	-	ND HUMAN SERVICES			FO	RM APPROVED
		MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		TE SURVEY
		315243	B. WING			C I <b>2/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		12/12/2024
MILLVILLI	E CENTER			54 SHARP STREET		
				MILLVILLE, NJ 08332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 00	00		
	Complaint #: NJ0017	76052 and NJ00181226				
	Census: 126					
	Sample Size: 6					
	42 CFR PART 483, S TERM CARE FACILI COMPLAINT VISIT.	I THE REQUIREMENTS OF SUBPART B, FOR LONG TIES BASED ON THIS				
F 607 SS=D	Develop/Implement A CFR(s): 483.12(b)(1)	Abuse/Neglect Policies -(5)(ii)(iii)	F 60	)7		1/24/25
	§483.12(b) The facilit implement written po	ty must develop and licies and procedures that:				
	§483.12(b)(1) Prohib neglect, and exploita misappropriation of re	tion of residents and				
	§483.12(b)(2) Establi to investigate any suc	ish policies and procedures ch allegations, and				
	§483.12(b)(3) Include paragraph §483.95,	e training as required at				
	§483.12(b)(4) Establi QAPI program requir	ish coordination with the ed under §483.75.				
	facilities in accordance Act. The policies and	e reporting of crimes -funded long-term care ce with section 1150B of the d procedures must include the following elements.				
	§483.12(b)(5)(ii) Pos	sting a conspicuous notice of				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					01/17/2025

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.

PRINTED: 03/06/2025

		D HUMAN SERVICES MEDICAID SERVICES					FORM	: 03/06/2025 APPROVED . 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMPI	LETED
		315243	B. WING				( 12/*	; 12/2024
NAME OF PF	ROVIDER OR SUPPLIER		•	ST	IREET ADDRESS, CITY, STAT	E, ZIP CODE		
MILLVILLE	CENTER			-	I SHARP STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page employee rights, as d (3) of the Act. §483.12(b)(5)(iii) Pro retaliation, as defined (2) of the Act. This REQUIREMENT by: Complaint #: 181226 Based on interviews a (MR) and other pertin on 12/11/24 and 12/12 the facility failed to im Prohibition" policy due allegation of <b>NJ Ex (</b> deficient practice was 1. During an interview 12/11/24 at 11:57 A.M they were not able to but about a week ago (Certified Nursing Ass twice. They stated that that she <b>NJ Ex Orde</b> stated that they repor Resident #3 was adm incident was reported #2 <b>NJ Exectorder 2040</b> , and to get people in troubl According to the "Adm Resident #3 was adm including but not limite	a 1 efined at section 1150B(d) hibiting and preventing at section 1150B(d)(1) and is not met as evidenced and medical record review ent facility documentation 2/24, it was determined that plement their "Abuse to staff not reporting an <b>Drder 26.4(b)(1)</b> . This evidenced by the following: with the Surveyor on L, Resident #3 stated that remember the exact date, , Resident #3 stated that remember the exact date, , Resident #3 asked CNA istant) #1 to $N E \times Order 26.4(b)(1)$ at CNA #1 $N E \times Order 26.4(b)(1)$ to CNA #1 $N E \times Order 26.4(b)(1)$ to the incident to the $N = 100000000000000000000000000000000000$		607		ement Abuse/Negle mediately educate during patient car ect. number 3 were sted by the resider with t was interviewed tled and he states talk about it but th t let me do what I e facility have the ed by this deficient s were in-serviced	ect ed e he hat	
		), <sup>NJ Ex Order 26.4(b)(1)</sup>			reportable events by Nursing. Staff will be re-inserv			

