STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315194	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD , CEDAR GROVE, New Jersey, 07009

(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 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). Complaint #: NJ00430550 and NJ430551 Survey Dates: 07/21/25 to 07/24/25 Survey Census: 135 Sample Size: 27 Supplemental Residents: 10 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F0000		08/11/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060737	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD , CEDAR GROVE, New Jersey, 07009

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		08/11/2025
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 review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for	S0560	No residents were identified nor immediately affected by the failure to provide minimum staffing levels. All residents have the potential to be affected by this deficient practice. Staffing coordinator will inform DON or designee of any issues that result in insufficient staffing levels. This will be reported as soon as possible. Any staffing deficiencies will be filled prior to the start of the shift with other associates or agency as needed. Facility has signed an Agency contract to assist in meeting the required staffing. Staffing Coordinator and Human Resource works with our recruitment team with routine calls and updates to post our job openings online and create successful monthly job fairs which offer sign on and referral bonuses. Reported findings by Staffing Coordinator or designee any staffing issues during the monthly QAPI meetings for one year. Interdisciplinary team will determine if any further action is required.	08/12/2025

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S0560	Continued from page 1 the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 11/24/2024 to 11/30/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -11/24/24 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. -11/25/24 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. -11/26/24 had13 CNAs for 130 residents on the day shift, required at least 16 CNAs. 2. For the week of Complaint staffing from 03/09/2025 to 03/15/2025, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -03/09/25 had 11 CNAs for 146 residents on the day shift, required at least 18 CNAs. -03/10/25 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. -03/11/25 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs. -03/12/25 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -03/13/25 had 14 CNAs for 141 residents on the day shift, required at least 18 CNAs. -03/14/25 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. 3. For the 2 weeks of staffing prior to survey from 07/06/2025 to 07/20/2025, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows:	S0560		

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S0560	Continued from page 2 -07/06/25 had 14 CNAs for 140 residents on the day shift, required at least 17 CNAs. -07/07/25 had 14 CNAs for 140 residents on the day shift, required at least 17 CNAs. -07/08/25 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -07/09/25 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -07/10/25 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -07/12/25 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. -07/13/25 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. -07/14/25 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. -07/15/25 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. -07/16/25 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. -07/17/25 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. -07/18/25 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs.	S0560		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060737	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 8/15/2025 in relation to the 7/24/2025 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

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: 315194	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD , CEDAR GROVE, New Jersey, 07009

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/22/25 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Complete Care at St. Vincents is a two-story building constructed in 2001. It is composed of Type II (111) construction and is divided into ten smoke compartments. The facility has a completely automatic sprinkler system (wet and dry). The diesel generator powers 100% of the building. The number of occupied beds was 135 out of 151. Smoke detectors are installed in resident sleeping rooms.	K0000		08/15/2025
K0222 SS = F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K0222	During Life Safety rounds it was determined that the facility failed to ensure that the delayed egress locking system did not release in the direction of egress after 15 seconds for designated exit door at stairwell D and Stairwell E. A vendor came to the facility on 10/2/25 Maintenance Staff was educated on the requirement to check delayed egress operation doors. (Attached is a letter from the company that issue was resolved.) All residents have the potential to be affected by the deficient practice. Maintenance Director or designee will conduct weekly audits to ensure that we are in compliance with the delayed egress operations The Maintenance Director or designee will report the findings of these audits at the monthly Quality Assurance and Performance Improvement meetings and any additional action required will be determined by the IDT team.	10/02/2025

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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K0222 SS = F	Continued from page 1 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to meet the delayed-egress locking system requirements of NFPA 101 (2012), Section 7.2.1.6.1. This deficient practice had the potential to affect staff and 39 residents and was evidenced by the following:	K0222		

