

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
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F0000	INITIAL COMMENTS Complaint NJ# 178506 (407049) Survey Date: 9/22/25 Census: 125 Sample: 25 sample + 3 closed records =28 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		09/29/2025
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F0607	The Director of Human Resources immediately verified and documented the credentials and license status of Staff Members #6, #7, and #8 status and confirmed all were active and in good standing; dated printouts have now been placed in their personnel files. All residents have the potential to be affected by the deficient practice because the facility failed to ensure licensed staff credentials were verified upon hire. The U.S. FOIA (b) (6) was re-educated by the Administrator on the requirement to obtain and retain dated license verification documentation prior to or on the date of hire for all licensed staff. All license verifications are dated and documented before proceeding with the hiring process. The Human Resources Manager or designee will audit 100% of new licensed staff files within 48 hours of hire weekly for 4 weeks and monthly for 3 months and quarterly thereafter to ensure dated license verification documentation is present and properly filed. The Human Resource Manager or designee will review any findings of these audits monthly and then report findings to the Quality Assurance and Performance	10/24/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0607 SS = D	<p>Continued from page 1</p> <p>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to ensure licensed staff credentials were verified upon hire for 3 of 7 licensed staff of the total 10 newly hired staff reviewed, Staff Member (SM) #6, #7 and #8.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 9/18/25 at 12:40 PM, the surveyor reviewed the facility provided employee files of 10 randomly selected newly hired employees of which 7 were licensed staff which included the following:</p> <ol style="list-style-type: none"> 1. A review of Staff Member #6 (SM#6), a U.S. FOIA (b)(6) hired on NJ Ex Order 26.4 had a New Jersey Department of Health (NJDOH) online Public Registry license verification printout (used to verify the status of a CNA's license and to check the nurse aide registry) which was not dated. There was no documented evidence that SM#6's license was verified prior to the date of hire (doh). 2. A review of Staff Member #7 (SM#7), a CNA, hired on NJ Ex Order 26.4, had a NJDOH online Public Registry license verification printout which was not dated. There was no documented evidence that SM#7's license was verified prior to the doh. 3. A review of Staff Member #8 (SM#8), a U.S. FOIA (b)(6) hired on NJ Ex Order 26.4, had a NJDOH online Public Registry license verification printout which was not dated. There was no documented evidence that SM#8's license was verified prior to the doh. 4. A review of Staff Member #9 (SM#9), a U.S. FOIA (b)(6) hired on NJ Ex Order 26.4, had a NJDOH online Public Registry license verification printout which was dated NJ Ex Order 26.4. There was documented evidence that SM#9's license was verified upon hire. <p>On 9/18/25 at 1:16 PM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of the</p>	F0607	<p>Continued from page 1</p> <p>Improvement Committee quarterly to determine the frequency of the future audits.</p> <p>Completion Date: October 24, 2025</p>	

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F0607 SS = D	<p>Continued from page 2</p> <p>U.S. FOIA (b) (6) regarding the process for new hires and license verification. The U.S. FOIA stated that she would make sure their license was active and in good standing on the New Jersey website prior to the hire date. The surveyor showed the U.S. FOIA and U.S. FOIA the 3 SM's license verification printout that did not have a date. The U.S. FOIA stated that the printer did not always print the date on it. The surveyor then showed the U.S. FOIA and U.S. FOIA SM #9's license verification printout that had a date on it. The U.S. FOIA confirmed that SM #6, #7 and #8's license verification printouts did not have a date on them. The U.S. FOIA stated that the verification was done before the doh.</p> <p>On 9/19/25 at 12:18 PM, the surveyor notified the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FOIA (b) (6) the concern that three CNAs did not have documented evidence that their license verification was done prior to their doh.</p> <p>On 9/22/25 at 10:50 AM, in the presence of the U.S. FOIA, U.S. FOIA (b) (6), U.S. FOIA and U.S. FOIA the U.S. FOIA stated that staff were educated on the new hire process and that moving forward to have all proper documentation upon hire.</p> <p>The U.S. FOIA did not provide any additional information.</p> <p>A review of the facility's "New Hire Policy and Procedure" with a reviewed date of 2/2025, included the following:</p> <ol style="list-style-type: none"> Upon a successful completion of the facility's pre-screening process for a new hire (including but not limited to, background checks, interviews, reference checks, etc.) only than will the new hire be able to move forward with the onboarding process. <p>A review of the facility's "Resident Abuse/Neglect Misappropriation of Property Policy" with a reviewed/revised date of 4/1/25, included the following:</p> <p>Hiring Practices/Screening of Potential Employees and Volunteers</p> <p>The facility will not knowingly employ any individual who has a history of abusing other persons. Potential employees and volunteers shall be screened thoroughly through structured interviews, personal and employment reference checks, criminal background checks, and contact with State licensing boards and registries, when applicable....</p>	F0607		

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F0607 SS = D	Continued from page 3 For any individual applying for employment as a certified nursing assistant, the New Jersey Nurse Aide Registry will be contacted to determine if any findings of abuse, neglect, mistreatment of individuals and/or theft of property have been entered in the applicant's file...For any licensed professional applying for a position that may involve direct contact with a resident, his/her respective licensing board will be contacted to determine if any sanctions have been assessed against the applicant's license. N.J.A.C. 8:39-43.15	F0607		
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer.	F0628	The Director of Nursing updated discharge documentation for Resident #15 to include a complete discharge summary, physician order for transfer. Inservice education was provided to the Inter Disciplinary Team (IDT) Nursing, Social Services, Rehab, Dietary, and Recreation Staff by The Director of Nursing regarding discharge policy and transfer policy, and procedures with the completion of discharge summary and communication with the resident, resident representative and healthcare providers. All residents undergoing transfer or discharge have the potential to be affected by the facility failure to not ensure bed hold policy including the information about reserve bed payment policy plan, the explanation of the right to appeal the transfer and documentation in the medical records including discharge summary. Revised bed hold - notification forms provided to social service and nursing departments included bed-hold notification forms including the option for hold or not to hold the bed, rate for private and semi-private rooms and the information to whom the bed hold policy was given. The Inter Disciplinary Team (IDT) Nursing, Social Services, Rehab, Dietary, Recreation Staff and the Director of Nursing were in-serviced by the Administrator regarding discharge policy and transfer policy, and procedures with the completion of discharge summary and communication with the resident, resident representative and healthcare providers. Social Services and Nursing staff were re-educated by the Administrator on federal and state requirements for	10/24/2025

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F0628 SS = E	<p>Continued from page 4 Before a facility transfers or discharges a resident, the facility must-</p> <p>(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.</p> <p>(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</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(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.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(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</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p>	F0628	<p>Continued from page 4 Discharge Plan, Transfers, Bed Hold and the Ombudsman Notification Policy, on the requirements for content, documentation of delivery to the resident, resident representative and physician involvement in discharge/transfer notices.</p> <p>The Director of Social Services or designee will audit 100% of emergency transfer and discharge records, Bed - hold agreement weekly for 4 weeks and monthly for 3 months and quarterly thereafter to ensure compliance with notice content, documentation of delivery, and inclusion of reserve bed payment policy.</p> <p>The Director of Social services or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits</p> <p>Completion Date: October 24th, 2025</p>	

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F0628 SS = E	<p>Continued from page 5</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(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</p> <p>(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.</p> <p>§483.15(c)(6) Changes to the notice.</p> <p>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.</p> <p>§483.15(c)(8) Notice in advance of facility closure</p> <p>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</p>	F0628		

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F0628 SS = E	<p>Continued from page 6 required at § 483.70(l).</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.</p> <p>§483.21(c)(2) Discharge Summary</p> <p>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications</p>	F0628		

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F0628 SS = E	<p>Continued from page 7 with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure a.) the bed hold-policy that was provided to the Resident or Resident's Representative (RR) included information about the reserve bed payment policy plan, the explanation of the right to appeal the transfer, and the Resident and/or RR's information for 2 of 2 residents (Residents #2 and #16) reviewed for hospital transfer and b.) the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution, including the discharge summary for 1 of 1 resident (Resident #15) reviewed for transfer.</p> <p>The deficient practice was evidenced by the following:</p> <p>1. On 9/15/25 at 1:24 PM, Surveyor #1 (S#1) reviewed the electronic medical records (eMR) of Resident #2, and revealed:</p> <p>A review of the Admission Record (AR; an admission summary) or face sheet, revealed Resident #2 had been admitted with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) .</p> <p>A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Ex Order 26.4(b)(1) , reflected a brief interview for mental status (BIMS) score of NJ Ex Order 26.4(b)(1) of 15, indicated that the resident was NJ Ex Order 26.4(b)(1) .</p> <p>A review of the two most recent discharge return anticipated MDS (DRAMDS), revealed that the resident had an unplanned transfer to NJ Ex Order 26.4(b)(1) .</p> <p>On 9/16/25 at 10:28 AM, S#1 asked the NJ Ex Order 26.4(b)(1)) for the facility's Bed Hold Notifications files.</p>	F0628		

