekly for tracking and trending. Outcomes will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
F 881	Continued From page 18 day for NJ Exec Order 26.4b1 . Review of a facility document titled, "Medical Results," dated NJ Exec Order 26.4b1 and located under the "Misc" tab of the EMR, indicated the resident was seen and the document noted that R35 had a history of NJ Exec Order in NJ Exec NJ Exec Order 26.4b1 and was currently on NJ Exec Order 26.4b1 . During an interview on 3/06/25 at 8:57 AM, the US FOIA (b)(6)) stated her current electronic system did not permit the user to track resident NJ Exec Order 26.4b1 . The US FO stated she has never tracked the residents who were on an NJ Exec Order 26.4b1 unless they were a new admission with a new NJ Exec Order 26.4b1 order. During an interview on 03/06/25 at 10:33 AM, the US FOIA (b)(6) stated all residents who were on an NJ Exec Order 26.4b1 and long-term should be tracked. The US FOIA (b)(6) stated she was currently reviewing this issue this past week, but it had not been implemented prior to the recertification survey. The US FOIA (b)(6) was present during this interview. Review of a facility's policy titled, "Antibiotic Stewardship," dated 12/16/24, indicated " ... Centers will implement an Antibiotic Stewardship Program (ASP) as part of the facility's overall infection and control program. The Infection Preventionist (IP) is responsible for the Infection Prevention and Control program including ASP. The Administrator is ultimately responsible for the overall compliance with the ASP. The Director of Nursing (DON) and Medical Director are responsible for executing the ASP standards ...Reviews antibiotic use data and ensures best practices are followed ..." There was no evidence	F 881	be reviewed at the monthly quality Assurance Process Improvement Committee Meeting for 3 months or until the committee agrees the problem is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET MILLVILLE, NJ 08332**

