STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315266	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Crescent Healthcare & Rehabilitation Center	**480 PARKWAY DRIVE , EAST ORANGE, New Jersey, 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint #s 423088, 423096, 423099, 423102, 423103 STANDARD SURVEY: 8/12/25 - 8/20/25 CENSUS: 169 SAMPLE SIZE: 33 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F0000		09/24/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550	Facility Response F0550 Resident Rights/Exercise of Rights What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #182 was immediately provided with a NJ Exec Ord [redacted] that were in good condition and had no rips or tears and NJ Exec Order 26.4b1 were applied to NJ Exec Order 26. Nursing staff attempted to NJ Exe and NJ Ex resident #182's NJ Exec Order 26.4b but the resident NJ Exec Order 2 Resident #182 had a family meeting/phone conference conducted on NJ Exec Order 26.4. Family provided with resident NJ Exec Order 26.4b1 [redacted]. Family assisted with NJ Exe care of resident #182 and agreed to maintain routine schedule along with attempts from staff to perform NJ Exe care. Routine NJ Exec Order 2 completed on NJ Exec Order 26.4b1 care for resident #182. How will you identify other residents having the	10/01/2025

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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F0550 SS = D	Continued from page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to maintain the dignity of 1 of 33 residents (Resident # 182). The deficient practice was evidenced by the following: On 8/12/25 at 12:45 PM, the surveyor observed Resident #182 in a NJ Exec Order 26[illegible], in the dayroom. In the dayroom, near Resident #182, the surveyors observed 3 other residents and 2 activity staff members in the room as well. Resident # 182, in the NJ Exec Order 26[illegible] was observed with NJ Exec Order 26.4b1, the resident had a pair of NJ Exec Or[illegible] on which were NJ Exec[illegible] and NJ Exec Orde[illegible] and the resident's NJ Exec Order 26.4[illegible] was NJ Exec Order 2[illegible] The surveyor observed that the resident's NJ Exec Order 26.4[illegible] were NJ Exec Orde[illegible] and about NJ Exec Order 26.4b1 past the resident's NJ Exec Order 26.4[illegible] The surveyor also observed that the resident's NJ Exec Order[illegible] were about NJ Exec Order 26.4b1 extended past the resident's NJ Exec[illegible] and the resident's NJ Exec Orde[illegible] had NJ Exec Order 26.4b1 under the NJ Exec[illegible] On 8/14/25 at 10:54 AM, the surveyor observed Resident #182 in a NJ Exec Order 26.4[illegible] in the dayroom. In the dayroom, near Resident #182, the surveyors observed 9 other residents and 2 activity staff members in the room as well. Resident # 182, in the NJ Exec Order 26[illegible] was observed with NJ Exec Order 26.4b1 [redacted]. The resident was observed with a NJ Exec Order 26.4b1, and the resident's NJ Exec Order 26.4b1, and the resident's NJ Exec Order 26.4b1 [redacted] the resident's	F0550	Continued from page 1 potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by the deficient practice. A comprehensive review of all current resident's fingernails and toenails and clothing has been conducted by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) or designee to ensure that resident nail care and routine podiatry care has been completed, and resident clothing is free of rips/tears and is appropriate to maintain resident dignity. The policies titled Resident Rights, dated April 2025 and CNA Standard of Care dated February 2025 have been reviewed and determined no revisions or updates are necessary at this time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Assistant Director of Nursing has provided in-services to nursing staff on routine nail care, routine podiatry care and application of appropriate clothes to maintain resident rights/exercise residents' rights. -The systemic change will be that nail care will be added to the resident shower sheets for the Certified Nursing Assistants to fill out when providing showers for the residents which are then reviewed by the licensed nurse for any follow-up needed. Social services will be notified when resident clothes concerns arise and will contact resident representatives to assist with providing appropriate clothing in good condition. Routine podiatry care will continue every two months and as needed. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place? The Director of Nursing or designee will conduct random	

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F0550 SS = D	Continued from page 2 NJ Exec Order 26.4 The surveyor observed that the resident's NJ Exec Order 26.4 were NJ Exec Orde and about NJ Exec Order 26.4b1 extended past the resident's NJ Exec Order 26.4 The surveyor also observed that the resident's NJ Exec Order were about NJ E , and the resident's NJ Exec Order 26.4b1 had NJ Exec Order 26.4b1 under the NJ Exec On 8/14/25 at 11:01 AM, the surveyor interviewed the US FOIA (b)(6)) who was assigned to care for Resident # 182. The US FOIA stated that the resident was not compliant with NJ Exec Order 26.4b1 and family was responsible for doing the resident's NJ Exec Order 2 . The US FOIA stated that she could not recall when the family was at the facility last. The US FOIA stated that the staff should attempt to assist the resident with fixing their clothing. A review of the resident's medical records revealed that Resident # 182 had diagnoses which included but were not limited to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 A review of Resident # 182's quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Orde , revealed Resident # 182 had NJ Exec Order 26.4b1 . A review of the policy titled Resident Rights, dated NJ Exec Order 26.4 , revealed that residents should be treated with respect for their dignity and individuality. A review of the policy titled CNA standard of care, dated NJ Exec Order 26.4b1 , revealed that all resident's NJ Exec to be maintained NJ Exec O and NJ Exec Order 2 weekly. On 8/14/25 at 12:45 PM, the surveyor discussed the above concerns with US FOIA (b)(6) and the US FOIA (b)(6) . On 8/18/25 at 10:03 AM, the US FOIA stated that the staff should be responsible for NJ Exec Order 26 the resident's NJ Exec since they are not sure how frequently the family will come in to assist with NJ Exe care. The US FOIA stated that the staff should be responsible for ensuring that the resident is dressed appropriately. NJAC 8:39-4.1(a)12	F0550	Continued from page 2 audits of 10 residents weekly x 4, then monthly x 3 months of nail care, foot care and condition of clothing to ensure residents are treated respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. The results of these audits will be reviewed at the Quality Assessment and Assurance (QAA) quarterly meeting x 2 quarters to ensure that the facility's corrective action for the deficient practice will not recur. Completeion Date: 10/1/2025	
F0558 SS = D	Reasonable Accommodations Needs/Preferences	F0558	F0558 Reasonable accommodations Needs/ Preferences	10/01/2025

