STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315387	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD , FREEHOLD, New Jersey, 07728

(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 #2582137 Survey Dates 08/05/2025-08/12/2025 Census: 133 Sample Size: 12 A Complaint Survey was conducted at Allaire Rehab and Nursing from 08/05/2025 to 08/12/2025, to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. During the survey, findings which constituted an Immediate Jeopardy (IJ) were identified under 42 CFR 483.12(a)(1) F 600 and F610, as the facility failed to ensure residents were protected from [redacted] and all [redacted] were thoroughly investigated. During an interview with the surveyor on 8/06/2025, [redacted]) revealed that on [redacted] he observed the [redacted] at the facility and overheard the [redacted] tell the facility's [redacted] that Resident #8 was being "[redacted]" by the [redacted] who was caring for the resident. The [redacted] acknowledged that "[redacted]" could be considered [redacted] but at the time of the [redacted] Resident #8 was on the facility's premises out [redacted]. The [redacted] stated that the facility did not conduct an investigation including completing an incident report because Resident #8 was [redacted] and when the [redacted] asked the resident if they were okay, the resident stated they were [redacted] it was "[redacted]." The Administration was notified of the F 600 and F610 IJs and were provided the IJ Templates on 08/07/2025 at 5:59 P.M. Acceptable Removal Plans (RP) were received on 08/11/2025 at 10:27 A.M., indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient	F0000		

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

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

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F0000	Continued from page 1 practice including on NJ Exec Order 26.4b1 Resident #8's NJ Exec was attempted to be assessed and the resident NJ Exec Order 26 On NJ Exec Order 26.4b1, Resident #8 was interviewed, and they stated that they NJ Exec Order 2, and no NJ Exec Ord was occurring, that they wanted US FOIA (b) to continue NJ Exec Orde that it was "NJ Exec Order 26.4b1." Resident #8 was provided a NJ Exec Orde screen, the facility requested a NJ Exec Order 26.4b1 consultation, and Resident #8 was provided NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1, the US FOIA (b) educated the US FOIA (b)(6) to complete NJ Exec Order 26.4b1 on Resident #8 to ensure NJ Exec Order 26 until completion of investigation. The US FOIA (b)(6) were reeducated by the US FOIA (b)(6)) on proper reporting of NJ Exec Ord , the US FOIA (b)(6) was educated on proper procedures when NJ Exec Order 26.4b1 presents NJ Exec Order 26.4b1 and on NJ Exec Order 26.4b1, all staff began education on NJ Exec Ord identification and reporting. The survey team verified the implementation of the RP on-site during the continuation of the survey, and determined the IJs for F 600 and F 610 were removed as of 08/12/2025 at 12:45 P.M. The findings also constituted an IJ identified under CFR 483.70 F 835 as the facility's US FOIA (b)(6) failed to ensure policies and procedures were implemented for NJ Exec Orde protecting all residents from NJ Exec Ord and investigating all NJ Exec Order 26.4b1. The Administration was notified of the F 835 IJ, and was provided with the IJ template on 08/07/2025 at 5:59 P.M. An acceptable Removal Plan (RP) was received on 08/11/2025 at 10:27 A.M., indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the Administration attempted to NJ Exec Orde US FOIA (b) from the NJ Exec Order 2 pending an investigation, but Resident #8 NJ Exec Order 26.4b1. The US FOIA (b) educated the US FOIA (b)(6) to check Resident #8 every NJ Exec Order 26.4b1 to ensure no NJ Exec Ord while the investigation was being concluded. The US FOIA (b) received education from the US FOIA (b)(6 about NJ Exec Ord prevention oversight, reporting, and compliance timelines. The facility's NJ Exec Ord prevention program was reviewed and revised to reflect appropriate reporting timeframes in addition to the requirement of mandatory reporting and proper investigation. The US FOIA (b) was additionally educated by the US FOIA (b)(6 regarding regulatory requirements for F 600 and F 610.	F0000		

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F0000	Continued from page 2 The surveyor verified the implementation of the Removal Plan on-site during the continuation of the survey, and determined the IJ for F 835 was removed as of 08/12/2025 at 12:45 P.M.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Complaint # 2582137 Refer to F610 and F835 Based on observations, interviews, and review of pertinent facility documentation on 08/05/2025, 08/06/2025, and 08/07/2025, it was determined that the facility failed to implement their [redacted] policy to ensure a.) residents were protected from [redacted] after an [redacted] was made on [redacted], by the [redacted] regarding Resident #8 and their [redacted] This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #8). During an interview with the [redacted] on 08/06/2025, revealed that on [redacted], he observed the [redacted] at the facility, and overheard the [redacted] tell the facility's [redacted] that Resident #8 was being [redacted] by [redacted] who was caring for the resident. The [redacted] acknowledged that [redacted] could be considered [redacted] but at the time of the [redacted] Resident #8 was on the facility's premises out on [redacted]	F0600	1. Corrective Action for Resident(s) Affected: Part A: Resident #8 was interviewed on [redacted] and again on [redacted] regarding the [redacted]. Resident stated [redacted] and [redacted] was occurring. Resident was offered a [redacted] assessment on [redacted] but [redacted] on both occasions. Resident was provided with a [redacted] a [redacted] consult was requested, and [redacted] was offered. Administrator educated the [redacted] to complete [redacted] until investigation was concluded. Checks were documented and reviewed by the Administrator/designee. Part B: Upon discovery of the incident on [redacted], involving Resident #1 and Resident #2, the facility immediately [redacted] both residents and initiated assessments by licensed nursing staff. Upon return from hospital, Resident #2 was placed on [redacted] to ensure safety. Resident #2's [redacted] needs were clarified, and [redacted] responsibilities were reinforced with assigned staff. 2. Identification of Other Residents: Part A: All residents who receive visitors can be affected by this deficient practice. Part B: Residents who are care planned for aggression towards other residents can be affected by this deficient practice. 3. Systemic Changes to Prevent Recurrence: Part A: The facility's Abuse Prevention Policy was revised on 08/07/2025 by the Director of Nursing and the Administrator to ensure that all third-party abuse allegations are treated as reportable, investigated, and documented, even when the resident denies the abuse. Abuse identification and reporting training was started for all staff on 08/07/2025, led by the Director of Nursing or designee. Per Diem and agency staff received the same training upon next shift; those on vacation will complete the training before returning to duty. Part B: The Abuse Prevention Program policy and the Resident Supervision policy, as well as job	09/25/2025