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<p>F0628 SS = E</p>	<p>Continued from page 8 On 9/16/25 at 11:28 AM, S#1 reviewed the binder provided by the [redacted] with regard to bed hold policy notifications and revealed that the resident had two bed hold notifications, dated [redacted] for [redacted] and [redacted] for NJ Ex Order 26.4(b)(1)). In addition, the bed hold policy notifications (for dates [redacted] and [redacted]) did not include information about the reserve bed payment policy plan, the explanation of the right to appeal the transfer, and the information to whom the bed hold policy was given.</p> <p>On 9/18/25 at 12:25 PM, S#1 interviewed the [redacted] U.S. FOIA (b) (6) in the presence of another [redacted] U.S. FOIA (b) (6)) about facility's practice and policy with bed hold notification. The [redacted] U.S. FOIA (b) (6) informed S#1 the process was when the resident was being transferred to [redacted] U.S. FOIA (b) (6) , it was the responsibility of the social services department to fill out the Notice of Emergency Transfer and Bed Hold Policy notice (paper form) and the same form would be provided to [redacted] NJ Ex Order 26.4(b)(1) resident or to the RR if the resident was [redacted] NJ Ex Order 26.4(b)(1) . The [redacted] U.S. FOIA (b) (6) further stated that the filled out form then will be filed to the binder that was provided to the surveyor.</p> <p>On that same date and time, S#1 asked the [redacted] U.S. FOIA (b) (6) if there were documentation to whom the bed hold policy notice was given and if the reserve payment was provided to the resident or RR in the language that they were able to understand. The [redacted] U.S. FOIA (b) (6) responded that the social services mail the same filled out form or given to the resident and there was no evidence it was sent because it was sent as a regular mail and not as registered mail. The [redacted] U.S. FOIA (b) (6) further stated that there was no other documentation about reserve payment and other information except for the filled out.</p> <p>Furthermore, S#1 asked the [redacted] U.S. FOIA (b) (6) if she was aware of the regulation about notifying the resident or RR of the reserve payment for bed hold, and she responded that she was unaware. The [redacted] U.S. FOIA (b) (6) confirmed that the bed hold policy form in the Notice of Emergency Transfer had no reserve payment and no information whom the form was provided.</p> <p>On 9/19/25 at 12:18 PM, the survey team met with the [redacted] U.S. FOIA (b) (6) U.S. FOIA (b) (6)), [redacted] U.S. FOIA (b) (6) U.S. FOIA (b) (6)), [redacted] U.S. FOIA (b) (6) U.S. FOIA (b) (6)), and [redacted] U.S. FOIA (b) (6) U.S. FOIA (b) (6)), and S#1 notified them of the above concerns with Resident #2's bed hold policy notices for [redacted] NJ Ex Order 26.4(b)(1) and [redacted] NJ Ex Order 26.4(b)(1) .</p> <p>On 9/22/25 at 10:33 AM, the survey team met with the [redacted] U.S. FOIA (b) (6) U.S. FOIA (b) (6) U.S. FOIA (b) (6)), [redacted] U.S. FOIA (b) (6) U.S. FOIA (b) (6)) and the [redacted] U.S. FOIA (b) (6) U.S. FOIA (b) (6)). The [redacted] U.S. FOIA (b) (6) U.S. FOIA (b) (6))</p>	<p>F0628</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
(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
F0628 SS = E	<p>Continued from page 9 stated that the facility's policy with regard to bed hold was updated to include the rate for bed hold and the opportunity for the resident or RR the explanation of the right to appeal the transfer.</p> <p>A review of the facility's "Bed Hold and Ombudsman Notification Policy" that was provided by the [U.S. FOIA(b)] with a reviewed date of 8/2025, revealed, there were no information about reserve payment policy plan, the explanation of the right to appeal the transfer, and the RR's information.</p> <p>2. On 9/16/25 at 1:31 PM, S#1 reviewed the eMR of Resident #15, and revealed:</p> <p>A review of the AR revealed Resident #15 had been admitted with diagnoses which included but were not limited to: [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)].</p> <p>A review of the current personalized Care Plan (CP) with focus that the resident planned to remain for long term care, that was created and revised on [NJ Ex Order 26.4(b)(1)]. There was no documented evidence the resident had CP for transfer to another facility.</p> <p>A review of the Social Service quarterly progress notes (PN) with an effective date of [NJ Ex Order 26.4(b)(1)] revealed that long term care remained appropriate.</p> <p>A review of the quarterly MDS (qMDS), with an ARD of [NJ Ex Order 26.4(b)(1)], reflected [NJ Ex Order 26.4(b)(1)] was coded # [NJ Ex Order 26.4(b)(1)] indicated that the resident [NJ Ex Order 26.4(b)(1)] was [NJ Ex Order 26.4(b)(1)]. The qMDS also reflected that the resident participated in the assessment and goal setting and there was no plan for discharge (d/c).</p> <p>A review of the recent discharge return not anticipate Minimum Data Set (DRNAMDS), revealed that the resident had a planned transfer to [NJ Ex Order 26.4(b)(1)].</p> <p>A review of the Miscellaneous tab of eMR revealed [NJ Ex Order 26.4(b)(1)] meeting dates for [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] that were uploaded on [NJ Ex Order 26.4(b)(1)] there was no documented evidence about plan to transfer to [NJ Ex Order 26.4(b)(1)].</p>	F0628		

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F0628 SS = E	<p>Continued from page 10</p> <p>A review of the monthly nursing comprehensive summary in the PN dated [redacted], reflected that resident observed to be [redacted] and [redacted]. The PN also include that the resident's [redacted] was [redacted] and no change in [redacted].</p> <p>A review of the PN revealed that there was no documented evidence that the physician documented and was aware of the plan to transfer Resident #15 to another facility or [redacted] facility prior to transfer on [redacted]. The last physician PN was from [redacted] with documentation that there was no new issues with the resident.</p> <p>A review of the Social Service PN created on [redacted] at 11:51 AM, reflected that the [redacted] documented that the resident was scheduled for [redacted] to another facility, notified the RR of transfer, transportation was arranged for pick up at 1:00 PM, and nursing was made aware of transfer. There was no documented evidence that the physician was notified of the transfer and the order was obtained.</p> <p>A review of the assessment, "eINTERACT" Transfer Form, revealed:</p> <p>Description: Discharge to Hospital.</p> <p>Date: [redacted] 1:42 PM.</p> <p>Lock Date: [redacted] 2:06 PM.</p> <p>Treatment/discharge details: to [name of hospital] date [redacted], reason for transfer: [redacted]...</p> <p>Resident Representative: [name of RR and phone number].</p> <p>A review of the Universal Transfer Form (UTF) revealed, date of transfer [redacted] at 3:00 PM, transfer to, code status, reason for transfer, attached documents, sending and receiving facility contacts, form filled and completed by information were blank. The contact person was not the RR identified in the Social Service PN dated [redacted] at 11:51 AM, and was not in the Resident's AR or face sheet.</p> <p>A review of the [redacted] Order Summary Report revealed that there was no documented evidence that the physician ordered a transfer for [redacted] d/c to [redacted].</p> <p>On 9/19/25 at 10:44 AM, S#1 asked the [redacted] about the provided closed records of the resident, and the [redacted] confirmed that there were four files from [redacted] to [redacted].</p>	F0628		

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F0628 SS = E	<p>Continued from page 11 and one "physical chart". The [U.S. FOIA (b) (6)] informed S#1 that the [NJ Ex Ord] and [NJ Ex Ord] Resident's medical records were in the computer and "nothing else". The [U.S. FOIA (b) (6)] stated that the physician notes should be in the computer (or eMR). Both S#1 and [U.S. FOIA (b) (6)] reviewed the chart and there were no documents.</p> <p>On 9/19/25 at 11:02 AM, S#1 interviewed the [U.S. FOIA (b) (6)] about facility's d/c and transfer practice and policy. The [U.S. FOIA (b) (6)] informed S#1 that there should be an order for transfer from the physician, the nurse would do the transfer assessment and the UTF, the physician or [U.S. FOIA (b) (6)] would assess the resident before they leave, notify the RR of the transfer, and information should be documented in eMR.</p> <p>On that same date and time, S#1 asked the [U.S. FOIA (b) (6)] if she remembered Resident #15, and she responded yes, the resident was alert with confusion. She stated that she did not see or spoken to the RR since she started a week ago when the resident was transferred to another facility due to resident was [NJ Exec Order 26.4b1], with incidents with other staff, [NJ Exec Order 26.4b] and [NJ Exec Order] meds. She further stated that it was the responsibility of the [U.S. FOIA (b) (6)] to obtain an order from the physician the transfer of the resident and notify the physician. She acknowledged that there was no physician order obtained by nursing for the [NJ Ex Order 26.4b] transfer of the resident. She also acknowledged that there should be a documentation of the reason of transfer.</p> <p>On 9/19/25 at 11:16 AM, the [U.S. FOIA (b) (6)] informed S#1 that there was no other documentation in the chart about the resident's transfer to another facility by the physician and that the resident's physician only documented in the eMR. S#1 notified the [U.S. FOIA (b) (6)] of the above findings and concerns that there was no physician order for transfer to another facility, no documentation from the physician that he was aware of the transfer, and reason of transfer or any assessment from the physician prior to or on the date of transfer.</p> <p>On 9/19/25 at 11:48 AM, S#1 asked the [U.S. FOIA (b) (6)] for facility's policies with regard to planned and unplanned d/c, physician orders, and transfer to [NJ Ex Order 26.4(b)(1)].</p> <p>On 9/19/25 at 12:18 PM, the survey team met with the [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] and the [NJ Ex Order] and S#1 notified them of the above concerns with Resident #15's concerns with regard to transfer to [NJ Ex Order 26.4(b)(1)] with no physician order, no physician notes and d/c summary, discrepancies with PN, transfer form and UTF, including</p>	F0628		