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F0558 SS = D	Continued from page 3 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 2 (two) of the 33 residents (Residents #3 and #137) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following: 1. On 8/12/2025 10:39 AM, the surveyor observed Resident #3 in bed awake, NJ Exec Order 26.4b1 the surveyor's inquiry. The surveyor observed that the call light was located behind the resident's bedside table. On 8/12/2025 at 12:18 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who stated that the call bell must have been put there by the US FOIA (b)(6) [redacted] when giving care to the resident. The call bell should be placed within the reach of the resident. On 8/14/2025 at 11:56 AM, the surveyor reviewed the electronic medical record (eMR) of Resident #3, which revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #3 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]). A review of the recent quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care) dated NJ Exec Order 2 indicated that the facility assessed the residents' NJ Exec Order 26.4b1 using a Brief Interview for Mental Status (BIMS) score of N out of 15, which indicated that the resident had NJ Exec Orde NJ Exec Order 26.4b1. Further review of the Q/MDS, as reflected in section NJ Exec revealed that the resident was NJ Exec Order 26.4b1 on staff for daily living activities.	F0558	Continued from page 3 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #3's call light was immediately placed within reach and secured with a clip. Resident #137's call light was immediately placed within residents reach and secured with a clip.No other residents were affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have potential to be affected by the deficient practice. The Director of Nursing (DON) or designee has conducted an audit of all residents call light placement. All call lights are maintained within reach with a clip to keep them within resident reach. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Assistant Director of Nursing (ADON), or designee has provided re-education to nursing staff to ensure residents' call lights are always maintained within reach and secured with a clip. The systemic change that will be put into place to ensure that the same deficient practice will not occur will be: Nursing staff will conduct rounding at the beginning of their assigned shift, and during all encounters with the residents and check the placement of call lights to ensure they are within reach and secured with a clip. The policy titled "Call Bell System" which was updated in January 2025, was reviewed by the facility administrator and the DON and determined no updates were required at this time. 4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place?	

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F0558 SS = D	Continued from page 4 A review of the Care Plan (CP) report initiated on [NJ Exec Ord] focused on the resident's [NJ Exec Order 26.4b] related to [NJ Exec Order 26.4b1]. Interventions included, but were not limited to, keeping the call bell in reach and encouraging its use. 2. On 8/12/2025 at 10:35 AM, the surveyor observed Resident #137 sitting in bed [NJ Exec Order 26.4b1] the surveyor's inquiry. The surveyor observed that the resident's call light was hanging on the call light outlet. The surveyor interviewed the resident, who stated that he did not know where the call bell was located. On 8/14/2025 at 8:22 AM, while the [US FOIA] was giving a medication pass to Resident #137, the surveyor observed that the call light of Resident #137 was on the floor. The [US FOIA] took the call light from the floor and put it on top of the resident's bed. The [US FOIA] stated that it must be dropped on the floor by the resident. The [US FOIA] stated that there should be a clip to secure the call light to the bed, and she will let maintenance know. The [US FOIA] added that the call light should be within the resident's reach. On 8/14/2025 at 12:51 PM, the surveyor reviewed the electronic medical record (eMR) of Resident #137, which revealed the following: A review of the AR reflected that Resident #137 was admitted with diagnoses that included but were not limited to [NJ Exec Order 26.4b1]). A review of the recent Q/MDS dated [NJ Exec Order] indicated that the facility assessed the residents' [NJ Exec Order 26] status using a BIMS score of [N] out of 15, which indicated that the resident had [NJ Exec Order 26.4b1] in [NJ Exec Order 26.4] Further review of the Q/MDS, as reflected in section [NJ Exec] revealed that the resident [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1] for daily living activities. A review of the CP report initiated on [NJ Exec Ord] focused on the resident's [NJ Exec Order 26.4b] related to [NJ Exec Order 26] . Interventions included,	F0558	Continued from page 4 The DON or designee will conduct random audits of call light placement for 10 residents weekly x 4 weeks, then monthly x 3 months to ensure call lights are maintained within reach and secured with a clip. Audit results will be reviewed at Quality Assessment and Assurance (QAA) meeting quarterly x 2 quarters to ensure that facility corrective actions for the deficient practices will not recur. Completion date: 10/1/2025	

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F0558 SS = D	Continued from page 5 but were not limited to, keeping the call bell in reach and encouraged to use. On 8/12/2025 at 10:38 AM, the surveyor interviewed the US FOIA (who stated that the call light should be within the resident's reach, even if the resident cannot use it. On 8/12/2025 at 12:19 PM, the surveyor interviewed the US FOIA (b)(6)), who stated that the call light should be within the reach of the resident. On 8/19/2025 at 11:59 AM, the team of surveyors met with the US FOIA (b)(6)) to discuss the above concern, but did not provide further information. A review of the facility policy titled "Call Bell System," updated in January 2025, revealed under "Procedure: Maintain call light within easy access of resident at all times." NJAC 8:39-31.8(c)9	F0558		
F0577 SS = D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made	F0577	F0577 Right to Survey Results/ Advocate Agency Info What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The facility administrator immediately obtained copies of last 3- years of inspection reports and placed them in the survey book and the 7 residents who were at the group meeting were informed of the locations where the inspection reports can be reviewed. Maintenance provided areas for storage of the survey book so the most recent 3 years of inspection reports are easily accessible for all residents and visitors on the wall near the elevator in the main lobby, 2nd, 3rd and 4th floor nursing stations. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	10/01/2025

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F0577 SS = D	Continued from page 6 respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the most recent 3 years of inspection reports were readily accessible in a prominent area to residents and visitors without having to ask for the reports from facility staff. The deficient practice was identified during interview with 7 residents at the resident group meeting and 1 individual staff interview and was evidenced by the following. On 8/14/2025 at 7:59 AM, the surveyor observed signage located next to the 3rd floor elevator which indicated "Survey Report inside Nursing Station." The surveyor interviewed a 3rd floor unit nurse inquiring as to the location of the survey report binder. The nurse looked at the nursing station desk and then in an area behind the desk used as a charting room and found the binder on a shelf. The nurse told the surveyor she was unaware that the survey reports needed to be accessible to residents and visitors without having to ask staff. On 8/14/2025 at 11:30 AM, the surveyor observed signage outside the elevator on the 2nd floor indicating survey reports were in the lobby. On 8/18/2025 at 11:05 AM the surveyor conducted the resident group meeting with the US FOIA (b)(6) [redacted] and 6 other residents who regularly attend the monthly resident council meetings. The 7 residents were unaware of the location of the survey report binders. Additionally, they stated they would not normally go to the lobby, other than to exit or enter the building. The concern was discussed with the US FOIA (b)(6) [redacted] on 8/18/25.	F0577	Continued from page 6 All residents and visitors have potential to be affected by this deficient practice. No further resident/ visitor effected. The US FOIA (b)(6) [redacted] has been re-educated by the Vice President of Clinical Services on federal regulation CFR 483.10 to ensure that the most recent 3 years of inspection reports are readily accessible in a prominent area to residents and visitors without having to ask for the reports from facility staff. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not occur? The Assistant Director of Nursing (ADON) has provided in-service education to facility staff on the locations of survey/inspection books with 3 years of inspection reports to be accessible to residents and or visitors without having to ask. -During resident council monthly meeting, residents will be interviewed by the Recreation Director or designee on accessibility of survey book with last three years of results to ensure they know the locations of the inspection reports for the last 3 years. 4. How are corrective actions monitored to ensure deficient practice will not recure, i.e. What quality assurance will be put into place? - Interviews will be conducted by Social Service Workers with 5 random alert and oriented residents and/or visitors to ensure they know the location and accessibility of survey inspection reports weekly x4 weeks, then monthly x 3 months. Audit results will be reviewed at Quality Assessment and Assurance quarterly meeting x 2 quarters to ensure facility corrective actions for deficient practices will not recur. Completion date: 10/1/2025	