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F0600 SS = SQC-J	Continued from page 3 The US FOIA (b) stated that the facility did not conduct an investigation including completing an incident report because Resident #8 was NJ Exec Order 26.4b1 and when the US FOIA (b) asked the resident if they were NJ Exec O the resident stated they were NJ Exec O it was "NJ Exec Order 26.4b1." The facility's failure to implement their NJ Exec Orde policy including investigating all NJ Exec Order 26.4b1 and protecting all residents from NJ Exec Orde during the investigation, placed Resident #8, as well as all residents at risk for NJ Exec Orde This posed the likelihood of serious physical and emotional harm or injury which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Exec Order 26.4b1, after the police notified the facility. The facility's US FOIA (b)(6) was notified of the IJ on 08/07/2025 at 5:59 P.M. The facility submitted an acceptable Removal Plan (RP) on 08/11/2025 at 10:24 A.M. The surveyor verified the implementation of the RP on-site on 08/12/2025 at 12:45 P.M. The facility further failed to b.) protect a resident (Resident #1) from NJ Exec Order 26.4b1 when Resident #2 NJ Exec Order 2 Resident #1's NJ Exec O and attempted to NJ Exec Order 26.4b1 and Resident #1 NJ Ex Resident #2's NJ Exec Orde which resulted in NJ Exec Order 26. In response, Resident #2 NJ Ex Resident #1 who NJ Exec Order 26.4b1 to the NJ Exec O This deficient practice was identified for 1 of 3 residents reviewed for NJ Exec Orde (Resident #1). The evidence was as follows: Part A A review of the facility policy with a revision date of 01/2025, titled "Abuse Prevention Program" whose policy statement includes "…promotes an environment that does all to prevent resident abuse, neglect, misappropriation of property through the following components: screening and training of employees, prevention, identification, investigation, protection and reporting," Under section V Investigation: "an investigation is initiated for all allegations of suspected abuse, neglect or misappropriation." Further in #4 of Investigation it states that "the Abuse Investigator will complete a thorough investigation inclusive of interviewing the resident, alleged abuser and any witnesses." In section VII Reporting: it states that "The Abuse Investigator will be responsible to make all reports regarding abuse investigations" and indicates the agencies to report to.	F0600	Continued from page 3 descriptions for 1:1 and companions, were reviewed and revised to provide clear definitions and procedures regarding supervision, including the distinction between 1:1 monitoring and companion assignments. Nursing staff received in-service training by the Nurse Educator or designee covering abuse prevention, mandatory reporting requirements, the differences between 1:1 and companion roles, behavior management strategies, and supervision interventions. Staff assignment sheets were redesigned to clearly identify residents requiring enhanced supervision, including 1:1 monitoring or companion oversight. 4. Monitoring: Part A: The Director of Nursing (DON) or Unit Manager will review all abuse allegations daily to ensure compliance with policy and that immediate protection and documentation steps were completed. Audits will be performed 100% daily for four weeks, then weekly for three months, then monthly for three months. Findings will be reported at the Quality Assurance Committee meetings. The Administrator and DON are responsible for ensuring monitoring continues until compliance is sustained. Part B: Weekly audits will be conducted for four weeks, followed by monthly audits for two months, to review all residents assigned 1:1 monitoring or companion supervision. Audits will assess staff understanding of assignments. Daily supervisory rounds by nursing management, including evening and weekend shifts, will be conducted to visually confirm that monitoring assignments are followed and that residents are safe. Audit results and any corrective actions will be discussed in the facility's monthly QAPI (Quality Assurance and Performance Improvement) meetings. QAPI committee recommendations will be followed. 5. Completion Date: August 13, 2025.	

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F0600 SS = SQC-J	Continued from page 4 According to the Admission Record (AR), Resident #8 was admitted to the facility with the diagnoses which include but were not limited to; NJ Exec Order 26.4b1 [redacted] According to the Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, Resident #8 had a Brief Interview for Mental Status (BIMS) score of NJ E/15, indicating that the resident was NJ Exec Order 26.4b1. A review of Resident #8's Care Plan (CP) include a focus area dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 and NJ Exec Order and that the resident refused to meet with NJ Exec Order 26.4b Interventions included to monitor for NJ Exec Order 26.4b1 and to discuss concerns with [resident name's] family. On 08/06/2025 at 1:45 P.M., during an interview with the Unit Manager (UM #1), she stated that morning (NJ Exec Order 26.4b1), she became aware of an NJ Exec Order 26.4 of NJ Exec Ord involving Resident #8 and their US FOIA (b) (6) UUS FO UM #1 stated that the US FOIA (b)(6)) received a call from a [community name redacted] organization regarding an NJ Exec Order 26.4b1, and the US FO spoke to Resident #8 about it. UM #1 stated that she assumed the US FO investigated the NJ Exec Order 26.4 UM #1 stated that US FOIA (b) helped with Resident #8's care since the resident could be "NJ Exec Order" with staff. On 08/06/2025, at 1:59 P.M., the surveyor observed Resident #8's bedroom door closed. The surveyor knocked on the door and US FOIA (b) opened the door. The surveyor noted that Resident #8 was lying in bed eating lunch. There was no facility staff in the room with the resident at that time. On 08/06/2025 at 2:20 P.M., during an interview with the Licensed Practical Nurse (LPN #1), she confirmed that she was aware of the NJ Exec Order 26.4b1. LPN #1 stated that she had not seen US FOIA (b) NJ Exec Ord the resident. On 08/06/2025 at 2:34 P.M., during an interview with the US FO she confirmed that a [community name redacted] organization notified her that Resident #8's US FOIA (b) called them and reported that the US FOIA (b) was "NJ Exec Order 26 the resident. The US FO stated that she spoke with the resident who NJ Exec Orde the NJ Exec Order 26.4 that US FOIA (b) was NJ Exec Order 2 them. The surveyor continued to review Resident #8's medical record.	F0600		