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F0628 SS = E	<p>Continued from page 12 missing information from the UTF. S#1 also notified the concern about missing and discrepancies with documentation, communicating these information to the receiving provider was one way the facility can reduce the risk of complications and adverse events during the resident's transition to a new setting.</p> <p>On 9/19/25 at 1:00 PM, the U.S. FOIA (b) (6) called back and informed S#1 that the facility practice was for her to ask the U.S. FOIA (b) (6) if the resident's d/c information, the date, where to transfer, and reason for transfer. She also stated that she review the medical records for physician order for d/c or transfer. She confirmed that the information about d/c or transfer should be in the medical records of the resident. She further stated that she was responsible for MDS assessment in Section A for completing information about the d/c or transfer.</p> <p>On that same date and time, the U.S. FOIA (b) (6) stated that she remembered the resident who had a planned d/c. The U.S. FOIA (b) (6) stated that the resident's d/c was a short notice, "I was not sure" if the resident was coming off NJ Ex Order 26.4. The surveyor the notified the U.S. FOIA (b) (6) of the above findings and concerns that there were no order for transfer, no documentation from the physician that he was made aware of the transfer, the transfer form, UTF, and care plan did not include information about the reason of transfer. The U.S. FOIA (b) (6) stated, "to be honest with you I did not look for order of transfer" and did not look if the physician was made aware. She further stated, "I assume that it was done". She also stated, "I did not check also" the documentation of reason of transfer.</p> <p>On 9/19/25 at 4:09 PM, the resident's physician called back and informed S#1 that he remembered the resident and at that time he was visiting other resident at the facility when a nurse which he could not remember the name, notified him of the plan of transfer to another facility due to NJ Ex Order 26.4(b)(1) and being NJ Ex Order 26.4(b)(1). The physician stated that was on actual d/c date NJ Ex Order 26.4(b)(1), around after 11:30 AM because that was "my" usual rounds and "I said okay". The physician confirmed that he did not have a privilege to NJ Ex Order 26.4(b)(1) where the resident was transferred and that "honestly, I did not know that I have to document" about the resident's d/c to NJ Ex Order 26.4(b)(1). He confirmed that the last PN he had for the resident was on NJ Ex Order 26.4(b)(1) and that there were no prior arrangement or meeting about resident's transfer not until NJ Ex Order 26.4(b)(1).</p> <p>On 9/22/25 at 8:46 AM, S#1 met with the U.S. FOIA (b) (6) for Quality Assurance Performance Improvement (QAPI)</p>	F0628		

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F0628 SS = E	<p>Continued from page 13 meeting and S#1 asked what areas of concerns that the surveyors identified that were not discussed in the facility's most recent QAPI meeting. The [redacted] stated the number one was communication, the documentation from nursing stand point, and physicians that we should have a clear pictures of what was going on with the resident with regard to d/c and transfer, and the bed hold procedure.</p> <p>On 9/22/25 at 10:33 AM, the survey team met with the [redacted] U.S. FOIA (b) (6), [redacted] and the [redacted] U.S. FOIA (b) (6). The [redacted] stated that the facility's policy with regard to bed hold was updated to include the rate for bed hold and the opportunity for the resident or RR the explanation of the right to appeal the transfer. The [redacted] U.S. FOIA (b) (6) informed the surveyor that the hospice documented an addendum to include the d/c to another facility and attestation from the physician after surveyor's inquiry.</p> <p>At that same time, S#1 notified about the information provided by the physician to S#1 on [redacted] NJ Ex Order 26. The [redacted] U.S. FOIA (b) (6) stated that the physician should have documented the transfer. The surveyor also asked as to why there was no note about the plan of transfer, reason of transfer, and obtained an order transcribed to the resident's medical record, and the facility management team did not respond.</p> <p>A review of the facility's "Discharge Plan Policy" that was provided by the [redacted] U.S. FOIA (b) (6) with a reviewed date of 8/2025, revealed:</p> <p>Policy: The resident's needs pertaining to post-d/c care will be assessed upon admission. The Interdisciplinary care team members will perform the assessment. A plan to meet these needs will be developed and interventions to meet specific d/c planning goals will be designed. The plan will be monitored and revised as necessary throughout the nursing home stay.</p> <p>Procedure:...3. Physicians will inform the resident of the anticipated d/c date and treatments that will take place while in the facility...6. All disciplines will document the resident's progress or lack of progress in the interdisciplinary PN. 7. D/c instructions will be completed by Interdisciplinary team in eMR. The current d/c instruction summary will be completed and given to the resident upon d/c.</p> <p>On 9/22/25 at 12:18 PM, the survey team met with the [redacted] U.S. FOIA (b) (6), [redacted] and the [redacted] U.S. FOIA (b) (6) for an exit conference, and there was no additional information provided by the [redacted] U.S. FOIA (b) (6)</p>	F0628		

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F0628 SS = E	<p>Continued from page 14</p> <p>3. On 9/15/25 at 10:51 AM, the Surveyor #2 (S#2) observed Resident #16's room with [redacted] signage on the door and Personal Protective Equipment (PPE-use of gloves and gowns for direct contact) cart in the hallway. S#2 interviewed the [redacted] U.S. FOIA (b) (6) [redacted], who stated that the resident was in hospital due to the [redacted] that the resident had, and that was why there was an [redacted] signage on the doorway.</p> <p>On 9/16/25 at 3:02 PM, S#2 reviewed the medical records of Resident #16, and revealed:</p> <p>A review of the resident's AR revealed diagnoses which included but not limited to: [redacted] [redacted], [redacted] [redacted], and [redacted] [redacted].</p> <p>A review of the qMDS, with an ARD of [redacted], reflected a BIMS score of [redacted] out of 15 indicating [redacted].</p> <p>Further review of the MDS, revealed that the resident was transferred on [redacted] to the [redacted] for [redacted] or [redacted] due to [redacted] and abdominal pain, and on [redacted] for [redacted].</p> <p>On 9/18/25 at 2:30 PM, S#2 reviewed the Social Services and Nursing PN in the eMR regarding the discharge/transfer to the hospital on [redacted]; [redacted], and [redacted] which included:</p> <p>On [redacted], the resident had [redacted] while going to [redacted] and was admitted in the hospital for hypotension. There was no documented evidence regarding Resident #16 and the RR were notified (informed) on bed reserve payment.</p> <p>On [redacted], the resident was transferred to the hospital due to [redacted]. There was no documented evidence regarding Resident #16 and the RR were notified on [redacted].</p> <p>On 7/30/25, the resident was transferred to the emergency room due to the [redacted] U.S. FOIA (b) (6) [redacted] order for [redacted] [redacted]. There was no documented evidence regarding</p>	F0628		

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F0628 SS = E	<p>Continued from page 15 Resident #16 and the RR were notified on bed reserve payment.</p> <p>A review of the miscellaneous tab in eMR revealed a Notice of Emergency Transfer forms for the three dates above were completed but no information on reserve payment. The form did not contain a signature from the resident or RR that they were informed of the bed hold policy and did not specify who the form was given to.</p> <p>On 9/19/25 at 9:40 AM, S#2 interviewed the [U.S. FOIA (b) (6)] in the presence of the [U.S. FOIA (b) (6)], and reviewed the bed hold transfer notification transfer binder. S#2 asked the [U.S. FOIA (b) (6)] if she was aware of the notification for bed hold reserve payments and that residents and families had to be notified, and she replied, "No, I'm not aware." S#2 asked if she was aware of the regulations for reserved payment for bed hold and she replied "No." S#2 asked if they had any other documentation, notifications or notes in eMR regarding bed hold transfer notifications for reserve payments, and she replied she did not have other documentation.</p> <p>On 9/19/25 at 12:18PM, the survey team met with the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and S#2 notified them of the concern regarding bed hold policy that the resident and RR were not informed of reserve payments for the dates of emergency transfers on [NJ Ex Order 26], [NJ Ex Order 26], and [NJ Ex Order 26]. The [U.S. FOIA (b) (6)] stated that they had on admission packet upon admission for the information needed. S#2 notified the [U.S. FOIA (b) (6)] that the regulation specifically explained the reserve bed payment bed hold policy to be submitted upon admission and on every emergency transfer there had to be a reissuance. S#1 also stated that the facility form did not state or include information on who was informed on the bed hold transfer because the form did not specify and there were no resident or RR signatures on the forms.</p> <p>NJAC 8:39-5.1(a); 5.4(c)</p>	F0628		
F0636 SS = D	<p>Comprehensive Assessments & Timing</p> <p>CFR(s): 483.20(b)(1)(2)(i)(iii)</p> <p>§483.20 Resident Assessment</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>§483.20(b) Comprehensive Assessments</p>	F0636	<p>The Resident #4 MDS has been reviewed and validated for clinical accuracy; although completed late, the care plan has been updated to reflect current needs, and the interdisciplinary team has confirmed that no resident harm occurred due to the delay.</p> <p>All residents have the potential to be affected by the facility failure to complete the Admission Minimum Data Set, a periodic and federally mandated, standardized assessment tool within the required time frame.</p>	10/24/2025