Event ID: LV5011

Facility ID: NJ60608

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 03/06/2025 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		LETED
		315243	B. WIN	G			C 12/2024
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	-
MILLVILLE	CENTER						
					AILLVILLE, NJ 08332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607		<sub>, and</sub> NJ Ex Order 26.4(b)(1)		= 607	and Neglect policy. Staff will be re-inserviced on the griev policy	ance	
	assessment tool date Resident #3 had a Br Status (BIMS) score of Resident #3 was NEX Daily Living). The facility provided a 12/6/24, in addition to statement obtained by was also reviewed. To or NEXCOMPTON Resident # was also reviewed. To or NEXCOMPTON Resident # Continued NEXCOMPTON while resident NEXCOMPTON while revealed that CNA #2 NEXCOMPTON and stated th to NEXCOMPTON and stated th to NEXCOMPTON and stated th	ief Interview of Mental of <sup>MEN</sup> indicating that Order 26.4(0)(1), and was nce with ADLs (Activities of a "Grievance Form" dated of the Grievance Form, a y the U.S. FOIA (b) (c) MEXORE the statement revealed that #3 asked CNA #1 to MEXORE CNA #1 MEXORE that she MEXORE ant #3 stated CNA #1			<ul> <li>4. The administrator or designee will audit all grievances to ensure they are handled/reported accordingly. The administrator or designee will audit partner rounds to ensure all are handled/reported accordingly. The administrator or designee will audit resident council meeting minutes to ensure all are handled/reported accordingly. The audits will be completed and turn into the DON weekly for tracking and trending. Outcomes will be reviewed at the mor quality Assurance Process Improveme Committee Meeting for three months of until the committee agrees the problem corrected.</li> </ul>	it all it all ned thly ent or	
	going to activity in day with Surveyor.	M., Resident #6 observed yroom, declined to speak Resident #6 was admitted					
FORM CMS-256	NJ Ex Order 26.4	ing but not limited to <sup>NVEXCITATION</sup> ), (b)(1)	011	Fa	cility ID: NJ60608 If cont	nuation she	et Page 3 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/06/2025 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315243	B. WING			_		C 12/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
				54	4 SHARP STREET				
MILLVILL	E CENTER			м	IILLVILLE, NJ 08332				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S	PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRE	CTIVE ACTION SHOULD B		COMPLETION	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG			NCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
						DEFICIENCI)			
F 607	Continued From page	e 3	F	607					
	NJ Ex Orde and NJ Ex Ord	der 26.4(b)(1)							
	A review of the MDS								
	that Resident #6 had	a Brief Interview of Mental							
	Status (BIMS) score of	of <sup>Mex</sup> indicating that							
	Resident #6 was NJ Ex	Order 26.4(b)(1), and required							
	NJ Ex Order 26.4(b)(1) with ADL	s (Activities of Daily Living).							
		e Resident Council minutes							
		aled that under "Nursing,"							
	residents pointed out	that some Aides had							
		towards them across all							
	shifts. Additionally, ur	nder "Additional concerns,"							
	Resident #6 stated fe								
		ified that it was across the							
		nursing. There was no							
	response documente	d for the concerns.							
	During an interview w	vith Surveyors on 12/12/24 at							
		DIA (b) (6) for Long Term							
		advocated for the residents,							
		igations for grievances.							
		gations involved collecting							
		lents, and for allegations							
		mbers, she would interview							
	•	he allegation, then other							
		member's assignment. She							
		uld formerly write up her							
		n turn her information into							
		(6) ), and the use for the opposite the oppo							
		vestigating the employee. e surveyor, the used reviewed							
	the statement from R								
		ad given the statement to stated that she did not							
		m other residents on CNA							

Facility ID: NJ60608

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	MENT OF HEALTH AN					FORM	): 03/06/2025 APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315243	B. WING		_	( 12/	) 12/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MILLVILLI	E CENTER			54 SHARP STREET MILLVILLE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	#1's and CNA #2's as During an interview w on 12/12/24 at 12:15 and if majority of the r concern, then the con minutes, and then a r and documented by th stated that there w NEX OTHER Should have the concerns express would report any incide stated NJ EX Order 26:4(b)(1) NJ EX Order 26:4(b)(1)	signments. with Surveyors via telephone P.M., the US.FOA(b)(6) that if there was a concern residents agreed with the acern would be written in the esponse would be signed the department heads. The was not a response to the ident Council minutes, and e been a written response to ed. I stated that she	F 607		DEFICIENCY)		
	entailed speaking to the roommate, resident's involved staff, the staff's assignment sector a copy of all She further stated that of the concerns in the minutes, and if she hat addressed the concern During an interview w 1:56 P.M., the U.S. F	he resident, resident's family members, and if the then the other residents on t. She further stated that as a form of N Ex order 264(0)(1) gated. US FOTA stated that she Resident Council minutes. at she was not made aware N Exorem 204(0) resident council ad been, she would have m.					