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F0600 SS = SQC-J	Continued from page 5 A review of Resident #8's Progress Notes (PN) did not include documentation of the NJ Exec Order 26.4b1. The PN also did not include documentation from the US FO that she received a phone call from a [community name redacted] organization NJ Exec Order Resident #8 was NJ Exec Order A review of the medical record also did not include any documentation that a NJ Exec assessment was conducted after the NJ Exec Order 26.4b1 was made. On 08/06/2025, at 4:33 P.M., during an interview with the US FOIA (b)(6) he stated that he was aware of the NJ Exec Or being at the facility yesterday, and he overheard them telling the US FOIA (b)(6) at that time that Resident #8 was being "NJ Exec Order 26.4b1 by US FOIA (b) who was caring for them. When asked if "NJ Exec Order 26.4b1 could be considered NJ Exec Orde the US FOIA (b) agreed. The US FOIA (b) further stated that it was "presented as a third-party claim of NJ Exec Orde and added; I went outside and spoke to them right away." When the surveyor asked about what should be done when there was an NJ Exec Order 26.4b1 of a resident, the US FOIA (b) responded, "First, make sure they are not NJ Exec O The US FOIA (b) further stated that "if the NJ Exec Orde is a NJ Exec Or it's technically the same as staff and they need to be NJ Exec Order 26.4b1 The US FOIA (b) also that at the time, the resident was on the property premises, "NJ Exec Orde " and that the NJ Exec Order 26.4b1 US FOIA (b) (6 was on the other side of the facility parking lot. The US FOIA (b) stated that he wrote a statement about the claim and did not write an incident report since the resident had a BIMS of NJ Ex and that the resident NJ Exec Orde US FOIA (b) was NJ Exec Order them. When asked if an incident report should have been filed, the US FOIA (b) replied, "I would have to check our NJ Exec Or policy." On 08/07/2025, at 9:30 A.M., the surveyor observed US FO in the facility' s elevator headed up towards the resident's room. On 08/07/2025 at 10:40 A.M., during a follow-up interview with UM #1, she stated that she was not asked to provide a statement regarding the NJ Exec Order 26.4 or instructed to collect any statements from any potential witnesses. UM #1 acknowledged that there was no NJ Exec assessment conducted for Resident #8, and that she would try to complete one. UM #1 also stated that US FOIA (b) was in the facility that morning when she arrived at work on NJ Exec Order 26.4b1 On 08/07/2025, at 11:29 A.M., during a follow-up interview with the US FOIA (b)(6) he re-stated that the NJ Exec Or were at the US FOIA (b)(6) area when he walked into the lobby. Per the US FOIA (b)(6) the NJ Exec Or acknowledged his presence but continued to talk with the US FOIA (b)(6)	F0600		

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F0600 SS = SQC-J	Continued from page 6 The US FOIA (b) confirmed that he did not inquire from the NJ Exec Or specific details regarding the NJ Exec Order 26.4 because he assumed that the NJ Exec Or were NJ Exec Orde to NJ Exec Order 26.4b1 the NJ Exec Order 26.4b The US FOIA (b) also stated that US FOIA (b) (NJ Exec Order 26.4b1) was not NJ Exec Order 26.4b from Resident #8 because he "ruled out NJ Exec Or as resident is NJ Exec O and NJ Exec Order The US FOIA (b) stated "I feel like if we were doing an assessment, all these measures would need to be taken into account. I was able to rule out NJ Exec Or instantaneously." At that time, the US FOIA (b) stated "The thought process was these measures are typically taken to rule out NJ Exec Orde they had a BIMS of NJ Ex I thought once ruled out the other steps weren't necessary." When the surveyor asked if that was the facility's policy, the US FOIA (b) responded, "Per the policy all these steps are part of an investigation and should have been done." The US FOIA (b) further confirmed that nursing staff did not perform a NJ Exec Order 26.4b1 on the resident to check for NJ Exec Order 2 The US FOIA (b) also confirmed that there were no staff interviews conducted. The US FOIA (b) stated that he felt that he initiated an investigation by talking with Resident #8 because the resident was NJ Exec O and NJ Exec Order 26 and stated they felt NJ Exec O When questioned about protection for Resident #8 from the NJ Exec Order 26.4b1, the US FOIA (b) stated that the NJ Exec Order 26.4b US FOIA (b) (6 was not NJ Exec Order 26.4b from the resident because he felt that he ruled out NJ Exec Or since the resident was NJ Exec O and NJ Exec Or and "had a BIMS of NJ Exec The US FOIA (b) acknowledged that an assessment should have been done. On 08/07/2025 at 2:24 P.M., during a follow-up interview with the US FOI she stated, "US FOIA (b)(6) or myself is responsible for initiating an investigation when there is an NJ Exec Order 26.4b1." On 08/07/2025 at 2:27 P.M., during an interview with the Certified Nursing Assistant (CNA #1), she stated that when US FOIA (b) (NJ Exec Order 26.4b1) was at the facility, "they" do not want to be bothered. CNA #1 stated that the resident and US FOIA (b) kept the door shut and she had to wait for them to ring. On 08/07/2025, at 3:37 P.M., during an interview with the US FOIA (b)(6)), she stated that when notified of an NJ Exec Order 26.4b1, the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 must be immediately NJ Exec Order 26.4b the investigation begins and then call the NJ Exec Orde An acceptable Removal Plan (RP) was received on 08/11/2025 at 10:27 A.M., indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a	F0600		

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F0600 SS = SQC-J	Continued from page 7 corrective action plan to remediate the deficient practice including: on NJ Exec Order 26.4b1 , Resident #8's NJ Exec was attempted to be assessed and the resident NJ Exec Order 26 On NJ Exec Order 26.4b1 , Resident #8 was interviewed, and they stated that they felt NJ Exec and no NJ Exec Or was occurring, that they wanted US FOIA (b) to NJ Exec Order 26.4b1 that it was "NJ Exec Order 26.4b1 ." Resident #8 was provided a NJ Exec Order 26.4b1 , the facility requested a NJ Exec Order 26.4b1 consultation, and Resident #8 was provided NJ Exec Order 26.4b1 . On NJ Exec Order 26.4b1 the US FOIA (b) educated the US FOIA (b)(6) to complete NJ Exec Order 26.4b1 on Resident #8 to ensure NJ Exec Order 26 until completion of investigation. The US FOIA (b)(6) were reeducated by the US FOIA (b)(6) on proper reporting of NJ Exec Order 26.4b1 , the US FOIA (b)(6) was educated on proper procedures when NJ Exec Order 26.4b1 presents NJ Exec Order 26.4b1 and on NJ Exec Order 26.4b1 , all staff began education on NJ Exec Or identification and reporting. The survey team verified the implementation of the RP on-site on 08/12/2025 at 12:45 P.M. Part B A review of the facility policy dated revised 01/2025, titled "Abuse Prevention Program" whose policy statement is "…promotes an environment that does all to prevent resident abuse, neglect, misappropriation of property through the following components: screening and training of employees, prevention, identification, investigation, protection and reporting." The purpose of the policy states "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion by an individual …" A review of the Facility Reported Event (FRE) submitted to the New Jersey Department of Health (NJDOH) dated NJ Exec Order 26.4b1 , indicated that Resident #1 informed facility staff that Resident #2 had 'NJ Exec Order 26.4b1' with them. The FRE indicated that the NJ Exec Or were called to the facility, and that both residents were sent to the local hospital for treatment. Both residents returned to the facility the same day, and Resident #2 was placed on NJ Exec Order 26.4b1 . A review of the facility's Incident Report (IR) revealed that on the date of the incident, Resident #1's Certified Nursing Assistant (CNA #2) entered the resident's room and observed Resident #2 NJ Exec Order 26.4b1 . When CNA #2 asked Resident #1 what happened, the resident stated that Resident #2 NJ Exec Order 26.4b1 .	F0600		