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F0577 SS = D	Continued from page 7 NJAC 8:39-4.1	F0577		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F0584	F0584 Safe/ Clean/Comfortable/ homelike Environment What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified to have been affected by the deficient practice. The following identified areas have been repaired by the Director of Maintenance (DOM): Room #[redacted] - scratches on the wall between the resident's bathroom door and the sink inside the room, which exposed the sheet rock and the upper dresser drawer. Room #[redacted] - scratches on the wall exposed which exposed sheet rock between the resident's bathroom door to the handwashing sink. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in the facility have the potential to be affected by the deficient practice of the facility, failing to maintain a clean, sanitary and homelike environment. The [redacted] has been re-educated by the facility administrator on the importance of maintaining resident rooms, (including furniture) in a clean, safe and homelike environment. A comprehensive review of all resident rooms and furniture has been completed by the DOM and the administrator. All areas identified that need repairs have been completed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DOM or designee has educated facility staff on the importance of maintaining resident rooms, including	10/29/2025

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F0584 SS = D	Continued from page 8 This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined the facility failed to maintain the residents' living environment in a clean, sanitary, and homelike manner for 2 resident rooms (Room # [NJ Exec] and [NJ Exec] on the [NJ Exec] floor. The deficient practice was evidenced by the following: 1. During initial tour, on 8/12/25 at 12:00 PM, in room [NJ Exec] the surveyor observed 3 areas with approximately 6 foot long linear area of scratches on the wall between the resident's bathroom door and the sink inside the room, which exposed the sheet rock. The surveyor also observed 3 scratches to the right side of the window sill in the resident's room, and approximately a 10 inch long broken piece to the resident's upper dresser drawer. 2. The surveyor entered room [NJ Exec] on 8/14/25 at 10:41 AM and observed an approximately 6 foot long linear area of exposed sheet rock from the bathroom door to the handwashing sink. On 8/18/25 at 12:51 PM, the surveyor discussed the above concerns with the [US FOIA (b)(6)] NJAC 8:39-31.2(e)	F0584	Continued from page 8 furniture, in a clean, safe and homelike environment and reporting anything in disrepair to the DOM. The DOM or designee will conduct monthly random audits of at least 5 rooms on each unit to identify any maintenance issues with resident room walls or furniture that need repairs. How will the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? The Licensed nursing home administrator or designee will conduct weekly environmental audits of 10 resident rooms x 4 weeks, then monthly x 3 months to ensure repairs are completed timely and to ensure a homelike environment is maintained. The results of these audits will be presented and reviewed at the Quarterly Quality Assurance meeting x 2 quarters to ensure that facility corrective actions for deficient practices will not recur. Completion date: 10/29/2025	
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	F0645	F0645 PASRR Screening for MD & ID What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #12 has their [NJ Exec Order 26.4b1] updated to include a diagnosis of [NJ Exec Order 26.4b1] and will continue to be routinely followed by [NJ Exec Order 26.4b] Services. The updated [NJ Exec Order 26] has been uploaded into the resident's electronic health record. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	10/01/2025

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F0645 SS = D	Continued from page 9 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental	F0645	Continued from page 9 All residents who reside in the facility with a diagnosis of schizophrenia have the potential to be affected by the deficient practice of not having their PASARR updated to reflect current diagnoses that may require specialized services. A comprehensive review of all residents who reside in the facility with a diagnosis of schizophrenia has been completed and no other residents were found to have inaccurate PASARRs. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The US FOIA (b)(6) has been re-educated by the facility administrator on the requirement that they are responsible for reviewing the PASARR Level 1 screening for accuracy. The Director of Nursing (DON) or designee will review residents who are admitted to the facility or are newly diagnosed with a diagnosis of NJ Exec Order 26.4b1 to ensure their PASARR is completed accurately and if necessary to have the social worker create new PASARR based on the new diagnosis. The facility policy titled “Policy and Procedure for MDS 3.0 PASSR Requirement Compliance” was reviewed by the Administrator and DON and it was determined no updates or revisions are required at this time. How will the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? The Social Worker or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months of 5 residents who have a diagnosis of schizophrenia to ensure that the PASARR is accurate. The results of these audits will be reviewed at Quality Assessment and Assurance quarterly meeting x 2 quarters to ensure facility corrective actions for deficient practices will not recur. Completeion date: 10/1/2025	

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F0645 SS = D	Continued from page 10 disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure a [redacted] was completed accurately for 1 (one) of 1 resident reviewed for [redacted] (Resident #12). This deficient practice was evidenced by the following: On 8/12/2025 at 10:42 AM, the surveyor observed Resident #12 out of bed to the wheelchair, able to answer the surveyor's inquiry. On 8/18/2025 at 11:09 AM, the surveyor reviewed the electronic Medical Record (eMR) of Resident #12, which revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #12 was admitted with diagnoses that included but were not limited to [redacted] with a start date of [redacted]. A review of the annual Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) dated [redacted] indicated that the facility assessed the residents' [redacted] status using a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident had [redacted] Further review of the A/MDS reflected in section [redacted]: Use and Indication stated that Resident #12 is taking [redacted] medication on a routine basis. A review of the Order Summary Report (OSR) revealed an order of [redacted] by mouth at bedtime and [redacted] by mouth in the morning, with a start order date of [redacted]	F0645		