Facility ID: NJ60608

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/06/2025 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE : COMPI	SURVEY LETED
		315243	B. WING		_	( 12/1	; 12/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			5	4 SHARP STREET			
MILLVILL	ECENTER		N	MILLVILLE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	can either be notified stated that she did no was she informed of t Resident Council meet During an interview w 2:31 P.M., Admini of verbal abuse were name, yelling and scr presence of the Surve reviewed the stateme #3's grievance, she the should have been rep A review of the facility U.S. FOIA (b) (6) Prohibition" dated 7/1 10/24/22, included but following: under the h "Centers prohibit abus misappropriation of ref "patient") property and Centers also to striv Justice Act (EJA). Undesignated as manda obligated to immediate suspicion of a crime a will implement an abut through the following: incidents or allegation Investigation of incide protection of patients Under the heading for Immediately upon reconcerning a report of abuse, mistreatment, Administrator or design	t the nursing department verbally or in writing. She treceive the minutes, nor the Private eting. With Surveyors on 12/12/24 at strator stated that examples calling someone out of their eaming at residents. In the eyors, U.S. FOIA (b) (6) Int from the Private for Resident then stated that the incident ported for abuse. T's policy presented by the (13, reviewed and updated at was not limited to the eading for Policy, it states, se, mistreatment, neglect, esident/patient (hereinafter d exploitation for all patients ve to comply with the Elder der the EJA, employees are ted reporters and are ely report any reasonable against a patient. The Center use prohibition program Identification of possible ns which need investigation; ents and allegations; during the investigation. r process, it states: 7. eeiving information f suspected or alleged or neglect, the	F 607				

Facility ID: NJ60608

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		315243	B. WING	C 12/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO	DE
MILLVILLE	ECENTER			HARP STREET LVILLE, NJ 08332	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLET THE APPROPRIATE DATE
F 607	hours after the allega	ual, mental) not later than 2 tion is made.	F 607		
F 609 SS=D	N.J.A.C: 8:39-4.1 (a) Reporting of Alleged CFR(s): 483.12(b)(5)(	Violations	F 609		1/24/25
	- ,, .	se to allegations of abuse, or mistreatment, the facility			
	involving abuse, negle mistreatment, includir source and misapprop are reported immedia hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not rest the administrator of th officials (including to t adult protective service for jurisdiction in long	ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to			
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the eged violation is verified a action must be taken.			

Facility ID: NJ60608

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	-	D HUMAN SERVICES MEDICAID SERVICES			FO	ED: 03/06/2025 RM APPROVED IO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		315243	B. WING		1	C 2/12/2024
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP		
MILLVILLE	CENTER		-	4 SHARP STREET IILLVILLE, NJ 08332		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 609	Continued From page	- 7	F 609			
	(MR) and other pertin on 12/11/24 and 12/12 facility staff failed to re- to face to face Jersey Department of to their "Abuse Prohi reporting an allegation for 2 of 6 reside Resident #6). This de evidenced by the follow 1. During an interview 12/11/24 at 11:57 A.W they were not able to but about a week ago (Certified Nursing Ass twice. They stated that that she <b>NJ Ex Order</b> stated that they repor . Resident #3 incident was reported #2 <sup>NJ Ex Order 26.4(b)(1)</sup> According to the "Adm Resident #3 was adm including but not limite	wing: with the Surveyor on I., Resident #3 stated that remember the exact date, , Resident #3 asked CNA sistant) #1 to NJ Ex Order 26.4(b)(1) at CNA #1 NJ Ex Order 26.4(b		<ol> <li>Corrective Action         CNA 1 and 2 were immed             on being considerate durin             and abuse and neglect.         CNA s for resident numb             reassigned as requested b             Resident number 3 is very             reassignment of staff.             Partner Rounds were initia             every patient is assigned t             head to see several times             handle/report any concerr             Resident number 6 was in             regarding being             VJ Exec Order 26             ".      </li> <li>All residents in the faci             potential to be affected by             practice.         </li> <li>Department heads wer             on the difference between             reportable events by the             Nursing.         </li> <li>The administrator or desig             partner rounds to ensure a             handled/reported accordin             The administrator or desig             partner rounds to ensure a             handled/reported accordin             The administrator or desig             partner rounds to ensure a             handled/reported accordin         </li> </ol>	er 3 were by the resident. thappy with the ated where to a department weekly to as. terviewed and states <b>6.4b1</b> but that <b>6.4b1</b> but that <b>6.</b>	
	A review of the Minim	num Data Set (MDS), an		The audits will be comple	ted and turned	