(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
F 881	Continued From page 19 in the facility's policies that addressed standards for extended antibiotic use for residents. NJAC 8:39-19.4(d)	F 881		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060608	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	Corrective Action: Center is currently using sign on bonuses, referral bonuses, and various other incentives for current staff to meet staffing standards. Nursing employees salaries were increased effective January 1, 2025. II. Identification of other residents or areas having the potential to be affected by this deficient practice All residents have the potential to be affected by this deficient practice III. Measures put into place to prevent the recurrence. Staffing coordinator was re-educated on NJ staffing mandate	4/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060608	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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) COMPLETE DATE
S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 07/28/2024 to 08/03/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/28/24 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs. -07/29/24 had 13 CNAs for 144 residents on the day shift, required at least 18 CNAs. -07/30/24 had 12 CNAs for 142 residents on the day shift, required at least 18 CNAs. -07/31/24 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs. -08/01/24 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs. -08/02/24 had 14 CNAs for 141 residents on the day shift, required at least 18 CNAs. -08/03/24 had 13 CNAs for 141 residents on the day shift, required at least 18 CNAs. 2. For the week of Complaint staffing from	S 560	Center will continue recruiting functions, which drive various forms of media to increase the number of applicants Continue to establish external partnerships with schools to train Students and transition them into CNAs. The Facility will be exploring the possibility of having a CNA class within the next few months pending state approval. Weekly labor management calls with regional support team IV. Monitoring corrective action The Labor management team will maintain a listing of current recruiting efforts, and document weekly the results of these efforts. The Administrator or designee will audit these efforts weekly x 4 weeks, then monthly x 2 to ensure the Center team is following up on all recruitment tasks. The Administrator or Designee will report findings to the Performance Improvement Committee monthly for three months. The Performance Improvement Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060608	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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) COMPLETE DATE
S 560	Continued From page 2 09/01/2024 to 09/07/2024, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -09/01/24 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. -09/03/24 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -09/04/24 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs. -09/05/24 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. -09/06/24 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -09/07/24 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. 3. For the week of Complaint staffing from 12/01/2024 to 12/07/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -12/01/24 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs. -12/02/24 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. -12/03/24 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -12/04/24 had 13 CNAs for 129 residents on the day shift, required at least 16 CNAs. -12/05/24 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/06/24 had 11 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/07/24 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs. 4. For the 3 weeks of Complaint staffing from 12/29/2024 to 01/18/2025, the facility was deficient in CNA staffing for residents on 21 of 21	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060608	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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) COMPLETE DATE
S 560	Continued From page 3 day shifts as follows: -12/29/24 had 8 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/30/24 had 10 CNAs for 127 residents on the day shift, required at least 16 CNAs. -12/31/24 had 11 CNAs for 127 residents on the day shift, required at least 16 CNAs. -01/01/25 had 12 CNAs for 127 residents on the day shift, required at least 16 CNAs. -01/02/25 had 10 CNAs for 127 residents on the day shift, required at least 16 CNAs. -01/03/25 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -01/04/25 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -01/05/25 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -01/06/25 had 11 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/07/25 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/08/25 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/09/25 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/10/25 had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/11/25 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/12/25 had 11 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/13/25 had 12 CNAs for 134 residents on the day shift, required at least 17 CNAs. -01/14/25 had 14 CNAs for 134 residents on the day shift, required at least 17 CNAs. -01/15/25 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs. -01/16/25 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060608	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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) COMPLETE DATE
S 560	Continued From page 4 -01/17/25 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -01/18/25 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. 5. For the week of Complaint staffing from 02/02/2025 to 02/08/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -02/02/25 had 14 CNAs for 141 residents on the day shift, required at least 18 CNAs. -02/03/25 had 12 CNAs for 141 residents on the day shift, required at least 18 CNAs. -02/04/25 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs. -02/05/25 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs. -02/06/25 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/07/25 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/08/25 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. 6. For the 2 weeks of staffing prior to survey from 02/16/2025 to 03/01/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -02/16/25 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/17/25 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/18/25 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/19/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/20/25 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060608	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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) COMPLETE DATE
S 560	Continued From page 5 -02/21/25 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/22/25 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/23/25 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/24/25 had 11 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/25/25 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/26/25 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/27/25 had 13 CNAs for 140 residents on the day shift, required at least 17 CNAs. -02/28/25 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. -03/01/25 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315243 Y1	A. Building B. Wing Y2	4/22/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0623	Correction	ID Prefix F0645	Correction	ID Prefix F0656	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(k)(1)-(3)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	04/16/2025	LSC	04/16/2025	LSC	04/16/2025
ID Prefix F0881	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/16/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/6/2025	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315243 Y1	A. Building B. Wing Y2	4/22/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0623	Correction	ID Prefix F0645	Correction	ID Prefix F0656	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(k)(1)-(3)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	04/16/2025	LSC	04/16/2025	LSC	04/16/2025
ID Prefix F0881	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/16/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/6/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060608 Y1	A. Building B. Wing Y2	4/22/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/16/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/6/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060608	A. Building B. Wing	4/22/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/16/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/6/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING **01** B. WING _____	**03/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET** **MILLVILLE, NJ 08332**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/06/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/06/25 and was found to be in noncompliance 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. Millville Center is a one-story building built in 1986. It is composed of Type V (111) protected construction. The facility is divided into eight - smoke zones. The generator powers approximately 60 % of the building per the US FOIA (b)(6) . The current occupied beds are 133 of 167.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT	K 222		4/16/25

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

Electronically Signed | 03/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING **01** B. WING _____	**03/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET** **MILLVILLE, NJ 08332**

(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
K 222	Continued From page 1 LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING **01** B. WING _____	**03/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET** **MILLVILLE, NJ 08332**