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F0645 SS = D	Continued from page 11 A review of the recent NJ Exec Order 26.4b1 progress notes dated NJ Exec Order 2 documented continuing the current medications of NJ Exec Order 26.4 for the diagnosis of NJ Exec Order 26.4b1 A review of the Care Plan (CP) report initiated on NJ Exec Order 2 focused on the resident receiving NJ Exec Order 26.4b1 medications related to NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 form with a handwritten date on NJ Exec Orde revealed in Section N – NJ Exec Order 26.4b1 that Resident #12 had no NJ Exec Order 26.4 or evidence of NJ Exec Order 26.4b1 limited to NJ Exec Order 26.4b1 disorders, and the NJ Exec Orde was NJ Exec Order 26 There is no other NJ Exec Order 26.4b1 form that accurately states that the resident has a diagnosis of NJ Exec Order 26.4b1 On 8/18/2025 at 11:12 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the NJ Exec Order 26 of Resident #12 should be updated since the resident has a diagnosis of NJ Exec Order 26.4b1 The US FO added that the hospital initiated the NJ Exec Order 26.4 On 8/19/2025 at 11:59 AM, the team of surveyors met with the US FOIA (b)(6) and the US FOIA (b)(6)) to discuss the above concern, but did not provide further information. A review of the facility policy titled “Policy and Procedure for MDS 3.0 PASRR Requirement Compliance” with an update in March 2025 stated under “Procedure: The Social Worker (SW) is responsible for: 1. Reviewing the Level 1 screening for accuracy.”	F0645		
F0711 SS = E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each	F0711	F711 Physician visits- Review Care/Notes/Orders What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #180 no longer resides in the facility, but the primary care physician has signed and dated the monthly physician orders.	10/01/2025

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F0711 SS = E	Continued from page 12 visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is NOT MET as evidenced by: REPEAT DEFICIENCY Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders. The deficient practice was observed for 9 of 33 residents reviewed (Resident #3, 6, 9, 14, 17, 65, 76, 87, 180) and occurred over an extended period. The evidence was as follows: 1.A review of the hybrid medical record (paper and electronic documentation) for Resident #6 revealed the physician had last signed the resident's monthly physician orders on [redacted] 2.A review of the hybrid medical record for Resident #14 revealed the physician had last signed the resident's monthly physician orders on [redacted] 3.A review of the hybrid medical record for Resident #76 revealed the physician had last signed the resident's monthly physician orders on [redacted] 4.A review of the hybrid medical record for Resident #87 revealed the physician had last signed the resident's monthly physician orders on [redacted] 5.A review of the hybrid medical record for Resident #180 revealed the physician had last signed the resident's monthly physician orders last signed on [redacted] 6. A review of the electronic medical record for Resident #3 revealed	F0711	Continued from page 12 Residents #3, #6, #9, #14, #17, #65, #76 and #87's primary care physicians have signed and dated the monthly physician orders and they are now up to date. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing in the facility have the potential to be affected by the deficient practice of not having their primary care physicians sign and date their physician orders monthly. A comprehensive review of current residents who reside in the facility has been conducted by the Director of Nursing (DON) or designee to determine if any other physician orders are not signed and dated on a monthly basis. All primary care physicians who are not in compliance have been re-educated by the facility Administrator and have signed and dated their monthly physician orders and are currently up to date. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All current primary care physicians have been re-educated by the facility Administrator on the Federal Requirement CFR(s): 483.30(b)(1)-(3) and the facility policy titled 1.0 Prescribing Authorization that states that All medications and biological orders are written, dated and signed by the person lawfully authorized to give such an order and that all orders are valid for one month (unless specified) once signed by the facility's authorized physician. The DON or designee will conduct a monthly review of current resident EHR to determine if the primary care physicians are up to date with signing and dating their resident's physician orders each month. How will the corrective action be monitored to ensure the deficient practice will not recure, i.e. what quality assurance program will be put into place? LNHA or DON or designee will conduct weekly random audits x 4 weeks, then monthly x 3 months of 10	

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F0711 SS = E	Continued from page 13 the physician has not electronically signed the monthly physician orders from NJ Exec Ord to NJ Exec Order 26.4b1 7. A review of the electronic medical record for Resident #9 revealed the physician has not electronically signed the monthly physician orders for NJ Exec Order 26.4b 8. A review of the electronic medical record for Resident #17 revealed the physician has not electronically signed the monthly physician orders for NJ Exec Order 26.4b1. 9. A review of the electronic medical record for Resident #65 revealed the physician has not electronically signed the monthly physician orders for NJ Exec Order 26.4. On 8/18/2025 at 11:50 AM, the surveyor interviewed the US FOIA (b)(6)) who stated that the physician usually signed the order electronically and all the documents are in the computer system. On 8/18/2025 at 11:52 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that they do not have a physical chart anymore; everything was documented electronically. The physician should be signing the monthly orders in the computer. On 8/19/2025 at 11:59 AM, the team of surveyors met with the US FOIA (b)(6)) and the US FOIA (b)(6)) to discuss the above concern, but did not provide further information. A review of the facility policy titled 1.0 Prescribing Authorization, with an effective date of 2022, under Procedure: B. All medications and biological orders are written, dated, and signed by the person lawfully authorized to give such an order. C. 1. All orders are valid for one month (unless specified) once signed by the facility's authorized physician. NJAC 8:39-23.2(b)	F0711	Continued from page 13 residents' attending physicians' documentation to ensure compliance. The results of these audits will be reviewed during facility Quality Assessment and Assurance meeting (QAA) held quarterly. Completion date: 10/1/2025	
F0712 SS = E	Physician Visits-Frequency/Timeliness/Alt NPP	F0712	F0712 Physician visits/ Frequency/ Timeliness/ Alt NPP	10/01/2025

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F0712 SS = E	Continued from page 14 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 assure that the physician responsible for supervising the care of residents conducted face to face visits and wrote progress notes at least every 60 days. This deficient practice continued over several months for 10 of 33 residents (Resident #3, 4, 6, 9, 12, 17, 65, 76, 87, 180) reviewed and was evidenced by the following. 1. A review of physician progress notes documented in the hybrid medical record (paper and electronic documentation) for Resident #6 revealed there were no physician notes written for over [redacted]. 2. A review of physician progress notes documented in the hybrid medical record for Resident #76 revealed there were no physician notes written for over [redacted] 3. A review of physician progress notes documented in the hybrid medical record for Resident #87 revealed there were no physician notes written for over [redacted]	F0712	Continued from page 14 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #180 no longer resides in the facility. The primary care physician assigned to resident #180 has been re-educated on the requirement of documenting a physician progress note at least every 60 days in the resident's electronic health record. Residents #6, # 76 and #87 have had their primary care physician document a physician progress note in their electronic health record. Residents #3, #4 and #17 have had face-to face visits with a physician progress note written and documented in their electronic health record. Residents #9, #12 and #65's primary care physicians have been re-educated by the facility Administrator on the requirement of documenting their physician visit progress notes in the electronic health record in a timely manner which occurs no later than 10 days after the visit was required. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in the facility have the potential to be affected by the deficient practice. A comprehensive audit of current resident attending physician's face-to-face visits with physician progress notes entered into the residents' electronic health record and timely physician progress notes entered not more than 10 days past the required visit has been conducted by the Administrator, DON or designee to determine that current attending physicians are in compliance with the requirement for Physicians Visits per the facility policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility policy titled "Physician Visits" has been reviewed by the Administrator and DON and determined that no revisions or updates are necessary at this	