Event ID: LV5011

Facility ID: NJ60608

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	03/06/2025 APPROVED 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE S COMPLE	
		315243	B. WING			C 12/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
MILLVILLI	ECENTER		-	4 SHARP STREET IILLVILLE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 609	assessment tool date Resident #3 had a Bri Status (BIMS) score of Resident #3 was W EX NEX Order 264(b)(1) assista Daily Living). The facility provided a NEX OF COMPACT Resident for twice, and C Resident factors while resident get dressed. revealed that CNA #2 NEX OF COMPACT and stated that to NEX OF COMPACT was provided for surv incident. 2. 12/12/24 at 2:18 P. going to activity in day with Surveyor. According to the AR, 1 with diagnoses includ NJ EX Order 26.4	a "Grievance Form" dated a "Grievance Form" dated b the Grievance Form" dated b the Grievance Form, a y the U.S. FOIA (b) (6) MEROMETER (A a sked CNA #1 to MEROMETER (CNA #1 MERO	F 609	into the DON weekly trending. Outcomes will be revi quality Assurance Pro Committee Meeting for until the committee as corrected.	iewed at the month ocess Improvemen or three months or	nt .	

Event ID: LV5011

Facility ID: NJ60608

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	2: 03/06/2025 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315243	B. WING		_	( 12/ <sup>,</sup>	C 12/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
<b></b>			5	4 SHARP STREET			
MILLVILL	ECENTER		N	MILLVILLE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	A review of the MDS of that Resident #6 had Status (BIMS) score of Resident #6 was WEX supervision with ADLs A review of the Private dated Exercised of the Private stated that her investi statements from resid involved staff member resident making the a residents on the staff further stated that wor investigation, and the the U.S. FOIA (b) would proceed with in In the presence of the the statement from Re and stated that she has the Exercised She further collect statements fro #1's and CNA #2's as During an interview w on 12/12/24 at 12:15	dated to compare of Mental a Brief Interview of Mental of the indicating that Order 26.4(D)(1), and required a (Activities of Daily Living). e Resident Council minutes aled that under "Nursing," that some aides had towards them across all ader "Additional concerns," eling "Mesorer 20.4(D)(1) ified that it was across the nursing. There was no d for the concerns. th Surveyors on 12/12/24 at <b>IA (b) (6)</b> for Long Term advocated for the residents, igations involved collecting lents, and that allegations rs, she would interview the llegation, then other member's assignment. She uid formerly write up her n turn her information into <b>(6)</b> ), and the <b>Mesor</b> vestigating the employee. e surveyor, the SW reviewed esident #3 dated <b>Mesor</b> ad given the statement to stated that she did not m other residents on CNA signments.	F 609				

Facility ID: NJ60608

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION		LETED
		315243	B. WING				C <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLVILL	E CENTER				54 SHARP STREET		
					MILLVILLE, NJ 08332		
(X4) ID PREFIX TAG					(X5) COMPLETION DATE		
F 609	and if majority of the r concern, then the com minutes, and then a r documented by the do stated that there was very private Resis that there should have the concerns express would report any inclu- stated that very any inclu- reported. During an interview w 1:08 P.M., the very stated that of the concerns in the minutes, and if she has addressed the concern During an interview w 1:56 P.M., the very stated that in the council would ask She stated that when department that the c respond to the concern The very stated that when department that the c respond to the concern the very stated that when department that the c respond to the concern the very stated that when department that the c respond to the concern the very stated that when department that the c respond to the concern the very stated that when department that the c respond to the concern the very stated that when department that the c respond to the concern the very stated that when department that the c respond to the concern the very stated that when department that the c respond to the concern the very stated that when department that the c	residents agreed with the esponse is signed and epartment heads. The first not a response to the ident Council minutes, and e been a written response to resident of first The first resident is considered er, this incident was not with Surveyors on 12/12/24 at tated that an investigation the resident, resident's family members, and if the then the other residents on t. She further stated that as a form of first order205(0)(1) gated. first stated that she Resident Council minutes. at she was not made aware first surveyors on 12/12/24 at the was not made aware first surveyors on 12/12/24 at the surveyors on 12/12/24 at	F	609			