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F0636 SS = D	<p>Continued from page 16</p> <p>§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:</p> <ul style="list-style-type: none"> (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility</p>	F0636	<p>Continued from page 16</p> <p>The U.S. FOIA (b) (6) or and nursing staff was re-educated by The Regional MDS for completion timelines per CMS RAI Manual (within 14 calendar days of admission).</p> <p>The MDS Coordinator or designee will conduct a monthly audit of 100% - new admission MDS submission weekly for 4 weeks and monthly for 3 months and quarterly thereafter to ensure timely completion and transmission.</p> <p>The MDS Coordinator or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits</p> <p>Completed by October 24, 2025</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
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F0636 SS = D	<p>Continued from page 17 must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete the Admission Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1 of 1 resident (Residents #4) reviewed for timing of assessments.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2024, page 2-17, the Comprehensive Admission assessment must be completed no later than the admission date + 13 calendar days.</p> <p>On 9/22/25 at 9:09 AM, the surveyor reviewed the electronic medical record (eMR) of Resident #4, reflected that the resident was admitted to the facility on [NJ Ex Order 26.4]. The Comprehensive (and modified) Admission MDS with an assessment reference date (ARD) of [NJ Ex Order 26.4], was completed on [NJ Ex Order 26.4] and transmitted and accepted on [NJ Ex Order 26.4]. The MDS was completed more than 14 days of the required timeframe.</p> <p>On 9/22/25 at 9:33 AM, the surveyor interviewed the [U.S. FOIA (b) (6)], who stated that the MDS assessment on a new admission was due within 14 days of admission. She further stated that she was responsible for the MDS assessments of all residents in the facility while the [US FOIA (b)(6)] who left [NJ Exec Order 26.4b1] was responsible for scheduling MDS. She also stated that she was not at the facility for three weeks in the [NJ Ex Order 26.4b]. She acknowledged that the admission MDS for ARD [NJ Ex Order 26.4] was completed late and</p>	F0636		

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F0636 SS = D	<p>Continued from page 18 should have been completed on ^{NJ Ex Order 29} [REDACTED].</p> <p>On 9/22/25 at 10:33 AM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and the U.S. FOIA (b) (6), and the surveyor notified them of the above concerns with late MDS of Resident #4.</p> <p>A review of facility's "MDS Policy" that was provided by the U.S. FOIA (b) (6), with a reviewed date of 12/2024, reflected:</p> <p>Policy: It is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS regulations and requirements.</p> <p>Purpose:</p> <ol style="list-style-type: none"> 1. To outline the procedure of identifying and addressing residents' strengths and needs through the RAI process. 2. To provide information on the resident's condition 3. To facilitate development of a comprehensive care plan (CP). 4. To ensure care delivery that enhances the resident's quality of life. 5. To help achieve the highest and practical level of self-sufficiency. <p>Procedure:</p> <p>MDS Department</p> <ol style="list-style-type: none"> 1. Schedules MDS and CP Meeting in accordance to existing regulations governing RAI process... 3. Assures the completeness and accuracy of the information in the MDS... 5. Coordinates, signs and certifies the completion of the MDS. 6. Submits MDS data in required format to CMS... 8. Reviews and corrects errors with the MDS Coordinator. 9. Files final validation submission report. 	F0636		

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F0636 SS = D	Continued from page 19 On 9/22/25 at 12:18 PM, the survey team met with the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] for an exit conference, and there was no additional information provided by the [U.S. FOIA (b) (6)]. NJAC 8:39-11.1; 11.2(e)(h)	F0636		
F0712 SS = D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the residents Attending Physician visited and documented monthly visits, every other month when the [U.S. FOIA (b) (6)] visited on the subsequent month for 1 of 28 residents reviewed (Resident #11). This deficient practice was evidenced by the following: On 9/17/25 9:31 AM, the surveyor reviewed Resident #11's hybrid (paper and electronic) medical record which revealed that the resident's attending physician had no documented visit from [NJ Ex Order 26,400] through [NJ Ex Order 26,400]. The remaining documented visits in the resident's electronic medical record were done by the [U.S. FOIA (b) (6)] for the same time frame.	F0712	Resident #11 - The attending physician conducted a comprehensive assessment and updated the medical record accordingly with a full progress note documented in the electronic medical record (EMR), including resident identifiers, clinical findings, and care plan updates. The [U.S. FOIA (b) (6)] was in-serviced by the Medical Director that future visits will strictly alternate between the physician and the Advanced Practice Nurse (APN) as required by regulation. All residents have the potential to be affected by the facility failure to ensure that the residents Attending Physicians visited and documented with a full progress note documented in the electronic medical record (EMR), including resident identifiers, clinical findings, and care plan updates, also facility failure to ensure the future visits will be strictly alternate between the physician and the Advanced Practice Nurse (APN) as required by regulation. The Nursing department/Medical records received the inservice education by the Administrator focusing on adherence to the existing Physician Visits Policy, emphasizing the importance of scheduling and documenting physician and the Advanced Practice Nurse (APN) visits in accordance with state and federal regulations. The Physicians and Nurse Practitioners received the inservice education by the Medical Director focusing on adherence to the existing Physician Visits Policy, emphasizing the importance of scheduling and documenting physician and the Advanced Practice Nurse (APN) visits in accordance with state and federal regulations. The Director of Nursing or designee will conduct monthly audits of physicians and the Advanced Practice Nurse (APN) visit documentation weekly for 4 weeks and monthly for 3 months and quarterly thereafter the next 90 days.	10/24/2025

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F0712 SS = D	<p>Continued from page 20</p> <p>A review of Resident #11's Admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted] NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1) [redacted].</p> <p>Further review of the resident's medical record also reflected that they were receiving hospice care, which was a specialized form of healthcare designed to provide comfort, support, and dignity to individuals in NJ Ex Order 26.4(b)(1) [redacted].</p> <p>On 9/17/25 at 10:40 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted], who stated that the U.S. FOIA (b) (6) [redacted] comes in "once in a while" or "once in a blue moon", usually probably in the evenings. The U.S. FOIA (b) (6) [redacted] also stated that the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6) [redacted] visited the resident.</p> <p>On 9/18/25 at 9:56 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] who stated that they were a contracted vendor with the facility for two years and visited three days a week. The U.S. FOIA (b) (6) [redacted] further stated that they supplement physician visits, and usually sees Resident #11 alone, without the MD. The surveyor asked the U.S. FOIA (b) (6) [redacted] if they recall the last time that the resident was seen and evaluated by the MD, and the U.S. FOIA (b) (6) [redacted] responded that they believed it was last year.</p> <p>On 9/22/25 at 9:26 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] and asked if there was anywhere else that Resident #11's MD documented other than the paper chart. The U.S. FOIA (b) (6) [redacted] stated no, other than a note that was entered into the electronic medical record (EMR) on NJ Ex Order 26.4(b)(1) [redacted].</p> <p>On 9/22/25 at 10:58 AM, the survey team met with the U.S. FOIA (b) (6) [redacted], the U.S. FOIA (b) (6) [redacted], The U.S. FOIA (b) (6) [redacted], the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6) [redacted]. The surveyor showed the U.S. FOIA (b) (6) [redacted] Resident #11's paper chart and asked if they could locate any MD notes for the period of NJ Ex Order 26.4(b)(1) [redacted] through NJ Ex Order 26.4(b)(1) [redacted]. The U.S. FOIA (b) (6) [redacted] stated that they could not locate any. The surveyor asked if Resident #11's MD documents anywhere else other than the paper chart. The U.S. FOIA (b) (6) [redacted] stated that the MD documented in the paper chart and only recently in the EMR.</p> <p>At that same time, the U.S. FOIA (b) (6) [redacted] stated that U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted] both see the resident and document. The surveyor</p>	F0712	<p>Continued from page 20</p> <p>The Director of Nursing or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits.</p>	