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F0712 SS = E	Continued from page 15 4. A review of physician progress notes documented in the hybrid medical record for Resident #180 revealed there were no physician notes written for over [redacted]. 5. On 8/12/2025 10:39 AM, the surveyor observed Resident #3 in bed awake, NJ Exec Order 26.4b1 the surveyor's inquiry. On 8/14/2025 at 11:56 AM, the surveyor reviewed the electronic medical record (eMR) of Resident #3, which revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #3 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1). A review of the recent quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care) dated NJ Exec Order 26 indicated that the facility assessed the residents' NJ Exec Order 26 status using a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident had NJ Exec Orde [redacted] A review of the Physician Progress Notes (PPN) that the medical doctor (MD #1) revealed that the physician did not conduct face-to-face visits from NJ Exec Order 26.4b1 NJ Exec Or 6. On 8/12/2025 10:34 AM, the surveyor observed Resident #4 in bed, sitting, NJ Exec Order 26.4b1 [redacted] the surveyor's inquiry in NJ Exec Order 26.4b1 . On 8/14/2025 at 11:56 AM, the surveyor reviewed the eMR of Resident #4, which revealed the following: A review of the AR reflected that Resident #4 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 following NJ Exec Order 26.4b1 [redacted]	F0712	Continued from page 15 time. All current attending physicians and licensed nursing staff have been educated by the facility Administrator or DON (Director of Nursing) and provided with a copy of the Physicians Visit policy to include documentation at least every 60 days of face-to-face visits with alternating Nurse Practitioner visits and education to document timely, accurate dates in their physician progress notes in the resident electronic health record (EHR). The DON or designee will conduct a monthly review of current residents EHR to determine which physicians are not in compliance and alert the physicians of the upcoming required face-to-face visits and required timely physician progress note documentation. This monthly review will continue to be completed x 3 months and then reviewed by the Quality Assessment and Assurance (QAA) committee to determine the need for additional review. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place? The Administrator or DON or designee will conduct weekly random audits x 4 weeks, then monthly x 3 months of 10 resident charts to ensure attending physicians' face-to-face visits and documentation meets the requirements outlined in the Physician Visits Policy. The results of these audits will be reviewed during the facility Quarterly Quality Assessment and Assurance meeting (QAA). Completeion Date: 10/1/2025	

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F0712 SS = E	Continued from page 16 A review of the recent Q/MDS dated [NJ Exec Order 2] indicated that the facility assessed the residents' [NJ Exec Order 26] status using a BIMS score of [NJ E] out of 15, which indicated that the resident had NJ Exec Order 26.4b1 [redacted] A review of Resident #4's PPN revealed that MD#1 did not conduct face-to-face visits from NJ Exec Order 26.4b1 [redacted] 7. On 8/12/2025 at 10:40 AM, the surveyor observed Resident #9 in bed, asleep, covered with a blanket. On 8/14/2025 at 11:56 AM, the surveyor reviewed the eMR of Resident #9, which revealed the following: A review of the AR reflected that Resident #9 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]. A review of the significant change (SC/MDS) dated [NJ Exec Order 2] indicated that the facility assessed the residents' [NJ Exec Order 26] status using a BIMS score of [N] out of 15, which indicated that the resident had [NJ Exec Order 2] [redacted] A review of the PPNs in the eMR reflected the following "Effective Date," "Created Date," and/or "Late Entry" (any documentation that is recorded in the eMR beyond 24-48 hours of the encounter is classified as a late entry) designation which indicated the PPN of MD #1 was not documented on the effective date (Date of Service): 1. PPN with an effective date of [NJ Exec Ord] and a created date of [NJ Exec Order 2]. 2. PPN with an effective date of [NJ Exec Ord] and a created date of [NJ Exec Order]. 3. PPN with an effective date of [NJ Exec Order 2] and a created date of [NJ Exec Order 26] 4. PPN with an effective date of [NJ Exec Order 26.4b1] a created	F0712		

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F0712 SS = E	Continued from page 17 date of [NJ Exec Order 2] 5. PPN with an effective date of [NJ Exec Order] and a created date of [NJ Exec Order 26] 6. PPN with an effective date of [NJ Exec Ord] and a created date of [NJ Exec Order 2] 7. PPN with an effective date of [NJ Exec Ord] and a created date of [NJ Exec Order]. 8. PPN with an effective date of [NJ Exec Order 26.4b] a created date of [NJ Exec Ord]. 9. PPN with an effective date of [NJ Exec Order 2] and a created date of [NJ Exec Order] 10. PPN with an effective date [NJ Exec Order 26.4] and a created date of [NJ Exec Ord]. 11. PPN with an effective date of [NJ Exec Order 2] and a created date of [NJ Exec Order] 12. PPN with an effective date of [NJ Exec Order 2] and a created date of [NJ Exec Order] 13. PPN with an effective date of [NJ Exec Orde] and a created date of [NJ Exec Orde] 14. PPN with an effective date of [NJ Exec Order 2] and a created date of [NJ Exec Orde] 15. PPN with an effective date of [NJ Exec Order] and a created date of [NJ Exec Ord]. 16. PPN with an effective date of [NJ Exec Order 2] and a created date of [NJ Exec Orde] 8. On 8/12/2025 at 10:42 AM, the surveyor observed Resident #12 out of bed to the wheelchair, able to answer the surveyor's inquiry. On 8/18/2025 at 11:09 AM, the surveyor reviewed the eMR of Resident #12, which revealed the following: A review of the AR reflected that Resident #12 was admitted with diagnoses that included but were not limited to [NJ Exec Order 26.4b1 [redacted]].	F0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315266	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0712 SS = E	Continued from page 18 A review of the annual (A/MDS) dated NJ Exec Order indicated that the facility assessed the residents' NJ Exec Order 26 status using a BIMS score of [redacted] out of 15, which indicated that the resident had NJ Exec Order 26.4b1 [redacted]. A review of Resident #12's PPN of MD #1 in the eMR reflected the following: 1. PPN with an effective date of NJ Exec Ord and a created date of NJ Exec Orde 2. PPN with an effective date of NJ Exec Ord and a created date NJ Exec Order 26. 3. PPN with an effective date of NJ Exec Order and a created date of NJ Exec Orde 4. PPN with an effective date of NJ Exec Order and a created date of NJ Exec Order 5. PPN with an effective date of NJ Exec Order 2 and a created date of NJ Exec Ord. 6. PPN with an effective date of NJ Exec Ord and a created date of NJ Exec Orde 7. PPN with an effective date of NJ Exec Order 2 and a created date of NJ Exec Orde 8. PPN with an effective date of NJ Exec Order 2 and a created date of NJ Exec Orde 9. On 8/12/2025 at 10:46 AM, the surveyor observed Resident #17 out of bed to the wheelchair in the hallway, NJ Exec Order 26.4b1 the surveyor's inquiry. On 8/13/2025 at 12:27 PM, the surveyor reviewed the eMR of Resident #17, which revealed the following: A review of the AR reflected that Resident #17 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of the recent Q/MDS dated NJ Exec Order 2 indicated	F0712		