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K0222 SS = F	Continued from page 2 An observation on 07/22/25 at 10:41 AM of the designated exit door at Stairwell D, revealed that the delayed egress locking system did not release in the direction of egress after 15 seconds. A sign on the door indicated "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" but neither occurred after the US FOIA (b) (6) applied pressure for over 30 seconds to the door. An observation on 07/22/25 at 10:46 AM of the designated exit door at Stairwell E, revealed that the delayed egress locking system did not release in the direction of egress after 15 seconds. A sign on the door indicated "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" but neither occurred after the US FOIA (b) (6) applied pressure for over 30 seconds to the door. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the findings and stated the facility was unaware the delayed egress locking device was not functioning prior to the survey. NJAC 8:39-31.1(c), 31.2(e)	K0222		
K0223 SS = D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	K0223	During the Life Safety rounds the findings of a hold-open device installed on the bottom of the door that was not tied to the fire alarm system, preventing the self-closing device from functioning in a fire emergency. Maintenace Director removed the installed device on the Maintenance Shop door and Central Storage Room door both located in the corridor by the Kitchen. Pictures attached. All other doors in the facility have been further checked and all are operatable and serviced. All residents have the potential to be affected by this deficient practice. Maintenance Director or designee will conduct weekly audits to ensure that we are in compliance with doors with self-closing devices in the facility. The Maintenance Director or designee will report the findings of these audits at the monthly Quality Assurance and Performance Improvement meetings and any additional action required will be determined by the IDT team.	07/25/2025

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K0223 SS = D	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure doors with self-closing devices were automatic closing and only held open with approved hold-open devices in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.8.2. This deficient practice had the potential to affect staff and limited residents and was evidenced by the following: Observations on 07/07/25 at 11:37 AM of the door to the Central Storage Room located in the Corridor by the Kitchen, revealed a hold-open device installed on the bottom of the door that was not tied to the fire alarm system, preventing the self-closing device from functioning in a fire emergency. Combustibles were stored in the room, which measured over 50 square feet in size. Observations on 07/07/25 at 11:39 AM of the door to the Maintenance Shop, located in the Corridor by the Kitchen, revealed a hold-open device installed on the bottom of the door that was not tied to the fire alarm system, preventing the self-closing device from functioning in a fire emergency. Combustibles were stored in the room, which measured over 50 square feet in size. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the findings and stated the facility was unaware that doors with self-closing devices could not be held open with devices that were not tied to the fire alarm system. NJAC 8:39-31.2(e)	K0223		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K0345	During Life Safety rounds it was determined that the facility failed the "Fire Alarm Inspection and Test Report". On the report dated 5/20/25. A vendor came to the facility on 8/12/25, and 4 smoke detectors failed inspection to replace the smoke detectors, and any other failed inspections on 8/21/25. The company came back and replaced on 8/29/25. See attached invoice with corrective action. Maintenance Staff was educated on the requirement to follow up on inspections that show failed equipment. All residents have the potential to be affected by the deficient practice.	08/29/2025

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K0345 SS = F	Continued from page 4 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to ensure the fire alarm system was maintained in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 9.6.1.3. This deficient practice had the potential to affect all 135 residents and was evidenced by the following: A record review on 07/22/25 at 12:00 PM of the facility's "Fire Alarm Inspection and Test Report," dated 05/20/25, revealed photoelectric smoke detectors installed at the following locations failed their annual test and needed to be replaced: Room 106, Room 117, Room 122, Room 127, Room 130, Room 263, Room 279, and Nurses' Station at Spruce Lane. Documentation that the deficiencies had been corrected was requested by the surveyor at 12:13 PM, 1:20 PM, 3:40 PM, and 5:05 PM, but the facility was unable to provide the documentation. Observations on 07/22/25 at 2:45 PM revealed the facility has smoke detectors installed in all resident rooms and at smoke doors. NJAC 8:39-31.1(c), 31.2(e) NFPA 72 Interview with the US FOIA (b)(6) at the time of the observations confirmed the findings and revealed the facility was not aware if the deficiencies had been corrected.	K0345	Continued from page 4 Maintenance Director or designee will conduct annual audits to ensure that we are in compliance with the testing and maintenance of the Fire Alarm System. The Maintenance Director or designee will report the findings of these audits at the monthly Quality Assurance and Performance Improvement meetings and any additional action required will be determined by the IDT team.	
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K0353	During the Life Safety rounds the findings of the weekly inspections of the dry sprinkler system was not provided and the three-year full trip test was not provided. US FOIA (b)(6) was educated on updating the inspections to ensure all inspections are in compliance. All residents have the potential to be affected by this deficient practice. Maintenance Director or designee will conduct weekly audits as of to ensure that we are in compliance with	07/28/2025