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PRINTED: 03/06/2025

	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/06/2025 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315243	B. WING			_		C 12/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
				54	SHARP STREET			
	E CENTER			М	ILLVILLE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page	9 11	F 6	09				
	2:31 P.M., the U.S. FOI of Wex order 23:4(0) presence of the Surver reviewed the stateme #3's grievance, she th should have been rep A review of the facility Director of Nursing (D Prohibition" dated 7/1 10/24/22, included but following: under the h "Centers prohibit abut misappropriation of re "patient") property and Centers also to striv Justice Act (EJA). Undesignated as manda obligated to immediat suspicion of a crime a will implement an abut through the following: incidents or allegation Investigation of incide protection of patients Under the heading for Immediately upon reco concerning a report o abuse, mistreatment, Administrator or desig following. 7.2 Report	nt from the first for Resident hen stated that the incident borted abuse. T's policy presented by the OON), titled "Abuse /13, reviewed and updated t was not limited to the eading for Policy, it states, se, mistreatment, neglect, esident/patient (hereinafter d exploitation for all patients ve to comply with the Elder der the EJA, employees are ted reporters and are ely report any reasonable against a patient. The Center ise prohibition program Identification of possible is which need investigation; ents and allegations; during the investigation. r process, it states: 7. ieiving information f suspected or alleged or neglect, the gnee will perform the allegations involving abuse ual, mental, not later than 2 tion is made.						

Facility ID: NJ60608

If continuation sheet Page 12 of 18

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	· · · ·	MPLETED
						С
		315243	B. WING		1	2/12/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
MILLVILL	E CENTER			54 SHARP STREET MILLVILLE, NJ 08332		
				,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 610	Continued From page	e 12	F 6 <sup>2</sup>	10		
F 610	Investigate/Prevent/C	Correct Alleged Violation	F 6 <sup>-</sup>	10		1/24/25
SS=D	-					
	\$483.12(c) In respon	se to allegations of abuse,				
		or mistreatment, the facility				
	must:					
	8483 12(c)(2) Have e	evidence that all alleged				
	violations are thoroug					
	\$492 12(a)(2) Proven	t further potential abuse,				
		or mistreatment while the				
	investigation is in pro					
	§483.12(c)(4) Report	the results of all				
		administrator or his or her				
		ative and to other officials in e law, including to the State				
		n 5 working days of the				
		leged violation is verified				
		e action must be taken.				
		is not met as evidenced				
	by: Complaint #: 181226	3		F610 Investigate/Prever Violation	nt/Correct Alleged	
	Based on interviews	and medical record review				
		nent facility documentation		1. Corrective Action:		
		2/24, it was determined that		CNIA 1 and 0 wars in the	diataly advected	
	facility failed to thorou allegation of NJ Ex Order 26	<sup>34(b)(1)</sup> for 2 of 6 residents		CNA 1 and 2 were immed on NJ Ex Order 26.4(b)(1) dur		
	-	sident #6). This deficient		and NJ Ex Order 26.4(b)(1)		
	practice was evidenc			CNA⊡s for resident num		
				reassigned as requested	by the resident.	
		v with the Surveyor on /l., Resident #3 stated that		Resident number 3 <sup>NJ Exect</sup> reassignment of staff.	with the	
		remember the exact date,		Partner Rounds were init	iated where	
	but about a week ago	o, Resident #3 asked CNA		every patient is assigned		
	(Certified Nursing As	sistant) #1 to <sup>NJ Ex Order 26.4(b)(1)</sup>		head to see several times	•	
	twice. They stated the	at CNA #1		handle/report any concer	ns.	