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F0600 SS = SQC-J	Continued from page 8 It also indicated that Resident #1 was observed with a NJ Exec Order 26.4b1 and Resident #2 was NJ Exec Order 26 from the NJ Exec Orde and that both residents were sent to the local hospital for treatment. Further review of the IR indicated that facility placed Resident #2 on NJ Exec Order 26.4b1. According to the statement from CNA #3, who was assigned as a NJ Exec Order 26.4b1 for Resident #2, CNA #3 stated that he was distracted by an aide "Who came to speak to me for a moment. I looked back; I didn't see them. A few minutes later an aide came and told me that NJ Exec Order 26.4b1." According to the Admission Record (AR), Resident #1 was admitted to the facility with the diagnoses which include but were not limited to: NJ Exec Order 26.4b1 According to the Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, Resident #1 had a Brief Interview for Mental Status (BIMS) score of /15, indicating that the resident NJ Exec Order 26.4b1. According to the AR, Resident #2 was admitted to the facility with the diagnoses which included but were not limited to: NJ Exec Order 26.4b1 According to the MDS dated NJ Exec Order 26.4b1, Resident #2 had a BIMS score of /15, indicating that the resident was NJ Exec Order 26.4b1. A review of the Resident #2's Physician Order Sheet (POS) included an order for a NJ Exec Order 26.4b1) dated NJ Exec Order 26.4b1, to the back of the wheelchair and to check placement every shift. A Care Plan (CP) report for Resident #2 included a "Focus" of the potential to be NJ Exec Order 26.4b1 and NJ Exec Order 26.4 at times related to NJ Exec Order 26.4b1 According to the CP, Resident #2 had an NJ Exec Order 26.4b with another resident after becoming NJ Exec Order 2 on NJ Exec Order 26.4b. The Intervention/task dated NJ Exec Order 26.4 was that the resident given a NJ Exec Order 26.4b1 and NJ Exec Orde to the NJ Exec Order 26.4b1. On 08/05/2025 at 9:42 A.M., the surveyor observed Resident #1 in their room NJ Exec Order 2 and NJ Exec Order 26 The surveyor observed a NJ Exec Orde to the NJ Exec Order 26.4b of the	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315387	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

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F0600 SS = SQC-J	Continued from page 9 resident's [NJ Exec Order] that NJ Exec Order 26.4b1 . There was also a [NJ Exec Order 26.4b1] observed to the resident's [NJ Exec] [NJ Exec] The resident was NJ Exec Order 26.4b1 and did not want to [NJ Exec Order 26.4b1] . When interviewed, the resident told the surveyor that Resident #2 tried to [NJ Exec Order 26.4b] and that they [NJ Exec] Resident #2, and that Resident #2 then NJ Exec Order 26.4b1 Resident #2 was not in the facility at the time of survey. On 08/05/2025 at 12:19 P.M., the surveyor interviewed UM #1, who stated that she was made aware of the NJ Exec Order 26.4b1 that night. When the surveyor asked how Resident #2 was [NJ Exec] to [NJ Exec] to [NJ Exec Order 26.4b1] (since Resident #2 NJ Exec Order 26.4b1), UM #1 stated that Resident #2 often went to their unit for activities. UM #1 continued that due to Resident #2 having an [NJ Exec Order 26.4] [NJ Exec Order] she requested the [NJ Exec Order 26.4b1] to accompany the resident. During an interview with the [US FOIA (b)] on 08/05/2025 at 2:55 P.M., the [US FOIA (b)] stated that each floor had "[NJ Exec Order 26.4b1] 1-2 per floor." The [US FOIA (b)] stated that the purpose of the companion was to accompany any resident who might [NJ Exec Order] or had a [NJ Exec Orde]. The [US FOIA (b)] stated that a companion did not usually have a care assignment, but they could be asked to perform other tasks when the resident was not going off the floor. The [US FOIA (b)] further stated that he "wouldn't consider this [NJ Exec] It wasn't related to [NJ Exec Order 26] was related to [NJ Exec] and when residents leave the unit for visual contact of the resident." During an interview on 08/06/2025 at 10:20 A.M., with UM #2 for the floor where Resident #2 resided, she stated that someone was supposed to be with Resident #2, but not as [NJ Exec] Their job was "just [NJ Exec Or] the resident." During an interview with the [US FOIA] on 08/06/2025 at 11:15 A.M., she stated that the role of the [NJ Exec Order 26.4b1] was to go with the resident and keep them safe, to "[NJ Exec Order 26.4b]" The [US FOIA] further stated that while some of the staff consider it [NJ Exec] it was really a [NJ Exec Order 26.4b1] The [US FOIA] stated that Resident #2 NJ Exec Order 26.4b1 for [NJ Exec Order 26.4] and to use the NJ Exec Order 26.4b1 and to attend activities on another floor. The [US FOIA] stated that she did not feel a "[NJ Exec Order 26.4b1]" should be care planned." The [US FOIA] stated that it was not the type of [NJ Exec] that required a physician's order. The [US FOIA] did not provide further information for how both Residents #1 and Resident #2 were not protected from [NJ Exec Order 26.4b1] on the day of the incident.	F0600		