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F0712 SS = D	<p>Continued from page 21</p> <p>asked the [U.S. FOIA] if they were aware of the regulations for MD and non-physician practitioners that reflect that an [U.S. FOIA] could only alternate with the MD every other month. The [U.S. FOIA] agreed that that was the regulation. The surveyor showed the [U.S. FOIA] and [U.S. FOIA] the recently provided MD notes for [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)] that reflected the MD had documented monthly, not alternating as was suggested. The surveyor asked the [U.S. FOIA] if any of the notes from [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)] reflected as being comprehensive progress notes. The [U.S. FOIA] stated no that they do not look like comprehensive notes.</p> <p>The MD notes for [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)] did not reflect the resident's name or any other identifier.</p> <p>On 9/22/25 at 11:54 AM, the survey team met with the [U.S. FOIA] and [U.S. FOIA] and the [U.S. FOIA] provided documentation of a Quality Assurance Performance Improvement (QAPI) report dated [NJ Ex Order 26.4(b)(1)] titled Physician Visit Documentation Compliance. The facility did not provide MD progress notes for the period of [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)] as requested.</p> <p>The [U.S. FOIA] did not provide any further pertinent information.</p> <p>A review of the facility's "Physician Visits Policy", dated as reviewed 12/24, reflected under Policy: It is the policy and procedure of this facility that the Attending Physician must make visits in accordance with applicable state and federal regulations. Procedure: 1. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admissions, and then at least every sixty (60) days thereafter. 2....an alternate schedule of visits may be established, but not to exceed every sixty (60) days. A ...nurse practitioner may make alternate visits...</p> <p>N.J.A.C. 8:39-23.2(d)</p>	F0712		
F0761 SS = D	<p>Label/Store Drugs and Biologicals</p> <p>CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>	F0761	<p>The 19 unidentified loose medications found in the East medication cart on 9/16/25 were immediately and properly disposed of in the facility's self-contained drug disposal system under direct observation; no resident was harmed, and no medications were administered from this compromised stock.</p> <p>The Unit Managers / designees immediately audited all other nursing carts in the facility, no other loose medications were found.</p>	10/24/2025

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F0761 SS = D	<p>Continued from page 22</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication per manufacturer specifications and standards of practice. This deficient practice was identified in 1 of 3 medication carts observed on 1 of 2 nursing units of the facility.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."</p> <p>On 9/16/25 at 1:55 PM, the surveyor began to inspect selected medication (med) storage areas in the facility and observed the following:</p> <p>The surveyor in the presence of U.S. FOIA (b) (6) inspected the med cart identified as the East Cart. The surveyor observed a total of 19 unidentified tablets (tabs) and/or capsules (caps) located in the bottom of the 3rd drawer. The surveyor</p>	F0761	<p>Continued from page 22</p> <p>All residents receiving medications have the potential to be affected by the deficient practice by facility to failure to properly store medication per manufacture and specifications and standards of practice.</p> <p>The Unit Manager or designee conducted immediate cleaning and reorganization of all medication carts (North -South-East- West Units)</p> <p>All nursing staff was educated by The Director of Nursing or designee on proper Medication Storage Policy, so that all medications must remain in original labeled containers, never be stored loose.</p> <p>The Unit Managers, Pharmacy Consultants or designee will conduct weekly audits of medication carts weekly for 4 weeks and monthly for 3 months and quarterly thereafter.</p> <p>The Unit Manager or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits</p>	

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F0761 SS = D	<p>Continued from page 23</p> <p>asked the [U.S. FOIA] if they could identify the loose tabs or caps and if they should be stored that way. The [U.S. FOIA] stated that they were in the process of cleaning out the cart and could not identify what the med was or who it was for and that it should not be stored that way since it was not clean.</p> <p>The surveyor showed the [U.S. FOIA (b) (6)] the loose medications (meds) and asked if the meds should be stored loose. The [U.S. FOIA (b) (6)] stated that the meds should not be in the cart that way and thought that the cart had been previously cleaned. The surveyor observed the [U.S. FOIA] assigned to the med cart dispose of the unidentified meds in a self-contained drug disposal system.</p> <p>On 9/18/25 at 1:17 PM, the survey team met with the facility [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] to discussed the above findings and concerns.</p> <p>On 9/22/25 at 10:33 AM, the survey team met with the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], and [U.S. FOIA (b) (6)], and the [U.S. FOIA] provided a copy of staff education for med storage and loose pills.</p> <p>A review of the facility's "Medication Storage Policy" dated reviewed June 2025, reflected under Policy: ...facility to store meds in a safe and proper manner...</p> <p>Procedure: 1. Meds are stored in the containers in which they are received. 7.Meds are stored in an orderly manner in cabinets, drawers or carts.</p> <p>The [U.S. FOIA] did not provide any further pertinent information for med storage.</p> <p>NJAC 8:39-29.4(d)(g)</p>	F0761		
F0842 SS = D	<p>Resident Records - Identifiable Information</p> <p>CFR(s): 483.20(f)(5),483.70(h)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information.</p> <p>(i) A facility may not release information that is resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p>	F0842	<p>F0842 Resident Records – Identifiable Information</p> <p>For Resident #2: Physician attestation on recommendations has been reviewed and documented by the attending physician and added to the electronic medical record.</p> <p>For Resident #15: Physician attestation on acknowledgement of discharge arrangement was documented by the primary care physician and added to the electronic medical record.</p>	10/24/2025

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F0842 SS = D	<p>Continued from page 24</p> <p>§483.70(h) Medical records.</p> <p>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p>	F0842	<p>Continued from page 24</p> <p>All residents have the potential to be affected by the facilities failure to maintain a complete, accurately, accessible, and systematic organization of medical records</p> <p>All clinical staff including primary care physicians was re-educated by The Director of nursing or designee on requirements that every consultation, care plan change, discharge notice, and physician communication must be promptly and accurately documented in the Electronic medical records with clear accountability for documentation timeliness and completeness.</p> <p>The Director of nursing or designee will audit 15 resident charts monthly for 90 days to ensure completeness, accuracy, accessibility, and systematic organization of medical records, including documentation of consultation follow-up, care plan updates, and discharge notifications.</p> <p>The Director of nursing or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
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F0842 SS = D	<p>Continued from page 25 (iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain a complete, accurately documented, readily accessible, and systematically organized medical records. This deficient practice was identified for 2 of the 28 residents reviewed (Residents #2 and #15).</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 9/15/25 at 1:24 PM, The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #2, and revealed:</p> <p>A review of the Admission Record (AR; an admission summary) or face sheet, revealed Resident #2 had been admitted with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), [REDACTED], NJ Ex Order 26.4(b)(1), [REDACTED], [REDACTED], and NJ Ex Order 26.4(b)(1), [REDACTED], [REDACTED].</p> <p>A review of the comprehensive Minimum Data Set (MDS), with an assessment reference date (ARD) of NJ Ex Order 26.4</p>	F0842		

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F0842 SS = D	<p>Continued from page 26 reflected a brief interview for mental status (BIMS) score of NJ Ex Order 26.4(b)(1) of 15, indicated that the resident was NJ Ex Order 26.4(b)(1).</p> <p>A review of the NJ Ex Order 26.4(b)(1) consult (paper consult) dated NJ Ex Order 26.4(b)(1), revealed recommendations for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) follow up in two months.</p> <p>A review of the NJ Ex Order 26.4(b)(1) consult (paper consult) dated NJ Ex Order 26.4(b)(1) revealed recommendations for NJ Ex Order 26.4(b)(1) monitor given, follow up in a month, continue medications including NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).</p> <p>Further review of the above NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) consults revealed that there were no documented evidence that Resident #2's physician was notified of the above recommendations for NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) and follow up with NJ Ex Order 26.4(b)(1) in two months and the recommendations for NJ Ex Order 26.4(b)(1) and follow up in a month were followed, or as to why it was not followed.</p> <p>On 9/16/25 at 11:04 AM, the surveyor asked the U.S. FOIA (b) (6) if the recommendations were followed and where were the results for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) consults, and the U.S. FOIA (b) (6) responded that it should be with the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) who was in the nursing station also responded that the NJ Ex Order 26.4(b)(1) was not done because the resident was in and out of the facility and hospital, and the follow up was not done as well for the NJ Ex Order 26.4(b)(1) because the NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) was not done. The U.S. FOIA (b) (6) also stated that the NJ Ex Order 26.4(b)(1) was not sent "yet" for results because of the same thing, the resident was in and out of the hospital. The U.S. FOIA (b) (6) confirmed that the holter monitor was still at the facility and was not sent over (or returned to the office of the NJ Ex Order 26.4(b)(1) who provided the device).</p> <p>On 9/16/25 at 11:05 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding the facility's process with regard to physician consultations. The U.S. FOIA (b) (6) stated that recommendations would be relayed to the resident's primary physician, and if the physician agreed with the recommendations, it would be carried out. She further stated, if the physician declined the recommendations,</p>	F0842		