Event ID: LV5011

Facility ID: NJ60608

If continuation sheet Page 13 of 18

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		LETED
		315243	B. WING				C 12/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	4 SHARP STREET		
MILLVILLE	CENTER			N	IILLVILLE, NJ 08332		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	that she NJ Ex Orde stated that they then stated that they report Resident #3 incident was reported #2 <sup>NJ Ex Order 26.4(b)(1)</sup> , and to NJ Ex Order 26.4(b)(1) According to the "Adm Resident #3 was adm including but not limited related A review of the Minima assessment tool date Resident #3 had a Bri Status (BIMS) score of Resident #3 was NJ Ex NET OFFERENCE Daily Living). The facility provided a 12/6/24, in addition to statement obtained by was also reviewed. The on NET OFFERENCE twice, and Ofference NJ Ex Order 26.4(b)(1) while resident <sup>10</sup> Ex Order 26.4(b)(1) while resident <sup>10</sup> Ex Order 26.4(b)(1) revealed that CNA #2	er 26.4(b)(1). Resident #3 WEX Order 204(b)(1). Resident #3 ted the incident to the US FOLKED further stated that after the to the U.S. FOLA (b) (6), CNA d said that they were going ). nission Record (AR)" itted with diagnoses ed to NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) (NJ Ex Order	F	610	<ul> <li>Resident number 6 was interviewed regarding <sup>[M Ex Order 26.4(b)(1)</sup> and <sup>[M Ex Order 26.4(b)(1)</sup> but the it is when they NJ Ex Order 26.4(b)(1) but the it is when they NJ Ex Order 26.4(b)(1) but the potential to be affected by this deficien practice.</li> <li>Charlen 1 (1) (1) (1) (1) (1) (1) (1) (1) (1) (</li></ul>	t all t all t all t all t all	
	NJ Ex Order 26.4(b)(1) while resident <sup>NJ Ex Order 26.4(b)(1)</sup> . revealed that CNA #2	e she was helping the The statement further at Resident #3 on at she did not want CNA #1			until the committee agrees the problem		

Facility ID: NJ60608

If continuation sheet Page 14 of 18

PRINTED: 03/06/2025

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/06/2025 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315243	B. WING			_		C 12/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
MILLVILLI	E CENTER				54 SHARP STREET MILLVILLE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	occurred on Second 234. was provided for survincident. 2. 12/12/24 at 2:18 P. going to activity in day with Surveyor. According to the AR, with diagnoses includ NJ Ex Order 26.4 ) and NJ Ex Order A review of the MDS of that Resident #6 had Status (BIMS) score of Resident #6 was VIEX VIEX ORDER 236(0) with ADLS A review of the Privat dated VIEX ORDER 236(0) A review of the Privat dated VIEX ORDER 236(0) shifts. Additionally, ur Resident #6 stated VI employees, and spec building and not just r response documented During an interview w 10 A.M., the U.S. FC	No additional information reyor review regarding the 	F	610				
		DIA (b) (6) for Long Term advocated for the residents,						

Facility ID: NJ60608

If continuation sheet Page 15 of 18

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/06/2025 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315243	B. WING _			_	(   12/	C 12/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
				54	4 SHARP STREET			
MILLVILLI	ECENTER			М	IILLVILLE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORRE) CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	stated that her investi statements from resid that involved staff men the residents on the staff further stated that wor investigation, and the the <b>U.S. FOIA (b)</b> would proceed with in In the presence of the the statement from Re and stated that she has the <b>DEFINIT</b> She further collect statements frou #1's and CNA #2's as During an interview w on 12/12/24 at 12:15 <b>During an interview w</b> on 12/12/24 at 12:15 <b>During an interview w</b> <b>During a</b>	igations for grievances. If a gations involved collecting gations involved collecting lents, and for allegations mbers, she would interview he allegation, then other member's assignment. She uld formerly write up her in turn her information into (6) (a), and the formation into (6) (b), and the formation (6) (c), and the formation (6) (c)	F	;10				

Facility ID: NJ60608

If continuation sheet Page 16 of 18

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 03/06/2025 1 APPROVED 2: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315243	B. WING		_	( 12/ <sup>-</sup>	C 12/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MILLVILLI	ECENTER			4 SHARP STREET /ILLVILLE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	the other residents on further stated that """ of "Lexorder264(0)(1) and s stated that she receiv Council minutes. She not made aware of the resident council minut she would have addre During an interview w 1:56 P.M., the U.S. F stated that in the council would ask She stated that when department that the correspond to the concer The USTEWN stated that can either be notified stated that she did no was she informed of t Resident Council mee During an interview w 2:31 P.M., the U.S. FOI of NEXORE 264(0)(1) were mission dated 7/1 10/24/22, included bu following: under the h "Centers prohibit abus misappropriation of re-	the staff's assignment. She resident was a form hould be investigated. Show ed a copy of all Resident further stated that she was e concerns in the Storeton tes, and if she had been, essed the concern. ith Surveyors on 12/12/24 at <b>OIA (b) (6)</b> the absence of the Storeton her to sit in on meetings. there was a concern, the oncern fell under, would rn on the response form. t the nursing department verbally or in writing. She t receive the minutes, nor he Storeton to stated that examples <b>NJ Ex Order 26.4(b)(1)</b> Order 26.4(b)(1) residents. In the exyors, the U.S. FOIA (b) (6) nt from the Storeton for Resident the nursing for Resident the stated that the incident	F 610				