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F0600 SS = SQC-J	Continued from page 10 NJAC 8:39-4.1(a)(5)	F0600		
F0610 SS = SQC-J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Complaint # 2582137 Based on interviews and review of other pertinent facility documentation on 08/05/2025, 08/06/2025, and 08/07/2025, it was determined that the facility failed to implement their [redacted] policy by thoroughly investigating an NJ Exec Order 26.4b1 to a resident (Resident #8) that the [redacted] reported the [redacted] on [redacted] This deficient practice was identified for 1 of 3 residents reviewed for [redacted] (Resident #8). During an interview with the US FOIA (b)(6) [redacted] on 08/06/2025, revealed that on [redacted], he observed the [redacted] at the facility, and heard the [redacted] tell the facility's US FOIA (b)(6) that Resident #8 was being [redacted] by the US FOIA (b) (6) [redacted] who was caring for the resident. The [redacted] acknowledged that [redacted] could be considered [redacted] but at the time of the [redacted] Resident #8 was on the facility's premises out on pass. The [redacted] stated that the facility did not conduct an investigation including	F0610	1. Corrective Action for Resident(s) Affected: Upon learning of the [redacted] on [redacted] Administrator immediately interviewed Resident #8 and [redacted] from the NJ Exec Order 26.4b1 during [redacted] Resident was interviewed again on [redacted] and stated [redacted] US FOIA (b) (6) interviewed Resident #8 and documented no signs of [redacted] assessment was offered [redacted] Statements were collected from staff and the [redacted] Investigation was completed, and [redacted] was NJ Exec Order 26.4b1 [redacted] were implemented until investigation was concluded. 2. Identification of Other Residents: All residents who receive visitors can be affected by this deficient practice. 3. Systemic Changes to Prevent Recurrence: The facility's Abuse Prevention Program was revised by the Director of Nursing and the Administrator to clarify that any allegation, regardless of the source or resident's perception, triggers an immediate investigation. A new Abuse Investigation Checklist was implemented requiring documentation of resident protection steps, interviews, skin assessments, and timely notifications. All staff were re-educated on investigation procedures by the Staff Educator. The facility reviewed all incident reports and grievances for the previous 90 days. No other uninvestigated allegations were identified. Findings were documented and reviewed by the Administrator. 4. Monitoring: Director of Nursing or designee will review all reported allegations daily to ensure that updated Abuse Prevention Program is being followed, and include proper protective measures. The Director of Nursing or designee will audit 100% of abuse allegations daily for proper documentation, separation of alleged aggressor, and initiation of investigation for 4 weeks, then weekly for 3 months and monthly for 3 additional months. Findings will be reported to the Quality Assurance Committee. 5. Completion Date:	09/25/2025

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F0610 SS = SQC-J	Continued from page 11 completing an incident report because Resident #8 was NJ Exec Order 26.4b1 and when he asked the resident if they were NJ Exec O the resident stated that they were NJ Exec O it was "NJ Exec Order 26.4b1." The facility's failure to implement their abuse policy by investigating all NJ Exec Order 26.4b1 placed Resident #8, as well as all resident at risk for NJ Exec Orde This posed the likelihood of serious physical and emotional harm or injury which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Exec Order 26.4b1, after the NJ Exec Or notified the facility of the NJ Exec Order 26.4b The facility's US FOIA (b)(6) was notified of the IJ on 08/07/2025 at 5:59 P.M. The facility submitted an acceptable Removal Plan (RP) on 08/11/2025 at 10:24 A.M. The surveyor verified the implementation of the RP on 08/12/2025 at 12:45 P.M. The evidence was as follows: Refer F 600, F 835 A review of the facility policy dated revised 01/2025, titled "Abuse Prevention Program" whose policy statement is "…promotes an environment that does all to prevent resident abuse, neglect, misappropriation of property through the following components: screening and training of employees, prevention, identification, investigation, protection and reporting," Under section V Investigation: "an investigation is initiated for all allegations of suspected abuse, neglect or misappropriation." Further in #4 of Investigation it states that "the Abuse Investigator will complete a thorough investigation inclusive of interviewing the resident, alleged abuser and any witnesses." In section VII Reporting: it states that "The Abuse Investigator will be responsible to make all reports regarding abuse investigations" and indicates the agencies to report to. According to the Admission Record (AR), Resident #8 was admitted to the facility with the diagnoses which include but were not limited to; NJ Exec Order 26.4b1 [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, Resident #8 had a Brief Interview for Mental Status (BIMS) score of NJ E /15, indicating that the resident was NJ Exec Order 26.4b1.	F0610	Continued from page 11 August 13, 2025.	

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F0610 SS = SQC-J	Continued from page 12 A review of Resident #8's Care Plan (CP) include a focus area dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 and NJ Exec Orde and that the resident NJ Exec Order to meet with NJ Exec Order 26.4b Interventions include to monitor for NJ Exec Order 26.4b1 and to discuss concerns with [resident name's] family. On 08/06/2025 at 1:45 P.M., during an interview with the Unit Manager (UM #1), she stated that morning NJ Exec Order 26.4b1, she became aware of an NJ Exec Order 26.4 of abuse involving Resident #8 and their US FOIA (b) (6) (US FO UM #1 stated that the US FOIA (b)(6)) received a call from a [community name redacted] organization regarding an NJ Exec Order 26.4b1, and the US FOIA spoke to Resident #8 about it. UM #1 stated that she assumed the US FO investigated the NJ Exec Order 26.4b UM #1 stated that US FOIA (b) helped with Resident #8's care since the resident could be NJ Exec Order 2 with staff. On 08/06/2025, at 1:59 P.M., the surveyor observed Resident #8's bedroom door closed. The surveyor knocked on the door and US FOIA (b) opened the door. The surveyor noted that Resident #8 was lying in bed eating lunch. There was no facility staff in the room with the resident at that time. On 08/06/2025 at 2:20 P.M., during an interview with the Licensed Practical Nurse (LPN #1), she confirmed that she was aware of the NJ Exec Order 26.4b1. LPN #1 stated that she had not seen US FOIA (b) NJ Exec Ord the resident. On 08/06/2025 at 2:34 P.M., during an interview with the US FOIA she confirmed that a [community name redacted] organization notified her that Resident #8's US FOIA (b) called them and reported that the US FOIA (b) was NJ Exec Order 26 the resident. The US FOIA stated that she spoke with the resident who NJ Exec Orde the NJ Exec Order 26.4b1 The survey continued to review Resident #8's medical record. A review of Resident #8's Progress Notes (PN) did not include documentation of the NJ Exec Order 26.4b1. The PN also did not include documentation from the US FO that she received a phone call from a [community name redacted] organization NJ Exec Order 2 Resident #8 was NJ Exec Order 2 A review of the medical record also did not include any documentation that a NJ Exec assessment was conducted after the NJ Exec Order 26.4b1 was made. On 08/06/2025, at 4:33 P.M., during an interview with the US FOIA (b)(6) he stated that he was aware of the NJ Exec Ord being at the facility yesterday, and he overheard them	F0610		