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F0842 SS = D	<p>Continued from page 27 it would be documented in the progress notes (PN). The surveyor asked for documentation if the recommendations were carried out or not for neuro consult dated [redacted], and [redacted] consult on [redacted] and she stated that she would get back to the surveyor.</p> <p>On 9/16/25 at 11:47 AM, the [redacted] informed the surveyor that the resident's [redacted] was done on [redacted] at the hospital. The surveyor asked where the result was and the follow up appointment notes, and the [redacted] stated that the resident was out of the hospital that time in [redacted]. The surveyor notified the [redacted] that according to the resident's MDS, the resident was in the hospital [redacted], and not [redacted]. The [redacted] informed the surveyor that the holter monitor was done at the facility and that she would follow up the results. The surveyor also asked where were the consult notes that the resident was seen by [redacted] and [redacted] as follow up according to the recommendations, and the [redacted] responded that she would follow up and check.</p> <p>On 9/16/25 at 1:05 PM, the [redacted] provided a copy of [redacted] from hospital dated [redacted], which she confirmed that was due to resident [redacted] due to [redacted] and not due to recommendation of the [redacted] on [redacted]. The [redacted] stated that the [redacted] and [redacted] of [redacted] recommendations were not approved by the primary doctor. The [redacted] confirmed that there was no documentation from the physician and the nurse that the recommendations were relayed and declined by the physician. She also stated that she was unsure why the follow up with the two consultants were not followed. She further stated that it was the facility's practice to document all those information the resident's medical records.</p> <p>On 9/19/25 at 12:18 PM, the survey team met with the [redacted], [redacted], [redacted], [redacted], the [redacted], and the surveyor notified them of the above concerns with Resident #2's medical records and consults that were not followed.</p> <p>2. On 9/16/25 at 1:31 PM, the surveyor reviewed the discharge hybrid medical records of Resident #15, and revealed:</p> <p>A review of the AR revealed Resident #15 had been admitted with diagnoses which included but were not limited to: [redacted], [redacted], [redacted].</p>	F0842		

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F0842 SS = D	<p>Continued from page 28</p> <p>NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)</p> <p>, NJ Ex Order 26.4(b)(1)</p> <p>, and NJ Ex Order 26.4(b)(1)</p> <p>A review of the current personalized Care Plan (CP) with focus that the resident planned to remain for long term care, that was created and revised on NJ Ex Order 26.4(b)(1). There was no documented evidence the resident had CP for transfer to NJ Ex Order 26.4(b)(1).</p> <p>A review of the Social Service quarterly PN with an effective date of NJ Ex Order 26.4(b)(1), revealed that long term care remained appropriate.</p> <p>A review of the quarterly MDS (qMDS), with an ARD of NJ Ex Order 26.4(b)(1), reflected NJ Ex Order 26.4(b)(1) was coded #1, indicated that the resident cognition was NJ Ex Order 26.4(b)(1). The qMDS also reflected that the resident participated in the assessment and goal setting and there was no plan for discharge.</p> <p>A review of the recent discharge return not anticipate Minimum Data Set (DRNAMDS), revealed that the resident had a planned transfer to NJ Ex Order 26.4(b)(1)</p> <p>A review of the Social Service PN created on NJ Ex Order 26.4(b)(1) at 11:51 AM, reflected that the U.S. FOIA (b) (6) documented that the resident was scheduled for transfer to NJ Ex Order 26.4(b)(1) notified the Resident Representative (RR) of transfer, transportation was arranged for pick up at 1:00 PM, and nursing was made aware of transfer. There was no documented evidence that the RR had prior notice of transfer and/or was notified of the reason of transfer to another facility.</p> <p>On 9/19/25 at 11:02 AM, the surveyor interviewed the U.S. FOIA (b) (6) about facility's discharge and transfer practice and policy. The U.S. FOIA (b) (6) stated that all information about resident's transfer should be documented in electronic medical records (eMR) including the notification of the RR about the reason of transfer.</p> <p>On 9/19/25 at 12:18 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and the U.S. FOIA (b) (6) and S#1 notified them of the above concerns with Resident #15's concerns with regard to transfer to NJ Ex Order 26.4(b)(1) that there was no documented evidence that the RR was notified of the transfer prior to NJ Ex Order 26.4(b)(1) transfer and was aware of the reason of transfer. The surveyor also notified the</p>	F0842		

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F0842 SS = D	<p>Continued from page 29 facility management of the concerns that CP did not include information about plan to transfer the resident.</p> <p>On 9/22/25 at 8:46 AM, the surveyor met with the [U.S. FOIA (b) (6)] for Quality Assurance Performance Improvement (QAPI) meeting and the surveyor asked what areas of concerns that the surveyors identified and were not discussed in the facility's most recent QAPI meeting. The [U.S. FOIA (b) (6)] stated the concern of the surveyor with regard to medical records and documentation were not identified from the most recent QAPI meeting.</p> <p>On 9/22/25 at 11:48 AM, the survey team met with the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (9)]. The [U.S. FOIA (b) (6)] stated that she obtained a copy of the Interdisciplinary team meeting dated [NJ Ex Order], informing the RR of the transfer. The surveyor asked why it was not presented or provided by the [U.S. FOIA (b) (6)] [redacted] at the time of interview and when the surveyor asked for it on 9/19/25. The [U.S. FOIA (b) (6)] stated she did not know where she found the copy and shy it was not provided by the [U.S. FOIA (b) (6)]. The surveyor asked for the facility's medical records policy.</p> <p>A review of the facility's "Medical Records and Confidentiality of Information and Personal Privacy Policy" that was provided by the [U.S. FOIA (b) (6)] with a reviewed date of 6/2025, revealed there was no information about the regulation that in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized. <p>On 9/22/25 at 12:18 PM, the survey team met with the [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] for an exit conference, and there was no additional information provided by the [U.S. FOIA (b) (6)].</p> <p>NJAC 8:39-23.2 (a)(b); 34.1(a); 35.2</p>	F0842		

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		09/29/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: REPEAT DEFICIENCY Complaint #407049 (NJ#178506) Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day, evening and night shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for 18 day shift of a total of 84 shifts reviewed as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	S0560	The Staffing Coordinator conducted an immediate review of staffing schedules for all shifts from August–September 2025 and October 2024 and was educated on minimum direct care staff to resident ratio as mandated by the state of New Jersey. 2. All residents are affected by inadequate staffing and have the potential to be impacted by this deficient practice due to facility failure to ensure minimum staffing requirements. 3. The Staffing Coordinator and The Human Resources were re-educated by The Administrator on New Jersey minimum staffing requirements. The facility has posted job openings on job sites to promote CNA openings. The Facility has contracted with staffing agencies to assist with our staffing needs. The Staffing coordinator will offer staff the ability to pick up additional shifts for overtime. Intensive bonuses are being offered. Participating in job fairs The Staffing Coordinator or designee will conduct daily staffing audits weekly for 4 weeks and monthly for 3 months and quarterly thereafter to ensure compliance with mandated CNA-to-resident ratios on all shifts. 4. The Staffing Coordinator or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance	10/24/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S0560	<p>Continued from page 1</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>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</p> <p>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.</p> <p>1. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 10/06/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> -10/06/24 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/07/24 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/08/24 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/09/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -10/10/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -10/11/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -10/12/24 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -10/13/24 had 13CNAs for 121 residents on the day shift, required at least 15 CNAs. -10/14/24 had 13CNAs for 121 residents on the day shift, required at least 15 CNAs. -10/15/24 had 13CNAs for 121 residents on the day shift, required at least 15 CNAs. -10/16/24 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs. -10/17/24 had 13 CNAs for 119 residents on the day 	S0560	<p>Continued from page 1</p> <p>Improvement Committee to determine the frequency of future audits</p>	

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S0560	<p>Continued from page 2 shift, required at least 15 CNAs.</p> <p>-10/18/24 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs.</p> <p>-10/19/24 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs.</p> <p>2. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 08/31/2025 to 09/13/2025, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:</p> <p>-08/31/25 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs.</p> <p>-09/05/25 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs.</p> <p>-09/07/25 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs.</p> <p>-09/13/25 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs.</p> <p>On 9/19/25 at 11:01 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding staffing. The SC confirmed that she was aware of the required staffing ratios and that the facility was meeting the ratios on a consistent basis. The SC stated that she made the schedule and tried her best to replace any callouts. The SC stated that the schedule was discussed the day before with the Licensed Nursing Home Administrator and the Director of Nursing.</p> <p>A review of the facility provided policy titled "Staffing" with a reviewed date of 8/2025, included the following:</p> <p>Policy:</p> <p>It is the policy and procedure of this facility to adequately staff the facility in accordance with the recommended guidelines.</p> <p>Procedure:</p> <p>Daily Staffing</p> <p>1. The staffing coordinator along with the director of Nursing and the Administrator will staff the building based on the census and acuity of the building.</p> <p>2. Should there be a need, the facility will mitigate</p>	S0560		