Facility ID: NJ60608

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 03/06/2025 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315243	B. WING		_	( 12/	C 12/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
мнтунт	E CENTER		4	54 SHARP STREET			
				MILLVILLE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	BELAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Centers also to striv Justice Act (EJA). Un designated as manda obligated to immediat suspicion of a crime a will implement an abu through the following: incidents or allegation Investigation of incide protection of patients Under the heading for Immediately upon rec concerning a report o abuse, mistreatment, Administrator or desig following. 7.2 Report	ve to comply with the Elder der the EJA, employees are ted reporters and are ely report any reasonable against a patient. The Center use prohibition program Identification of possible as which need investigation; buts and allegations; during the investigation. r process, it states: 7. beiving information f suspected or alleged or neglect, the gnee will perform the allegations involving abuse ual, mental), not later than 2 tion is made.	F 610				

Facility ID: NJ60608

If continuation sheet Page 18 of 18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION ((	X3) DATE SURVEY COMPLETED
		060608	B. WING		C <b>12/12/2024</b>
IAME OF PF	OVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	FE, ZIP CODE	
<b>NILLVILLE</b>	CENTER		RP STREET .LE, NJ 08332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
S 000	Initial Comments		S 000		
	Complaint #: NJ0017	6052 and NJ00181226			
	Census: 126				
	Sample size: 6				
	Code, Chapter 8:39, Long Term Care Fact submit a plan of corre completion date, for that the plan is imple deficiencies may rest accordance with the	v Jersey Administrative Standards for Licensure of lities. The facility must ection, including a each deficiency and ensure mented. Failure to correct ult in enforcement action in Provisions of the New Jersey Title 8, Chapter 43E,			
S 560	8:39-5.1(a) Mandato	ry Access to Care	S 560		1/24/25
	-	ply with applicable Federal, , rules, and regulations.			
	by:	「 is not met as evidenced 6052 and NJ00181226		S 560 Mandatory Access to Care	
	failed to ensure staffi maintain the required ratios as mandated b	s determined that the facility ng ratios were met to I minimum staff-to-resident ry the state of New Jersey for he deficient practice was		1 Corrective Action All residents have the potential to be affected by this deficient practice . Cen is currently employing sign on bonuses, referral bonuses, and various other incentives for current staff to meet staffi standards. Nursing employees salaries were increased effective January 1, 202	ng

Electronically Signed

6899

01/17/25

## PRINTED: 03/06/2025 FORM APPROVED

	ey Department of Hea OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	(
		060608	B. WING		C 12/12/202	24
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MILLVILL	ECENTER		RP STREET LE, NJ 08332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE CON	(X5) MPLET DATE
S 560	<ul> <li>(NJDOH) memo, data with N.J.S.A. (New Ja 30:13-18, new minim nursing homes," india Governor signed into codified as N.J.S.A. ( established minimum nursing homes. The f effective on 02/01/20</li> <li>One Certified Nurse A residents for the day member to every 10</li> <li>shift, provided that no shall be CNAs and exit be signed into work a shall perform nurse a care staff member to night shift, provided t member shall sign in perform CNA duties.</li> <li>1. For the week of Co 08/04/2024 to 08/10/ deficient in CNA staff day shift, required at -08/05/24 had 13 CN day shift, required at -08/06/24 had 15 CN day shift, required at -08/08/24 had 15 CN day shift, required at</li> </ul>	sey Department of Health ed 01/28/2021, "Compliance ersey Statutes Annotated) num staffing requirements for cated the New Jersey o law P.L. 2020 c 112, 30:13-18 (the Act), which is staffing requirements in following ratio (s) were 221: Aide (CNA) to every eight shift. One direct care staff residents for the evening o fewer of all staff members ach direct staff member shall as a certified nurse aide and aide duties: and one direct every 14 residents for the that each direct care staff to work as a CNA and omplaint staffing from 2024, the facility was fing for residents on 5 of 7 As for 142 residents on the least 18 CNAs. As for 141 residents on the least 18 CNAs. As for 140 residents on the least 17 CNAs. As for 138 residents on the	S 560	<ul> <li>2. All residents have the potential affected by this deficient practice</li> <li>3. Staffing coordinator was re edu on NJ staffing mandate</li> <li>Center will continue recruiting fund which drive various forms of media increase the number of applicants</li> <li>Continue to establish external partnerships with schools to train \$ and transition them into CNAs.</li> <li>Weekly labor management calls w regional support team</li> <li>4. The Labor management team maintain a listing of current recruit efforts, and document weekly the point these efforts.</li> <li>The Administrator or designee will these efforts weekly x 4 weeks, the monthly x 2 to ensure the Center following up on all recruitment task.</li> <li>The Administrator or Designee will findings to the Performance Improvement Commevaluate and determine the effection of the plan to ensure substantial compliance is achieved and determ further monitoring and evaluation i required.</li> </ul>	a to Students Students will ing results audit team is (s. I report vement hs. The ittee will veness mine if	