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F0712 SS = E	Continued from page 19 that the facility assessed the residents' NJ Exec Order 26 status using a BIMS score of [redacted] out of 15, which indicated that the resident had NJ Exec Order 26.4b1 [redacted] A review of Resident #17's PPN revealed that MD#2 did not conduct face-to-face visits from NJ Exec Order 26.4b1 [redacted] 10. On 8/12/2025 at 10:50 AM, the surveyor observed Resident #65 in bed, asleep. On 8/13/2025 at 1:09 PM, the surveyor reviewed the eMR of Resident #65, which revealed the following: A review of the AR reflected that Resident #65 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]). A review of the recent Q/MDS dated NJ Exec Order [redacted] indicated that the facility assessed the residents' NJ Exec Order 26 status using a BIMS score of [redacted] out of 15, which indicated that the resident had NJ Exec Order 26.4b1 [redacted] A review of Resident #65's PPN of MD #1 in the eMR reflected the following: 1. PPN with an effective date of NJ Exec Order 26.4b1 a created date of NJ Exec Order. 2. PPN with an effective date of NJ Exec Order 2 and a created date of NJ Exec Order 26 3. PPN with an effective date of NJ Exec Order 2 and a created date of NJ Exec Order 2 4. PPN with an effective date of NJ Exec Orde and a created date of NJ Exec Order 2 5. PPN with an effective date of NJ Exec Order and a created date of NJ Exec Order. 6. PPN with an effective date of NJ Exec Order 26.4b1 a created date of NJ Exec Order.	F0712		

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F0712 SS = E	Continued from page 20 7. PPN with an effective date of [NJ Exec Order] and a created date of [NJ Exec Order 2] On 8/18/2025 at 11:50 AM, the surveyor interviewed the [US FOIA (b)(6)] regarding the [US FO] notes. The [US FOIA] stated that all the documentation is in the computer system since there is no physical chart anymore. The MDs should document in the computer every time they visit. On 8/18/2025 at 11:52 AM, the surveyor interviewed the [US FOIA (b)(6)]) regarding the MD's PPN. The [US FOIA (b)(6)] stated that the MDs were expected to document in the computer system, but did not provide any information on why there was no documentation of the MDs in the eMR. On 8/19/2025 at 11:59 AM, the team of surveyors met with the [US FOIA (b)(6)]) to discuss the above concern. The [US FOIA] stated, “It is what it is” regarding the PPN. A review of the facility policy titled Physician visits under Policy Interpretation and Implementation 2. The attending Physician must visit their patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. 4. After the first ninety (90) days, if the Attending Physician determines that a resident need not be seen by him/her every thirty (30), days an alternate schedule of visits may be established, but not to exceed every sixty (60) days. A Physician Assistant or Nurse Practitioner may make alternative visits after the initial ninety (90) days following admission, unless restricted by law or regulation. 6. A physician visit is considered timely if it occurs not later than ten (10) days after the date the visit was required. However, the subsequent visit must be timed in relation to when the previous one was due, not to when it was made. NJAC 8:39-23.2(a)(d)	F0712		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060733	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	Initial Comments THE FACILITY WAS 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		09/24/2025
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: Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for 6 of 14 day shifts as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:	S0560	S560 Mandatory Access to Care What corrective action will be accomplished for those residents found to have been affected by the deficient practice? -No residents were identified to be affected by deficient practices. A review of the care residents received for 2 weeks of 7/27/25 to 08/2025. The following dates 7/27/25, 7/31/25, 8/2/25, 8/3/25, 8/5/25, 8/9/25 for day shift revealed no complaints or grievances related to resident care and reported on these dates. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? -The deficient practice has the potential to affect all residents residing in the facility. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	10/01/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060733	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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S0560	Continued from page 1 (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 7/27/2025 and ending 8/20/2025 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements.The facility was deficient in CNA staffing for residents on on 6 of 14 day shifts as	S0560	Continued from page 1 - Staffing Coordinator is reeducated by DON on state department of health requirement on minimum of one certified nurse aide to every eight residents for day shift. -Staffing need are assessed daily and in event there is CNA shortage and ratio of one CNA to every eight resident on day shift is not being met then; nurse manager/supervisors will recruit CNA from previous or upcoming shift, and will continue to utilize CNA unit clerks to assist with providing resident care to meet day shift state requirements to meet minimum state staffing requirements of one CNA to every 8 resident on day shift. -Facility has and will continue to offer referral and sign on bonus; online advertisements are utilized to recruit new employees. Facility utilizes staff recruiters to monitor online sites and to set up interviews. -Facility has increased CNA rates and offer other options to increase CNA rates to assist in meeting minimum state staffing requirement of one CNA to every eight residents on day shift. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? LNHA, DON or designee will conduct weekly CNA staffing schedule audits x 4 weeks and then monthly x3 months. DON or designee will report audit findings to Administrator. Administrator will review audit findings and report during Quality Assurances Performance Improvement (QAPI) quarterly meeting x 2 quarters. Completion date: 10/1/25	

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S0560	Continued from page 2 follows: -07/27/25 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -07/31/25 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/02/25 had 18 CNAs for 166 residents on the day shift, required at least 21 CNAs. -08/03/25 had 20 CNAs for 166 residents on the day shift, required at least 21 CNAs. -08/05/25 had 17 CNAs for 166 residents on the day shift, required at least 21 CNAs. -08/09/25 had 18 CNAs for 165 residents on the day shift, required at least 21 CNAs. On 8/20/2025 at 9:45 AM the Facility Administrator and Director of Nursing were notified of staffing concerns.	S0560		

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/18/25 in relation to the 8/20/25 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	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