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F0610 SS = SQC-J	Continued from page 13 telling the US FOIA (b)(6) at that time that Resident #8 was being "NJ Exec Order 26.4b1" by US FOIA (b) who was caring for them. When asked if "NJ Exec Order 26.4b1" could be considered NJ Exec Orde the US FOIA (b) agreed. The US FOIA (b) further stated that it was "presented as a third-party claim of NJ Exec Orde and added; I went outside and spoke to them right away." When the surveyor asked about what should be done when there was an NJ Exec Order 26.4b1 of a resident, the US FOIA (b) responded "First, make sure they are not NJ Exec O The US FOIA (b) further stated that "if the NJ Exec Orde is a NJ Exec Orde it's technically the same as staff and they need to be NJ Exec Order 26.4b1 The US FOIA (b) also that at the time, the resident was on the property premises, "NJ Exec Orde " and that the NJ Exec Order 26.4b1 US FOIA (b) (6 was on the other side of the facility parking lot. The US FOIA (b) stated that he wrote a statement about the claim and did not write an incident report since the resident had a BIMS of NJ Exe and that the resident NJ Exec Orde the NJ Exec Orde When asked if an incident report should have been filed, the US FOIA (b) replied, "I would have to check our NJ Exec Orde policy." On 08/07/2025 at 10:40 A.M. during a follow-up interview with UM #1, she stated that she was not asked to provide a statement regarding the NJ Exec Order 26.4 or instructed to collect any statements from any potential witnesses. UM #1 acknowledged that there was no NJ Exec assessment conducted for Resident #8, and that she would try to complete one. UM #1 also stated that US FOIA (b) was in the facility that morning when she arrived at work on NJ Exec Order 26.4b1 On 08/07/2025, at 11:29 A.M., during a follow-up interview with the US FOIA (b)(6 he re-stated that the NJ Exec Orde were at the US FOIA (b)(6) area when he walked into the lobby. Per the US FOIA (b)(6 the NJ Exec Orde acknowledged his presence but continued to talk with the US FOIA (b)(6) The US FOIA (b) confirmed that he did not inquire from the NJ Exec Orde specific details regarding the NJ Exec Order 26.4 because he assumed that the NJ Exec Orde were unable to substantiate the NJ Exec Order 26.4b The US FOIA (b) also stated that US FOIA (b) (NJ Exec Order 26.4b1) was not NJ Exec Order 26.4b from Resident #8 because he "NJ Exec Order 26.4b1" as resident is NJ Exec and NJ Exec Orde The US FOIA (b) stated "I feel like if we were doing an assessment, all these measures would need to be taken into account. I was able to rule out NJ Exec Orde instantaneously." At that time, the US FOIA (b) stated "The thought process was these measures are typically taken to rule out NJ Exec Orde they had a BIMS of NJ Ex I thought once ruled out the other steps weren't necessary." When the surveyor asked if that was the facility's policy, the US FOIA (b) responded, "Per the policy all these steps are part of an	F0610		

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F0610 SS = SQC-J	Continued from page 14 investigation and should have been done." The US FOIA (b) further confirmed that nursing staff did not perform a NJ Exec Order 26.4b1 on the resident to check for NJ Exec Order 2 The US FOIA (b) also confirmed that there were no staff interviews conducted. The US FOIA (b) stated that he felt that he initiated an investigation by talking with Resident #8 because the resident was NJ Exec O and NJ Exec Order 26 and stated they felt NJ Exec O When questioned about protection for Resident #8 from the NJ Exec Order 26.4b1, the US FOIA (b) stated that the NJ Exec Order 26.4b US FOIA (b) (6 was not separated from the resident because he felt that he ruled out NJ Exec Ord since the resident was NJ Exec O and NJ Exec Ord and "had a BIMS of NJ Exe The US FOIA (b) acknowledged that an assessment should have been done. On 08/07/2025 at 2:24 P.M., during a follow-up interview with the US FOI she stated, "US FOIA (b)(6) or myself is responsible for initiating an investigation when there is an NJ Exec Order 26.4b1." The US FOI stated that an investigation required obtaining statements from staff, and the nurses wrote the Incident Report because the of the NJ Exec Order 26.4b1 and the nurse was responsible for notifying the physician. The US FOI stated that the facility was "technically still investigating" and there was no summary or conclusion at that time. On 08/07/2025, at 3:37 P.M., during an interview with the US FOIA (b)(6)), she stated that when notified of an "NJ Exec Order 26.4b1, the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 must be immediately NJ Exec Order 26.4b the investigation begins and then call the NJ Exec Orde The US FOIA (verified that an investigation should have been started when the NJ Exec Ord made the facility aware of the NJ Exec Order 26.4b1. The US FOIA stated that in her absence, the staff should have known what to do. An acceptable Removal Plan (RP) was received on 08/11/2025 at 10:27 A.M., indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: on NJ Exec Order 26.4b1, the US FOIA (b) after hearing the allegation from the NJ Exec Order 26.4b1, interviewed Resident #8 who stated they felt NJ Exec and there was no NJ Exec Ord occurring. Resident #8 stated they wanted to continue having US FOIA (b) visit them and it was "NJ Exec Order 26.4b1 and Resident #8 was provided NJ Exec Order 26.4 On NJ Exec Order 26.4b1, the US FO interviewed Resident #8, and a NJ Exec assessment was attempted but the resident NJ Exec Order 2 On NJ Exec Order 26.4b1, statements were collected from the staff. The staff collected a statement from US FOIA (b) (who NJ Exec Order 26.4b1 or NJ Exec Order 2 the resident. The US FOIA (b)(6) were immediately re-educated on the investigative process of NJ Exec Order	F0610		