(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
K 222	Continued From page 2 installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure two of 22 exit doors equipped with delayed egress were provided with a sign that stated "Push until alarm sounds door can be opened in 15 seconds" in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.6.1.1 (4). This deficient practice had the potential to affect all 137 residents and was evidenced by the following: Observations on 03/06/25 at 12:30 PM of the exit door near Room 301 on the third floor revealed the door was equipped with delayed egress, However, the door lacked the required signage of, "Push until alarm sounds, door can be opened in 15 seconds." Observations on 03/06/25 at 1:14 PM of the exit door at the employee entrance on the first floor revealed the door was equipped with delayed egress. However, the doors lacked the required signage of, "Push until alarm sounds, door can be opened in 15 seconds." During an interview at the time of the	K 222	I. Corrective Action: No individual residents identified. II. Identification of other residents or areas having the potential to be affected by this deficient practice. All residents have the potential to be affected by this deficient practice. III. Measures put into place to prevent the recurrence. The[redacted] were in-serviced on the requirement to meet K-222. The 2 identified doors have signage of delayed egress. IV. Monitoring corrective action The Maintenance Director or designee will audit all doors for signage of delayed egress weekly x 4 weeks and monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING 01 B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
K 222	Continued From page 3 observations, the US FOIA (b)(6) verified the exit doors were not equipped with the required signage. NJAC 8:39-31.2(e)	K 222	thereafter to ensure compliance. The audits will be completed and turned into the NHA/ DON weekly for tracking and trending. Outcomes will be reviewed at the monthly Quality Assurance Process Improvement Committee Meeting for three months or until the committee agrees the problem is corrected.	
K 341 SS=F	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. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure low voltage wiring under seven feet was in conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 760.130 (B) (1). This deficient practice had the potential to affect all 133 residents and was evidenced by the following:	K 341	I. Corrective Action: No individual residents identified. II. Identification of other residents or areas having the potential to be affected	4/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING **01** B. WING _____	**03/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET** **MILLVILLE, NJ 08332**

(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
K 341	Continued From page 4 An observation on 03/06/25 at 12:37 PM revealed low voltage wiring under seven feet for the fire alarm system's NAC panel in the electrical room by the fire alarm control panel was not protected in conduit. During an interview at the time of the observation, the US FOIA (b)(6) verified the low voltage wiring was not protected in the walls or in conduit. NJAC 8:39-31.2(e) NFPA 70	K 341	by this deficient practice. All residents have the potential to be affected by this deficient practice. III. Measures put into place to prevent the recurrence. The US FOIA (b)(6) were in-serviced on the requirement to meet K-341. The low voltage wiring will be covered by conduit. IV. Monitoring corrective action The Maintenance Director or designee will audit identified electrical weekly x 4 weeks and monthly thereafter to ensure compliance.. The audits will be completed and turned into the NHA/ DON weekly for tracking and trending. Outcomes will be reviewed at the monthly Quality Assurance Process Improvement Committee Meeting for three months or until the committee agrees the problem is corrected.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K 351		4/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING **01** B. WING _____	**03/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET** **MILLVILLE, NJ 08332**

(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
K 351	Continued From page 5 measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the sprinklers were the same throughout a compartment in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2012 Edition) Section 8.3.3.2. This deficient practice had the potential to affect all 133 residents and was evidenced by the following: Observations on 03/06/25 at 12:19 PM revealed quick response sprinkler and standard sprinklers in the same compartment in the lobby outside administrator's office. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the quick response sprinklers and the standard sprinklers were installed in the same compartment. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	I. Corrective Action: No individual residents identified. II. Identification of other residents or areas having the potential to be affected by this deficient practice. All residents have the potential to be affected by this deficient practice. All identified areas have been corrected. III. Measures put into place to prevent the recurrence. The US FOIA (b)(6) were in-serviced on the requirement to meet K-351. The sprinkler in the lobby was replaced. IV. Monitoring corrective action The documentation of the sprinkler head replacement will be submitted to QAPI. All Sprinkler inspections and work will be reviewed by QAPI. The sprinkler	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING 01 B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
K 351	Continued From page 6	K 351	inspections throughout the year will be submitted to QAPI for review.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure fire extinguishers were mounted at the proper height, not be obstructed, and shall not be sitting on the floor or windowsill in accordance with NFPA 10, Standard for Portable Fire Extinguishers (2010 Edition) 6.1.3.8.1, 6.1.3.3.1 and 6.1.2. This deficient practice had the potential to affect all 133 residents and was evidenced by the following: An observation on 03/06/25 at 12:33 PM revealed a 10 lbs. ABC fire extinguisher in the electrical room was mounted approximately 72-inches off the finished floor. An observation on 03/06/25 at 12:46 PM revealed a K-Guard fire extinguisher was blocked from access in the kitchen. An observation on 03/06/25 at 12:54 PM revealed a 10 lbs. ABC fire extinguisher in the laundry room was knocked off its hanger and was sitting on a windowsill. During an interview at the time of each	K 355	I. Corrective Action: No individual residents identified. II. Identification of other residents or areas having the potential to be affected by this deficient practice. All identified areas have been corrected. All residents have the potential to be affected by this deficient practice. All identified areas have been corrected. Remounted fire extinguishers per regulation. III. Measures put into place to prevent the recurrence. The US FOIA (b)(6) [redacted] were in-serviced on the requirement to meet K-355. IV. Monitoring corrective action	4/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING 01 B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
K 355	Continued From page 7 observation, the US FOIA (b)(6) confirmed the fire extinguisher was mounted too high, that the K-Guard fire extinguisher was blocked in the kitchen, and that the fire extinguisher in the laundry was sitting on the windowsill. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355	The Maintenance Director or designee will audit to validate there is are mounted at the appropriate height, no obstructions in front of fire extinguishers, extinguishers are hanging correctly weekly x 4 weeks and monthly thereafter. The audits will be completed and turned into the NHA/ DON weekly for tracking and trending. Outcomes will be reviewed at the monthly Quality Assurance Process Improvement Committee Meeting for three months or until the committee agrees the problem is corrected.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at least one fire drill per quarter per shift in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.7.1.6. This deficient practice had the potential to affect all 133 residents and was evidenced by the following:	K 712	I. Corrective Action: No individual residents identified. II. Identification of other residents or areas having the potential to be affected	4/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING 01 B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