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COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD , CEDAR GROVE, New Jersey, 07009

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K0353 SS = F	Continued from page 5 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain the fire sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition), Section 5.2.4.2 and Section 13.4.4.2.2.2. This deficient practice had the potential to affect all 135 residents and was evidenced by the following: A review of the facility's untitled sprinkler system inspection and test records for the past three years and provided by the facility, revealed that documentation of the weekly inspections of the dry sprinkler system was not provided. This documentation was requested by the surveyor on 07/22/25 at 9:00 AM, 1:29 PM, and 3:40 PM but was not provided by the facility during the survey. A review of the facility's untitled sprinkler system inspection and test records for the past three years revealed that documentation of the three-year full trip test was not provided. This documentation was requested by the surveyor on 07/22/25 at 9:00 AM, 1:29 PM, and 3:40 PM but was not provided by the facility during the survey. During an interview on 07/22/25 at 5:15 PM, the US FOIA (b)(6) confirmed the findings and stated the facility was unable to locate the missing documentation. NJAC 8:39-31.1(c), 31.2(e)	K0353	Continued from page 5 the weekly inspections as of 7/28/2025 for the dry sprinkler system by monitoring and recording the pressure readings on the gauges to ensure that normal air and water pressures are being maintained and Insert values on log sheets. Also, Inspect the condition of the gauges to verify there are no leaks or evidence of tampering. Last, the testing was conducted for the three-year full trip test and passed on 7/31/2025. The Maintenance Director or designee will report the findings of these audits at the monthly Quality Assurance and Performance Improvement meetings and any additional action required will be determined by the IDT team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315194	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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K0353 SS = F	Continued from page 6 NFPA 25	K0353		
K0363 SS = F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.6.3. This deficient practice had the potential to affect 75 residents and was evidenced by the following:	K0363	During the Life Safety rounds the observation of two corridor doors for room [redacted] and [redacted] failed to close and latch in the door frame. Maintenance Director fixed doors immediately. All other corridor doors in the facility were inspected and all are in compliance. Videos attached. All residents have the potential to be affected by this deficient practice. Maintenance Director or designee will conduct monthly audits as part of the facility maintenance program to ensure that we are in compliance with the weekly inspections of non-rated doors, including corridor doors to patient's rooms and smoke barrier doors. The Maintenance Director or designee will report the findings of these audits at the monthly Quality Assurance and Performance Improvement meetings and any additional action required will be determined by the IDT team.	07/25/2025

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K0363 SS = F	Continued from page 7 A observation on 07/22/25 at 9:45 AM revealed the corridor door of room [redacted] failed to close and latch in the door frame. An observation on 07/22/25 at 10:30 AM revealed the corridor door of room [redacted] failed to close and latch in the door frame. During an interview at the time of the observations, the [redacted] confirmed the findings and stated the facility was unaware the doors were not closing and latching prior to the survey. NJAC 8:39-31.2(e)	K0363		
K0372 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observations and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 135 residents and was evidenced by the following: An observation on 07/22/25 at 9:35 AM of the smoke barrier located by Room [redacted] revealed a two-inch	K0372	During the Life Safety rounds the observation of the smoke barrier located by Rm. [redacted] (by Med Room), Rm [redacted] Spruce Lane (by Electrical Room) and by Rm. [redacted] revealed unsealed gaps and penetrations in the smoke barriers. Maintenance Director sealed up the gaps immediately. All other potential areas were checked and are in compliance. Pictures attached. All residents have the potential to be affected by this deficient practice. Maintenance Director or designee rounded to ensure there were no other unsealed gaps and penetrations in the smoke barriers. This will be continued on a quarterly basis. The Maintenance Director or designee will report the findings of these audits at the monthly Quality Assurance and Performance Improvement meetings and any additional action required will be determined by the IDT team.	07/28/2025