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F0610 SS = SQC-J	Continued from page 15 NJ Exec Orde On 08/07/2025, the US FOIA (b)(6) revised the facility's NJ Exec Orc policy to clarify that any NJ Exec Order 26.4b regardless of source or resident's perception, triggers an immediate investigation. On 08/07/2025, training on the "Investigation of NJ Exec Orde was started for all staff by the US FOIA (b The survey team verified the implementation of the Removal Plan on-site on 08/12/2025 at 12:45 P.M. NJAC8:39-4.1(a)(5)	F0610		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Complaint # 2582137 Census: 137 Sample:12 Based on observations, interviews, medical record review and review of other pertinent facility documentation on 08/05/2025, 08/06/2025 and 08/07/2025 it was determined that the facility failed to administer medications according to the acceptable practice for 1 of 4 residents (Resident #8). The facility failed to follow their policy titled "Administering Medications." The deficient practice was evidenced by the following: Reference: New Jersey Statues Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions "b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means the	F0658	1. Corrective Action for Resident(s) Affected: The Unit Manager removed the medication cup from the resident's bedside as soon as it was brought to her attention by the surveyor. Resident #8 was assessed by licensed nursing staff to confirm NJ Exec Order 26.4b1 had occurred as a result of the delayed administration or improper storage of the medications. The pills left at the bedside were properly discarded, and a new dose was prepared and administered. The assigned nurse, LPN #1, was immediately re-educated on the facility's medication administration policy and was counseled regarding the critical importance of administering medications in accordance with professional standards and not leaving medications at the bedside. Resident #8's chart was updated to reflect preference of receiving medication administration with NJ Exec Order 26 2. Identification of Other Residents: All residents can be affected by this deficient practice. 3. Systemic Changes to Prevent Recurrence: Unit managers went to every room to check for medications at the bedside and none were found. All licensed nurses received mandatory re-education on safe medication administration, with emphasis on medication administration including medication storage and not leaving medication at the bedside. LPN #1 involved in the incident received individual performance counseling. 4. Monitoring: Unit managers complete random room checks for medications and bedside and report findings to DON twice a week for four weeks and then monthly times two months. Findings from audits are reported and analyzed during the facility's monthly QAPI (Quality Assurance and Performance Improvement) committee meetings.	09/25/2025

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F0658 SS = D	Continued from page 16 identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen within the scope of practice of the registered professional nurse. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human responses mean those signs, symptoms, and processes which denote the individual's health need or reaction to an actual or potential health problem. The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. According to the Admission Record (AR), Resident #8 was admitted to the facility with the diagnoses which include but is not limited to: NJ Exec Order 26.4b1 [redacted] Review of the Minimum data Set (MDS) an assessment tool dated NJ Exec Order 26.4b1, indicated that Resident #8 had a Brief Interview for Mental Status (BIMS) score of NJ E/15 indicating that the resident is NJ Exec Order 26.4b1. A review of the "Order Summary Report (OSR)" Active as o NJ Exec Order 26.4b1 included the following Physician Orders. (PO's): NJ Exec Order 26.4b1 by mouth two times a day. NJ Exec Order 26.4b1 give one tablet by mouth daily. NJ Exec Order 26.4b1 give one tablet twice daily. NJ Exec Order 26.4b1 give 1 tablet by mouth two times a day for NJ Exec Order 26.4b1 give on an empty NJ Exec Order 26 Give one hour prior to meal or two hours after. The surveyor observed Resident #8 on 08/06/2025 at 1:59 P.M., who was lying in bed while the NJ Exec Order 26.4 NJ Ex the	F0658	Continued from page 16 5. Completion Date: August 13, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315387	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD , FREEHOLD, New Jersey, 07728

(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
F0658 SS = D	Continued from page 17 resident lunch. The surveyor observed six pills in a medicine cup at the resident's bedside. On 08/06/2025 at 2:00P.M., the surveyor informed the US FOIA (b)(6)) of the medication in the cup. On 085/06/2025 at 2:04 P.M., the surveyor observed the US FO remove the medication cup from the resident's bedside table and notified the Licensed Practical Nurse (LPN#1) assigned to the resident. The surveyor then interviewed the NJ Exec Order 26.4 about the medication, and asked her if the medication was left for her to medicate the resident. The NJ Exec Order 26.4 replied that she doesn't administer medications to Resident #8 and the resident also shook their indicating that the NJ Exec Order 26.4 did not administer medications. The NJ Exec Order 26.4 stated that the nurse was waiting for NJ Exec Order 2 to use in administering the medication. The survey interviewed the US FO on 08/06/2024 at 2:07 P.M., and she identified the pills in the cup. When asked if it is policy to leave medications at residents' bedside, she replied, "No, absolutely not." On 08/06/2025 at 2:20 P.M., the surveyor interviewed LPN #1 who confirmed that she left the medication at the resident's bedside, and stated she knows she should not have, "It is not the policy." She further stated that she does not normally do that, but the resident's NJ Exec Order 26.4 wanted the medications to be given in NJ Exec Order 2 so she left the medications to wait for NJ Exec Order 26 During an interview with the US FOIA (b)(6)) on 08/06/5025 at 4 2:51 P.M., she stated that it was not the policy for nurses to leave medication at bedside. The expectation would be if they do not take the medication then mark them as refused. Review of the facility policy dated 01/2025 indicated; "Administering Medications" under the "Policy Statement", "Medications shall be administered in a safe and timely manner, and as prescribed." Under "Policy Interpretation and Implementation", "3. Medications must be administered in accordance with the orders, including any required time frame. 4.Medicaitons must be administered within one (1) hour of their prescribed time, unless otherwise specified." 18. "If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall indicate such on the MAR." NJAC 8:39-29.2 [d]	F0658		
F0835	Administration	F0835	1. Corrective Action for Resident(s) Affected:	09/25/2025