New Jersey State Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/18/25 in relation to the 8/20/25 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted on 08/12/2025, 08/13/2025 and 08/14/2025 and Park Crescent Healthcare and Rehabilitation Center 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. Park Crescent Healthcare and Rehabilitation Center is a five (5) story, Type I Fire Resistant building that was built in September 1968. The facility is divided into 13 smoke zones.	K0000		09/24/2025
K0347 SS = E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is NOT MET as evidenced by: Based on observations and interview, 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 19.3.4.5.2 and 19.3.6.1. This deficient practice had the potential to affect the 169 residents and was evidenced by the following: Observations on 08/13/2025 in the presence of the facility's US FOIA (b)(6)) at approximately 12:26 PM, on the first floor (near the Receptionist area), revealed there was an open lounge area. The surveyor observed no evidence of smoke detection in the room.	K0347	Plan of Correction – K0347: Smoke Detection Deficiency: The lobby area, which is open to the corridor, does not have a smoke detector as required. 1. How the deficiency will be corrected for the resident(s) affected: A licensed fire protection contractor has been scheduled to install a smoke detector in the lobby area that is open to the corridor. On Wednesday 9/10/2025 a smoke detector was installed in open lounge area. No residents were affected by the deficient practice. 2. How the facility will identify other residents who could be affected and what corrective action will be taken: All residents can potentially be affected by the deficient practice. A full audit of all areas open to corridors was conducted by the Maintenance Director to confirm that smoke detection is provided wherever required. No additional areas lacking smoke detection were identified. 3. What systemic changes will be put in place to ensure the deficient practice does not recur: The Facility administrator has educated the US FOIA (b)(6)	10/01/2025

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.

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K0347 SS = E	Continued from page 1 The surveyor measured and recorded the opening of the lounge opening to the corridor which was 6 foot-2-inches wide by 6-foot-9-inches high. In an interview, the finding was verified by the [US FOIA (b)(6)] at the time of observation. The [US FOIA (b)(6)] were informed of the deficient practice during the Life Safety Code survey exit on 08/14/2025 at approximately 12:56 PM. NJAC 8:39-31.2 (e)	K0347	Continued from page 1 [US FOIA (b)(6)] of NFPA smoke detector requirements. Any future renovations or structural changes will require review with the fire protection vendor to confirm compliance with smoke detection requirements prior to occupancy. 4. How the facility will monitor its performance to make sure the solution is sustained: BI-annual building inspections will be conducted by the Maintenance Director to ensure all required smoke detectors are present and operational. Results of audits and inspections will be presented to the Quality Assurance and Performance Improvement (QAPI) committee quarterly. Completion Date: 10/1/2025	
K0351 SS = D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and Interview in the presence of the facility's [US FOIA (b)(6)]), it was determined that the facility failed to install fire	K0351	Plan of Correction – K0351: Sprinkler System Deficiency: There is no sprinkler coverage in the lower landing of the stairwell. 1. How the deficiency will be corrected for the resident(s) affected: A licensed fire protection contractor was contacted immediately. A sprinkler head will be installed on 9/17/2025 in the lower landing of the stairwell to ensure full coverage. Until installation is complete, the stairwell will be monitored every shift by maintenance staff to ensure safety. No residents were affected by the deficient practice. 2. How the facility will identify other residents who could be affected and what corrective action will be taken: All residents can potentially be affected by the deficient practice. A full facility-wide audit of sprinkler coverage was conducted by the Maintenance Director in coordination with the fire protection vendor to verify all areas of the building are properly covered per NFPA requirements. No other areas were identified as lacking sprinkler coverage. 3. What systemic changes will be put in place to ensure the deficient practice does not recur:	10/01/2025

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K0351 SS = D	Continued from page 2 sprinklers as required by CMS regulation 483.90 (a) Physical Environment to all areas in accordance with NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler System 2012 Edition. This deficient practice had the potential to affect the 169 Residents and was evidenced by the following: Observations on 08/13/2025 during the building tour in the presence of the facility's US FOIA (at approximately 12:33 PM, revealed no evidence of fire sprinkler coverage inside the North Stairwells lower landing. In an interview at the time, the surveyor asked the US FOIA (b) "Do you see a sprinkler on the lower landing." The US FOIA (said, "No." The US FOIA (b)(6) were informed of the deficient practice on 08/14/2025 during the Life Safety Code Survey exit at approximately 12:56 PM. NJAC8:39-31.1 (c), 31.2 (e) NFPA 13	K0351	Continued from page 2 The US FOIA (b)(6) has been educated by the facility administrator on NFPA sprinkler coverage requirements. Any building renovations or structural changes will be reviewed with the fire protection vendor to confirm sprinkler compliance prior to completion. 4. How the facility will monitor its performance to make sure the solution is sustained: The Maintenance Director will conduct Bi-annual sprinkler inspections to ensure the facility is NFPA compliant. Results of these inspections will be reported to the facility's Quality Assurance and Performance Improvement (QAPI) committee on a quarterly basis. Any deficiencies identified will be addressed immediately. Completion Date: 10/1/2025	
K0531 SS = F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	K0531	Plan of Correction – K0531: Elevators / Emergency Communications Deficiency: The emergency phones in the elevators were not properly working. How the deficiency will be corrected for the resident(s) affected: The facility's elevator vendor was contacted immediately. The emergency phone in elevator #2 was reset by the vendor and is working properly. Work order to facility vendor was placed to replace phone in elevator #1. On September 23rd the facility elevator vendor reurned to complete the service on elevator #1, however after testing and reprogramming he concluded that the phone was working propery and did not need to be replaced. 2. How the facility will identify other residents who could be affected and what corrective action will be taken: All residents in the facility have the potential to be	10/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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Park Crescent Healthcare & Rehabilitation Center	480 PARKWAY DRIVE , EAST ORANGE, New Jersey, 07017

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K0531 SS = F	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 08/12/2025 in the presence of the facility's US FOIA (b)(6) it was determined that the facility failed to maintain emergency communications in proper working condition for 2 of 2 elevators tested in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3 and ASME/ANSI A17.3. This deficient practice had the potential to affect the 169 residents and was evidenced by the following: In an interview on 08/12/2025 during the Life Safety Code survey entrance at approximately 9:07 AM, the facility's US FOIA (b)(6) stated that there are two (2) elevators in the facility. Observation on 08/12/2025 revealed the following: At approximately 9:28 AM, a test of elevator #2 emergency communication telephone was performed. When the surveyor attempted to use the emergency telephone, the operator did answer. When the surveyor asked the operator if they knew the location of the call the operator told the surveyor that there was no pre-recorded message that would give the location and elevator number. At approximately 9:34 AM, a test of elevator #1 emergency communication telephone was performed. When the surveyor attempted to use the emergency telephone, the phone did not function. This test was repeated two (2) additional times with the same results. In an interview, the US FOIA (confirmed the findings at the times of observations. The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code survey exit on 08/14/2025 at approximately 12:56 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K0531	Continued from page 3 affected by deficient practice. The Maintenance Director, together with the facility elevator vendor, verified that all elevators in the building now have properly functioning emergency phones. No additional deficiencies were identified. 3. What systemic changes will be put in place to ensure the deficient practice does not recur: The US FOIA (b)(6) was educated by the facility administrator of the NFPA requirements for the elevators. The facility's Life Safety preventive maintenance checklist has been revised to include monthly testing of elevator emergency phones. 4. How the facility will monitor its performance to make sure the solution is sustained: Elevator emergency phones will be tested monthly by the Maintenance Director and results will be documented. Documentation will be reviewed quarterly by the Administrator in QAPI meetings. Any malfunction identified will be reported immediately to the facility elevator vendor for corrective action. Responsible Person: Maintenance Director	
K0918 SS = F	Electrical Systems - Essential Electric Syste	K0918	Plan of Correction – K0918: Electrical Systems / Generator Installation	12/05/2025