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S0560	Continued from page 3 any staffing openings with agency staff. 3. The facility will maintain sufficient agency contracts to meet their staffing needs. 4. The facility uses a bonus structure in order to incentivize staff to pick up shifts. As well as we utilize sign on bonuses for new staff and referral bonuses for staff.	S0560		
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility provided pertinent documentation, it was determined that the facility failed to ensure that 2 of 10 newly hired employees (Staff #3 and #4) had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment. This deficient practice was evidenced by the following: On 9/18/25 at 12:40 PM, the surveyor reviewed 10 randomly selected newly hired health employee files that the facility provided which revealed the following: Staff #3, a Speech Language Pathologist (SLP), hired [redacted], had an employee health examination dated [redacted], which was after the date of hire (doh). The SLP did not have a health history and examination upon hire. Staff #4, a Housekeeper (HK), hired [redacted], had an employee health examination dated [redacted], which was after the doh. The HK did not have a health history and	S1405	Verified and updated employee health files for Staff #3 and #4 to include properly dated pre-employment physical and health histories. Confirmed both staff completed required health screenings within required timeframes retroactively and are cleared for duty. All residents have the potential to be affected by the facilities failure to ensure that 2 of the 10 newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment. The Human Resources and Infection Preventionist were re-educated on requiring health history and physical examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment. The Human Resources Manager or designee will audit 100% of new employee health files within 24 hours of hire date weekly for 4 weeks and monthly for 3 months and quarterly thereafter to ensure compliance with pre-employment health screening requirements. The Human Resources Manager or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits	10/24/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060714	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
(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
S1405	<p>Continued from page 4 examination upon hire.</p> <p>On 9/18/25 at 1:16 PM, the surveyor interviewed the Human Resources Manager (HRM), in the presence of the Director of Operations (DoO) regarding the process for new hires and physicals. The HRM stated that the physical was done on the doh. The surveyor notified the HRM and DoO that Staff #3 and Staff #4 had physicals that were done after their doh.</p> <p>On 9/19/25 at 9:41 AM, the DoO stated that she was not sure what happened with the health files. She added that she believed that Staff #3 was at the facility on the 1st for orientation and maybe they wrote a 7 instead of a 1.</p> <p>On 9/19/25 at 12:18 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Nurse (RN), Chief Nursing Officer (CNO), DoO and Vice President of Operations (VPoO) the concern that 2 of the 10 newly employed SM did not have documented evidence that their physical was done two weeks prior or upon employment.</p> <p>On 9/22/25 at 10:50 AM, in the presence of the DON, RN, CNO and DoO, the LNHA stated that staff were educated on the new hire process and that moving forward to have all proper documentation upon hire to include physical.</p> <p>The LNHA did not provide any additional information.</p> <p>A review of the facility's "Employee Health Record Policy" with a reviewed date of 6/2025, included the following:</p> <p>Procedure:</p> <p>1. All new employees are required to have a physical examination, by a licensed physician within 30 days of their first day of employment.</p>	S1405		
S1410	<p>Mandatory Infection Control and Sanitation</p> <p>CFR(s): 8:39-19.5(b)(1)</p> <p>(b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration),</p>	S1410	<p>1.The Administrator updated the facilities health file procedure for NJ Ex Order 26.4(b)(1) test</p> <p>The Director Human Resources and Infection Preventionist were educated on the updated procedure for two-step Mantoux tuberculin skin test (PPD).</p> <p>2.All residents have the potential to be affected by the deficient practice due to facility failure to perform a two-step Mantoux tuberculin skin test (PPD) as required for new employees hired for tuberculosis (TB) for infection and disease screening upon hire.</p>	10/24/2025

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S1410	<p>Continued from page 5</p> <p>employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:</p> <p>1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and review of pertinent facility documents, it was determined that the facility failed to perform a NJ Ex Order 26.4(b)(1) as required for new employees hired for NJ Ex Order 26.4(b)(1) for infection and disease screening upon hire for 2 of 10 newly hired employees (Staff #3 and #4) reviewed.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 9/18/25 at 12:40 PM, the surveyor reviewed 10 randomly selected newly hired health employee files that the facility provided which revealed the following:</p> <p>Staff #3, a Speech Language Pathologist (SLP), hired NJ Ex Order 26.4(b)(1), had the NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1). The SLP did not have the NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) upon hire.</p> <p>Staff #4, a Housekeeper (HK), hired NJ Ex Order 26.4(b)(1) had the NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1). The HK did not have the NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) upon hire.</p> <p>On 9/18/25 at 1:16 PM, the surveyor interviewed the Human Resources Manager (HRM), in the presence of the Director of Operations (DoO) regarding the process for new hires and PPD. The HRM stated that the NJ Ex Order 26.4(b)(1) was done on the date of hire.</p> <p>On 9/19/25 at 12:18 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Nurse (RN), Chief Nursing Officer (CNO), DoO and Vice President of Operations (VPoO) the concern that 2 of the 10 newly employed SM did not have documented evidence that their first step of the NJ Ex Order 26.4(b)(1) was done upon employment.</p> <p>On 9/22/25 at 10:50 AM, in the presence of the DON, RN, CNO and DoO, the LNHA stated that staff were educated</p>	S1410	<p>Continued from page 5</p> <p>3.The infection Preventionist and The Human Resources Manager was educated by the Administrator with new procedure in place</p> <p>The Administrator updated New Hire Policy and Employee Health Record Policy that will ensure the importance of adhering to the timelines for Tuberculosis screening and proper documentation practices. The infection Preventionist and The Human Resources Manager were educated by Administrator on the requirement to administer the two-step PPD on or before the date of hire.</p> <p>The Human Resources Manager/ Infection Preventionist or designee will audit 100% of new hire employees health records weekly for 4 weeks and monthly for 3 months and quarterly thereafter.</p> <p>4.The Human Resource Manager/Infection Preventionist or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits</p>	

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S1410	Continued from page 6 on the new hire process and that moving forward to have all proper documentation upon hire to include NJ Ex The LNHA did not provide any additional information. A review of the facility's "Employee Health Record Policy" with a reviewed date of 6/2025, included the following: Procedure: 2. All employees are required to have a Mantoux, Tuberculin Test upon hire:...	S1410		
S2905	Certification of Nurse Aides CFR(s): 8:39-43.1(a)(2) (a) An individual who meets any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in New Jersey: 2. Has been employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of employment; or This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that 1 of 1 non-certified Nurse Aides (NA) were enrolled in an approved nurse aide training course during their employment with the facility, reviewed during the Sufficient and Competent Nurse Staffing task (NA #1). This deficient practice was evidenced by the following: On 9/18/25 at 12:40 PM, the surveyor reviewed the NA employee file that the facility provided which revealed the following: NA #1, with a date of hire of NJ Ex Order , had taken the Manual Skill portion of the NJ (New Jersey) CNA Competency Exam (a test that requires completion of an approved nurse aide training course) and passed the skill test on NJ Ex Order . There was no documented evidence in NA #1's employee file that they were currently enrolled in an approved nurse aide training course when	S2905	Immediate corrective action taken, the non-certified Nurse Aides (NA) #1's employment status is pending for now with his proceeding to compliant with state regulations also non-certified Nurse Aides (NA) #1 remains within the 120 days window and has a scheduled written test for September 23, 2025. This deficient practice has the potential to impact all residents due to facility failure to ensure that non-certified Nurse Aides (NA) were enrolled in an approved nurse aide training course during their employment with the facility. The Human resources received Inservice education by the Administrator for Hiring Nurse Aide Policy to emphasize the importance of verifying and documenting that non-certified Nurse Aides (NA) were enrolled in an approved nurse aide training course during their employment with the facility. The Human Resource Manager will audit 100% new non-certified Nurse Aides (NA) files weekly for 4 weeks and monthly for 3 months and quarterly thereafter to ensure that non-certified Nurse Aides (NA) were enrolled in an approved nurse aide training course during their employment with the facility. The Human Resources Manager or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits	10/24/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060714	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
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S2905	<p>Continued from page 7 they were hired.</p> <p>On 9/18/25 at 1:28 PM, the surveyor interviewed the Human Resources Manager (HRM), in the presence of the Director of Operations (DoO) regarding the hiring process for NAs. The HRM stated that the NA would provide a letter from the school and would have a skills exam prior to the end of schooling. She added that the NA then had 120 days to pass the written exam. HRM stated that NA #1 had pushed back the written test a couple times but was still within the 120 days. The surveyor asked if the NA had to be enrolled in the training program when hired. The DoO stated that they have to be enrolled to be hired. The surveyor notified the HRM and DoO that there was no documented evidence in NA #1's employee file that indicated the dates that NA #1 was enrolled in the training program when hired. The DoO confirmed that NA #1's skills test was dated NJ Ex Order 26.4(b)(1).</p> <p>On 9/19/25 at 9:43 AM, the DoO stated that NA #1 was enrolled in school when hired and that she had a letter from the school. She added that she was not sure why it was not in the file.</p> <p>On 9/19/25 at 11:47 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a document which revealed the following:</p> <p>[School name redacted] Health Care Training & Employment; February 2nd, 2025; This letter certifies NA #1 was a student at [School name redacted], he had successfully completed more than 16 hours of his Certified Nursing Assistant (CNA) training course...This letter was to let employers know that he was a student enrolled in the CNA Class since NJ Ex Order 26.4(b)(1)....The letter was signed by the Director of the Health Care Training Institute.</p> <p>On 9/19/25 at 12:14 PM, the surveyor interviewed the Director of the Health Care Training institution, via phone, regarding NA #1's school enrollment. The Director stated that NA #1 was enrolled in the training program from NJ Ex Order 26.4(b)(1) until NJ Ex Order 26.4(b)(1). The Director stated that the program was a six week class and the student will get a certificate of completion.</p> <p>On 9/19/25 at 12:40 PM, the surveyor requested from the LNHA, NA #1's certificate of course completion.</p> <p>On 9/19/25 at 12:18 PM, the surveyor notified the LNHA, Director of Nursing (DON), Regional Nurse (RN), Chief Nursing Officer (CNO), DoO and Vice President of</p>	S2905		