LV5011

## PRINTED: 03/06/2025 FORM APPROVED

STATEMEN	Sey Department of Hea T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		060608	B. WING		12	C 2/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
MILLVILL	E CENTER		RP STREET LE, NJ 08332				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
S 560	day shifts as follows: -11/24/24 had 12 CN/ day shift, required at -11/26/24 had 15 CN/ day shift, required at -11/27/24 had 15 CN/ day shift, required at -11/28/24 had 13 CN/ day shift, required at -11/29/24 had 13 CN/ day shift, required at -11/30/24 had 15 CN/ day shift, required at -12/01/24 had 11 CN/ day shift, required at -12/02/24 had 12 CN/ day shift, required at -12/03/24 had 13 CN/ day shift, required at -12/03/24 had 13 CN/ day shift, required at -12/04/24 had 13 CN/ day shift, required at -12/05/24 had 13 CN/ day shift, required at -12/06/24 had 11 CN/ day shift, required at -12/06/24 had 11 CN/ day shift, required at -12/06/24 had 11 CN/ day shift, required at	2024, the facility was ing for residents on 13 of 14 As for 130 residents on the least 16 CNAs. As for 126 residents on the least 16 CNAs. As for 126 residents on the least 16 CNAs. As for 126 residents on the least 16 CNAs. As for 131 residents on the least 16 CNAs. As for 132 residents on the least 16 CNAs. As for 132 residents on the least 16 CNAs. As for 128 residents on the	S 560				

LV5011

## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	
IDENTIFICATION NOWDER	A. Bullully			
315243 <sub>Y1</sub>	B. Wing	Y2	1/27/2025	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).

ITE	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0607 483.12(b)(1)-(5)(i	i)(iii) Completed 01/24/2025	ID Prefix Reg. # LSC	F0609 483.12(b)(5)(i)(A)(B)(c) (1)(4)	Correction Completed 01/24/2025	ID Prefix Reg. # LSC	F0610 483.12(c)(2)-(4)	Correction Completed 01/24/2025
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
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS) DMPLETED ON		SIGNATURE OF S	ED DEFICIENCIES			
12/12/20	24		UNC	ORRECTED DEFICIENCIES	6 (CMS-2567) SEN	I TO THE FAC		IS 🗌 NO

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER			DATE OF REVISIT	-
060608	A. Building B. Wing	Y2	1/27/2025	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		DATE	ITEM		DATE	ITEM		DATE
Y4 Y		Y5	Y4		Y5	Y4		Y5
ID Prefix	S0560	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	8:39-5.1(a)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		01/24/2025			-	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 Reg. #		Correction Completed	ID Prefix 		Correction	ID Prefix 		Correction Completed
LSC			LSC		-	LSC		
ID Prefix Reg. #		Correction Completed	ID Prefix		Correction	ID Prefix — Reg. #		Correction Completed
LSC			LSC		-	LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SU	JRVEYOR		DATE	
REVIEWED BY     REVIEWED BY       CMS RO     (INITIALS)		DATE TITLE				DATE		
FOLLOWUP TO SURVEY COMPLETED ON 12/12/2024				FOR ANY UNCORRECTE RECTED DEFICIENCIES				5 🗌 NO