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K0918 SS = F Bldg. 01	Continued from page 4 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observations and interview on 08/12/2025, 08/13/2025 and 08/14/2025 it was determined that the facility failed to 1) properly install a temporary Emergency Generator and 2) provide electrical wiring in accordance with National Electrical Code 70 (NEC-70). This deficient practice had the potential to affect all 169 residents and was evidenced by the following: Observations on 08/12/2025 during the building tour in the presence of the US FOIA (b)(6) at approximately 9:24 AM, outside of the building, revealed that the facility had a temporary Emergency Generator mounted on a mobile trailer with the electrical cable running along the ground and connected to the existing Emergency Generators control panel.	K0918	Continued from page 4 Deficiency: The wiring for the temporary generator was not installed properly, and there was no construction permit from East Orange Township for the temporary generator. 1. How the deficiency will be corrected for the resident(s) affected: The wiring issue was corrected by the licensed facility generator vendor on 8/22/25, ensuring the temporary generator is installed in compliance with code. The construction permit for the temporary generator was obtained from the Township of East Orange, NJ on 8/27/25. The temporary generator was replaced by the main generator on 10/24/25. The city East Orange buiding division approved it on 12/5/25 No residents were affected by the deficient practice. 2. How the facility will identify other residents who could be affected and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. A full review of the generator system and associated electrical connections was conducted by the licensed facility generator vendor and the Maintenance Director to verify no other wiring or compliance issues were present. No additional deficiencies were found. 3. What systemic changes will be put in place to ensure the deficient practice does not recur: The US FOIA (b)(6) been educated by the facility administrator on the generator NFPA requirements. The facility will require that any future electrical or generator work be performed only by a licensed vendor, with permits obtained before work begins. The Maintenance Director will be responsible for verifying that permits are secured for any work requiring township or state approval. 4. How the facility will monitor its performance to make sure the solution is sustained: The Maintenance Director will maintain a permit log for	

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K0918 SS = F Bldg. 01	Continued from page 5 In an interview at the time the surveyor asked the US FOIA (b) "Did the facility obtain a permit from the local Construction Official for the temporary Emergency Generator." The US FOIA (said he will ask the US FOIA (b)(6) In an interview on 08/13/2025 at approximately 8:31 AM, the local Construction Official stated the facility had not applied for a permit for the temporary Emergency Generator. On 08/14/2025 at approximately 11:22 AM, the Local Electrical Sub-Code Official arrived on-site and informed the US FOIA (that the facility needs to apply for a permit for the temporary Emergency Generator. In an interview at the time, the US FOIA (confirmed the findings. The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code survey exit on 08/14/2025 at approximately 12:56 PM. NJAC 8:39-31.2 (e), -31.2 (g) NFPA 70	K0918	Continued from page 5 all new construction, electrical, and generator projects. This log will be reviewed quarterly by the Administrator and discussed in the QAPI committee to ensure compliance. Responsible Person: Maintenance Director	

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E0000	Initial Comments Park Crescent Healthcare and Rehabilitation Center was found to be not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) facilities.	E0000		09/24/2025
E0004 SS = E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E0004	Plan of Correction – E0004 Deficiency: The facility's Emergency Preparedness Program did not reflect the current fuel source and lacked evidence of annual review. The Emergency Preparedness Binder inaccurately stated that the emergency generator runs on natural gas, while the current fuel source is diesel. Plan of Correction: What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Preparedness Binder has been immediately updated 10/1/2025 to accurately reflect the generator's current fuel source as diesel. The updated plan has been reviewed with the Administrator, Maintenance Director, and Emergency Preparedness Committee. The updated plan was corrected to have the active administrator on record. No residents were affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All resident can potentially be affected by the deficient practice.	12/04/2025

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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E0004 SS = E	Continued from page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is NOT MET as evidenced by: Based on interview and record review on 08/12/2025, 08/13/2025 and 08/14/2025 in the presence of the facility Administrator #1 (Admin. #1) and the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that the Emergency Preparedness Plan (EPP) was reviewed and updated annually. This deficient practice had the potential to affect the 169 Residents in the facility and was evidenced by the following: In an Interview, during the survey entrance on 08/12/2025 at approximately 9:07 AM, a request was made to the facility US FOIA (b) "How many EPP books are in the facility." The US FOIA (b) told the surveyor that there are six (6) EPP books in the building. There is one (1) EPP book at the Receptionist desk, one (1) EPP book 4th. floor Nursing Station, one (1) EPP book 3rd. floor Nursing Station, one (1) EPP book 2nd. floor Nursing Station, one (1) EPP book with maintenance and Admin #1 has one (1) EPP book. A review of the Admin. #1 EPP book on 08/14/2025 identified the following:Identified under the phone list of Employees had Administrator #2 as the Contact person and phone number.Under the Policy and Procedure for "Loss of Power" read in part, "Park Crescent is equipped with a generator that operates on Natural Gas." During the survey entrance on 08/12/2025, The US FOIA (b) told the surveyor that the facility has an Emergency Generator that operated on diesel fuel. The facility had no evidence of an annual review for 2024 and 2025 in the Admin. #1 EPP book provided to the surveyor. The Admin. #1 and the US FOIA (b) were informed of the deficient practice on 08/14/2025 at approximately 12:56 PM. NJAC 8:39-31.2 (e)	E0004	Continued from page 1 A full audit on all other emergency preparedness binders in the facility were conducted, and there were no deficient issues. What systemic changes will be put in place to ensure the deficient practice does not recur: The US FOIA (b)(6) [redacted] has been educated by the vice president of operations to review emergency preparedness binder annually to ensure it is up to date. The facility's Emergency Preparedness Program will be reviewed in full on an annual basis by the Emergency Preparedness Committee, with documentation of the review signed and dated. 4. How the facility will monitor its performance to make sure the solution is sustained: The Administrator or designee will conduct quarterly audits of the Emergency Preparedness Binder to verify accuracy of critical information (fuel source, emergency contacts, etc.). Results of audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee quarterly for one year for review and follow-up.	

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E0004 SS = E		E0004		

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/8/2025 in relation to the 8/20/2025 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.	K0000		

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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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/8/2025 in relation to the 8/20/2025 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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.

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