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K0372 SS = F	Continued from page 8 unsealed overcut around a group of wire penetrations above the ceiling and door to the Medication Room. An observation on 07/22/25 at 9:40 AM of the smoke barrier located by Room 126 revealed a two-inch unsealed overcut around a group of wire penetrations near the ductwork above the ceiling and smoke doors in the corridor. Observations on 07/22/25 at 10:05 AM of the smoke barrier located at Spruce Lane by the Electrical Room revealed a two-inch unsealed overcut around wire penetrations and at the end of a conduit penetration above the ceiling and smoke doors in the corridor. An observation on 07/22/25 at 10:34 AM of the smoke barrier located by room 201 revealed a three-inch unsealed overcut at the top of a pipe penetration above the ceiling and smoke doors in the corridor. During an interview conducted at the time of the observations, the US FOIA (b)(6) [redacted] confirmed the findings and stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers prior to the survey. NJAC 8:39-31.1(c), 31.2(e)	K0372		
K0914 SS = F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or	K0914	The electrical receptacle test was completed on 9/18/25 Maintenance Director was unable to be located the paperwork due to US FOIA (b) (6) [redacted] not placing the information in its correct file. Audit uploaded. A new system was implemented in the facility that will keep track of all inspections and audits that are due. The audits will be conducted on the program and saved electronically. Based on the information a checklist was conducted of all audits to ensure 100% compliance of all paperwork in its correct location. Education was provided by Administrator regarding the timeliness of audits and keeping record of all documents to both Maintenance and Maintenance	09/18/2025

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K0914 SS = F	Continued from page 9 renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to provide documentation of testing and for receptacles at resident bed locations as required by NFPA 99 (2012), Section 6.3.4. The deficient practice had the potential to affect all 135 residents and was evidenced by the following: A review of the facility's untitled life safety code survey documentation binder provided by the facility revealed no documented evidence the facility's electrical receptacles at resident bed locations were tested. This documentation was requested by the surveyor on 07/22/25 at 9:00 AM, 1:20 PM, and 3:40 PM but was not provided by the facility during the survey. During an interview on 07/22/25 at 5:20 PM, the US FOIA (b)(6) confirmed the finding and stated the facility was unable to locate the requested documentation. NJAC 8:39-31.2(e) NFPA 99	K0914	Continued from page 9 Assistant. Monitoring will be once a year the audit will be conducted by the Maintenance Director. A date was placed on the maintenance calendar to remind when the audit is due in April 2026. A QAPI will be conducted to review all audits by the Maintenance Director and each month we will review any findings of what is past due, completed and pending during the QAPI meeting.	
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste 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	K0918	During Life Safety rounds it was determined that the facility failed to ensure that the emergency and standby power generator diesel fuel quality was tested annually. The facility contacted the Generator Company for testing which is scheduled for 8/19/25. Contract attached. Maintenance Staff was educated on the requirement to have the generator diesel fuel tested annually. All residents have the potential to be affected by the deficient practice. Maintenance Director or designee will conduct quarterly audits to ensure that we are in compliance with the annual diesel fuel testing requirements. The Maintenance Director or designee will report the findings of these audits at the monthly Quality Assurance and Performance Improvement meetings and any additional action required will be determined by the	08/19/2025

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K0918 SS = F Bldg. 01	Continued from page 10 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 record review and interview, it was determined that the facility failed to maintain the emergency generator in accordance with NFPA 110 Emergency Power and Standby Power Systems (2010 Edition), Section 8.3.8. This deficient practice had the potential to affect all 135 residents and was evidenced by the following: A review of the facility's "Generator Inspection & Testing Records," provided by the facility revealed no documented evidence the facility tested the generator's fuel quality test in the past year. This documentation was requested on 07/22/25 at 9:00 AM, 3:40 PM, and 5:35 PM, but was not provided by the facility during the survey. During an interview on 07/22/25 at 5:35 PM, the US FOIA (b)(6) confirmed the finding and stated the facility could not locate the missing documentation. NJAC 8:39-31.2(e), 31.2(g) NGPA 99, 110	K0918	Continued from page 10 IDT team.	

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/22/25. The facility was found to be in compliance with 42 CFR 483.73.	E0000		08/15/2025

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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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/15/2025 in relation to the 7/24/2025 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