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S2905	<p>Continued from page 8 Operations (VPoO) the concern that NA #1, who had completed their training program prior to the skills test dated 3/6/25, was not currently enrolled in a training program when they were hired on [REDACTED] at the facility.</p> <p>On 9/22/25 at 10:50 AM, in the presence of the DON, RN, CNO and DoO, the LNHA stated that when an NA was hired that the facility will assure that they were in the training program and pass the skill and written exam and do not work past 120 days. The surveyor asked for NA #1's training program certificate.</p> <p>On 9/22/25 at 11:12 AM, the DoO provided the surveyor a document which included the following:</p> <p>Health Care Training</p> <p>This Certificate of Completion indicates that NA [NA's name redacted] has successfully completed the Certified Nursing Assistant this day February 18th, 2025 signed by the Director of the health care training facility.</p> <p>A review of the facility's "Hiring Nurse Aide" with a reviewed date of 6/2025, included the following:</p> <p>Policy: It is our policy and procedure of this facility to hire Nurse Aides in compliance with New Jersey regulation.</p> <p>Procedure: A long-term care facility may temporarily hire an individual who is not yet certified, provided they are enrolled or have completed an approved NATCEP (Nurse Aide Training and Competency Evaluation Program).</p> <p>1. Employment period: The individual can be temporarily employed as a nurse aide for a maximum of 120 days wile completing their certification requirements.</p> <p>a. Should the nurse aide not pass the written/oral exam within the 120 days from hire date, the employee will be terminated.</p> <p>2. The employee must provide the facility with documentation of enrollment in approved course...</p>	S2905		

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NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 12/12/2025 in relation to the 9/22/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
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K0000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 9/17/25 to 9/18/25 and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.</p> <p>Stratford Manor Rehabilitation and Care Center is a one-story building built in the 1970's and is composed of Type II (111) construction. The facility is divided into nine - smoke zones. The generator powers approximately 100 % of the building per the Maintenance Director. The current occupied beds are 125 of 131.</p>	K0000		10/03/2025
K0293 SS = F	<p>Exit Signage</p> <p>CFR(s): NFPA 101</p> <p>Exit Signage</p> <p>2012 EXISTING</p> <p>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.</p> <p>19.2.10.1</p> <p>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview on 9/17/25, in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined that the facility failed to ensure exit and directional exit signs were provided and marked by approved, readily visible signs in all case where the exit or way to reach the exit is not readily apparent to the occupants in accordance with NFPA 101:2012</p>	K0293	<p>1.Immediate action was taken to install readily visible exit signs at the fenced courtyard exit gate.</p> <p>2.This deficient practice has the potential to impact all residents due to facility failure to ensure the exit sign and directional exit signs were provided and marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants in accordance with NFPA.</p> <p>3.The U.S. FOIA (b) (6) was educated by the Administrator on the importance of maintaining clear and visible exit signage.</p> <p>The Director of Maintenance will implement a monthly audit for 3 months, and quarterly thereafter.</p> <p>4.The Director of Maintenance or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits.</p>	10/24/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025	
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052		
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K0293 SS = F	<p>Continued from page 1 Edition, Section 19.2.10.1 and 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 12:33 PM, revealed that the fenced courtyard exit gate to the exit discharge area was not provided with an exit or directional sign.</p> <p>In an interview at the time, the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) confirmed the observation.</p> <p>The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice at the Life Safety Code exit conference on 9/18/25 at 2:15 PM.</p> <p>N.J.A.C- 8:39-31.2(e)</p>	K0293		
K0321 SS = F	<p>Hazardous Areas - Enclosure</p> <p>CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure</p> <p>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p> <p>19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <ul style="list-style-type: none"> a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) 	K0321	<p>1.The laundry room's second door to the back exit corridor has been scheduled for replacement to eliminate the 1-inch gap at the bottom; the new door and door frame order was ordered on 10/1/2025.</p> <p>The south-wing copy room (used for combustible storage) was scheduled for replacement to ensure compliance. A new door and frame were ordered on 10/1/2025.</p> <p>2.This deficient practice has the potential to impact all residents due to facility failure to ensure that hazardous areas were protected in accordance with NFPA</p> <p>3.The U.S. FOIA (b) (6) was educated by the Administrator about maintaining NFPA compliance, focusing on the specific requirements for hazardous areas. Regular preventive maintenance schedules were established to ensure all hazardous areas and doors are continuously compliant.</p> <p>The Director of Maintenance will implement a monthly audit for 3 months, and quarterly thereafter.</p> <p>4.The Director of Maintenance or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits.</p>	10/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025	
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052		
(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
K0321 SS = F	<p>Continued from page 2</p> <p>f. Combustible Storage Rooms/Spaces (over 50 square feet)</p> <p>g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interview on 9/17/25, in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 11:19 AM, revealed that the laundry room's second door to the back exit corridor had an inch gap along the lower edge when it was tested by the MD.</p> <p>An observation at 2:10 PM, revealed that the south -wing copy room, next to the Exit door, was being used to store combustibles. The door had a gap long the top, when it was tested by the U.S. FOIA (b) (6).</p> <p>In an interview at the time, the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) confirmed the observations.</p> <p>The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice at the Life Safety Code exit conference on 9/18/25 at 2:15 PM.</p> <p>N.J.A.C 8:39-31.2(e)</p>	K0321		
K0347 SS = D	<p>Smoke Detection</p> <p>CFR(s): NFPA 101</p> <p>Smoke Detection</p> <p>2012 EXISTING</p> <p>Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.</p> <p>19.3.4.5.2</p> <p>This STANDARD is NOT MET as evidenced by:</p>	K0347	<p>1.A compliant smoke detection device has been installed in the Dining/Activity room, which is open to the corridor, in accordance with NFPA.</p> <p>2.This deficient practice has the potential to impact all residents due to facility failure to ensure that areas open to the corridor were provided with smoke detection in accordance with NFPA.</p> <p>3.The U.S. FOIA (b) (6) was educated by the Administrator on the requirements of NFPA regarding smoke detection systems.</p> <p>The Director of Maintenance will implement a monthly audit for 3 months, and quarterly thereafter.</p>	10/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
(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
K0347 SS = D	Continued from page 3 Based on observation and interview on 9/17/25, in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) , it was determined that the facility failed to ensure that areas open to the corridor were provided with smoke detection in accordance with NFPA 101: 2012 Edition, Section 19.3.6.1 and 19.3.4.5.2. This deficient practice had the potential to affect 25 of 125 residents and was observed in 1 of 1 occupied open area as evidenced by the following: An observation at 10:25 AM, in the Dining/Activity room revealed that the area was open to the corridor and was not provided with smoke detection system. In an interview at the time, the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) confirmed the observation. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice at the Life Safety Code exit conference on 9/18/25 at 2:15 PM. N.J.A.C 8:39-31.2(e) NFPA 72	K0347	Continued from page 3 4.The Director of Maintenance or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits.	
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K0353	1.All sprinkler heads in the laundry room, central soiled linen room, and fire alarm closet have been cleaned and repositioned to ensure there are no gaps in accordance with NFPA standards. The Director of Maintenance inspected all sprinkler heads in the facility to ensure that they are NFPA compliant. 2.This deficient practice has the potential to impact all residents due to facility failure to ensure that the fire sprinkler system was maintained in accordance with NFPA. 3.The U.S. FOIA (b) (6) was educated by the Administrator on Sprinkler system maintenance per NFPA standards. The Director of Maintenance will implement a monthly audit for 3 months, and quarterly thereafter. 4.The Director of Maintenance or designee will review any findings of these audits monthly and then present them quarterly with the Quality Assurance and Performance Improvement Committee to determine the frequency of future audits	10/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
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K0353 SS = F Bldg. 01	<p>Continued from page 4 This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interview on 9/17/25, in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that the fire sprinkler system was maintained in accordance with NFPA 101: 2012 Edition, Section 9.7.5, 9.7.7, 9.7.8, NFPA 25, 2011 Edition Section 5.2, 5.2.1.1.2 and 5.2.2. This deficient practice had the potential to affect all residents and was evidenced by the following</p> <p>An observation in the laundry room at 11:21 AM, revealed that two of the seven sprinkler heads were loaded with dust.</p> <p>An observation in the central soiled linen room at 12:45 PM, revealed that 1 of 1 fire sprinkler head had an inch gap in the ceiling.</p> <p>An observation in the fire alarm closet at 1:18 PM, revealed that 1 of 1 fire sprinkler head had dropped down exposing an approximately three-inch gap and the head was covered with electrical tape.</p> <p>In an interview at the time, the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) confirmed the observation.</p> <p>The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice at the Life Safety Code exit conference on 9/18/25 at 2:15 PM.</p> <p>N.J.A.C 8:39-31.1(c), 31.2 (e)</p> <p>NFPA 25</p>	K0353		

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NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/17/25 and 9/18/25. Stratford Manor Rehabilitation and Care Center was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		10/03/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER STRATFORD MANOR REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 787 NORTHFIELD AVE , WEST ORANGE, New Jersey, 07052	
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K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 12/12/2025 in relation to the 9/22/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.</p>	K0000		

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