(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
K 712	Continued From page 8 A review of the facility's fire drill records provided by the facility revealed no documented evidence that a fire drill was conducted on the third shift for the first quarter and third shift of the third quarter of 2024. During an interview on 03/06/25 at 4:15 PM, the US FOIA (b)(6) confirmed the fire drills on the third shift were not completed for the first and third quarters of 2024. NJAC 8:39-31.2(e)	K 712	by this deficient practice. All residents have the potential to be affected by this deficient practice. III. Measures put into place to prevent the recurrence. Unable to correct prior years fire drills. The US FOIA (b)(6) were in-serviced on the requirement to meet K-712. The maintenance director will complete 3 fire drills, one on each shift in the month of March. IV. Monitoring corrective action The Administrator and or designee will audit monthly fire drills by the 25th of every month to validate the fire drills have been completed as required by regulations. The audits will be completed and turned into the NHA/ DON Monthly for tracking and trending. Outcomes will be reviewed at the monthly Quality Assurance Process Improvement Committee Meeting for three months or until the committee agrees the problem is corrected.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.	K 761		4/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING **01** B. WING _____	**03/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET** **MILLVILLE, NJ 08332**

(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
K 761	Continued From page 9 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire doors were inspected annually by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 133 residents and was evidenced by the following: A review of the facility's untitled fire safety binder provided by the facility revealed the last time the fire doors were inspected was 2023. Continued review revealed no documented evidence that the facility's fire doors were inspected in 2024. Observations on 03/06/25 from 11:30 AM to 3:00 PM of the facility's fire doors revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of each observation, the [redacted] confirmed the fire doors had not been inspected in 2024. NJAC 8:39-31.2(e)	K 761	I. Corrective Action: No individual residents identified. II. Identification of other residents or areas having the potential to be affected by this deficient practice. All residents have the potential to be affected by this deficient practice. III. Measures put into place to prevent the recurrence. The [redacted] were in-serviced on the requirement to meet K-761. The doors will be inspected by April 4th IV. Monitoring corrective action The Administrator and or designee validate the audit has been completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. BUILDING **01** B. WING _____	**03/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	**54 SHARP STREET** **MILLVILLE, NJ 08332**

(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
K 761	Continued From page 10 NFPA 80	K 761	annually as required by regulations. The audits will be completed and submitted to QAPI.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315243 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/22/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLVILLE CENTER	54 SHARP STREET MILLVILLE, NJ 08332

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	04/16/2025	LSC K0341	04/16/2025	LSC K0351	04/16/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	04/16/2025	LSC K0712	04/16/2025	LSC K0761	04/16/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/6/2025	☐ YES ☐ NO