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F0835 SS = J	Continued from page 18 CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: Complaint # 2582137 Based on interviews and review of other pertinent facility documentation on 08/05/2025, 08/06/2025, and 08/07/2025, it was determined that the facility's US FOIA (b)(6)) failed to ensure himself, as well as staff, implemented the facility's NJ Exec Orc policies and procedures to ensure resident safety and well-being by a.) protecting a resident from an NJ Exec Order 26.4b1 pending a thorough investigation and b.) thoroughly investigating an NJ Exec Order 26.4b1. The US FOIA (b)(6)) was interviewed by the surveyor on 08/06/2025. The US FOIA (b) stated that on NJ Exec Order 26.4b1 he observed the NJ Exec Order 26.4b1 at the facility and overheard the NJ Exec Order 26.4b1 tell the facility's US FOIA (b)(6) that Resident #8 was being 'NJ Exec Order 26.4b1 by the US FOIA (b) (6) (US FOIA (b) (6) who was caring for the resident. The US FOIA (b) acknowledged that 'NJ Exec Order 26.4b1 could be considered NJ Exec Orde but at the time of the NJ Exec Order 26.4b Resident #8 was on the facility's premises NJ Exec Order 26.4b1 The US FOIA (b) stated that the facility did not conduct an investigation including completing an incident report because Resident #8 was NJ Exec Order 26.4b1 and when he asked the resident if they were NJ Exec O the resident stated they were NJ Exec O it was 'NJ Exec Order 26.4b1 ." The facility's failure to ensure the US FOIA (b)(6 as well as all staff, implemented their facility policies to ensure all residents were free from NJ Exec Orc by not protecting a resident from NJ Exec Orc and not investigating an NJ Exec Order 26.4b1 posed the likelihood for serious physical or emotional harm or injury. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Exec Order 26.4b1, after the police notified the facility of the NJ Exec Order 26.4b The facility's US FOIA (b)(6) was notified of the IJ on 08/07/2025 at 5:59 P.M. The facility submitted an acceptable Removal	F0835	Continued from page 18 Administration attempted to restrict Resident #8 NJ Exec Orde from premises pending investigation but honored Resident #8's request for continued NJ Exec Order 26.4 NJ Exec Order 26.4b1 were completed until investigation was concluded. NJ Exec Order 26.4b was reported to the State Agency on NJ Exec Order 26.4b1. 2. Identification of Other Residents: Residents who receive visitors may be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence: Facility's policy on Abuse Prevention Program was reviewed and revised to reflect appropriate reporting timeframes in addition to the requirement of mandatory reporting and proper investigation. The policy mandates timely reporting to appropriate authorities within the regulatory timeframe. The US FOIA (b) (6) department heads, and all managers received updated training on abuse prevention oversight, reporting, and compliance timelines. Delivered by the Director of Nursing or designee. All new hires and returning staff will receive the same education in orientation or upon return. The US FOIA (b)(6) was additionally educated by the Regional Director of Nursing regarding the regulatory requirements of F600 and F610, and a daily end of day report was implemented for administration to report to executive leadership on any incidents, accidents, or events for four weeks. Regional Director of Nursing/Regional Administrator will provide onsite support at least 16 hours per week for four weeks and participate in weekly compliance calls. 4. Monitoring: Administrator or DON will audit all abuse reports weekly for four weeks and monthly for three months to ensure timely reporting, complete investigation, and documentation. Audit results will be reported during QAPI meetings. 5. Completion Date: August 13, 2025.	

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F0835 SS = J	Continued from page 19 Plan (RP) on 08/11/2025 at 10:24 A.M. The surveyor verified the implementation of the RP on 08/12/2025 at 12:45 P.M. The evidence was as follows: Refer F 600, F 610 A review of the undated "Administrator - Job Description" provided by the facility included the following: Position Summary: this position is responsible to establish and maintain systems that are effective to operate the nursing home in a manner to safely meet residents' needs in accordance with federal, state, and local regulations… Essential Requirements, Duties, and Responsibilities…"develop, maintain and implement operational policies and procedures to meet residents' need compliance with federal, state and local requirements"…develop and enforce a monitoring program to assure compliance with federal, state, and local requirements…establish systems to enforce the facility policies and procedures…establish systems to ensure compliance with federal, state, and local regulations…observe all facility policies and procedures… A review of the facility policy that was revised on 01/2025, titled "Abuse Prevention Program" included policy statement "…promotes an environment that does all to prevent resident abuse, neglect, misappropriation of property through the following components: screening and training of employees, prevention, identification, investigation, protection and reporting," Under section V Investigation: "an investigation is initiated for all allegations of suspected abuse, neglect or misappropriation." Further in #4 of Investigation it states that "the Abuse Investigator will complete a thorough investigation inclusive of interviewing the resident, alleged abuser and any witnesses." In section VII Reporting: it states that "The Abuse Investigator will be responsible to make all reports regarding abuse investigations" and indicates the agencies to report to. On 08/06/2025 at 1:45 P.M., during an interview with the Unit Manager (UM #1), she stated that morning (NJ Exec Order 26.4b), she became aware of an NJ Exec Order 26.3 of NJ Exec Ord involving Resident #8 and their US FOIA (b) (6) US FO UM #1 stated that the US FOIA (b)(6) received a call from a [community name redacted] organization	F0835		

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F0835 SS = J	Continued from page 20 regarding an NJ Exec Order 26.4b1, and the US FOIA spoke to Resident #8 about it. UM #1 stated that she assumed the US FOIA investigated the NJ Exec Order 26.4b1 UM #1 stated that US FOIA (b) helped with Resident #8's care since the resident could be "NJ Exec Order 2 with staff. On 08/06/2025, at 1:59 P.M., the surveyor observed Resident #8's bedroom door closed. The surveyor knocked on the door and US FOIA (b) opened the door. The surveyor noted that Resident #8 was lying in bed eating lunch. There was no facility staff in the room with the resident at that time. On 08/06/2025 at 2:34 P.M., during an interview with the US FOIA she confirmed that a [community name redacted] organization notified her that Resident #8's US FOIA (b) called them and reported that the US FOIA (b) was "NJ Exec Order 26 the resident. The US FOIA stated that she spoke with the resident who NJ Exec Orde the NJ Exec Order 26.4b1 On 08/06/2025, at 4:33 P.M., during an interview with the US FOIA (b)(6) he stated that he was aware of the NJ Exec Or being at the facility yesterday, and he overheard them telling the US FOIA (b)(6) at that time that Resident #8 was being "NJ Exec Order 26.4b1 by US FOIA (b) who was caring for them. When asked if "NJ Exec Order 26.4b1 could be considered NJ Exec Orde the US FOIA (b) agreed. The US FOIA (b) further stated that it was "presented as a third-party claim of NJ Exec Or and added; I went outside and spoke to them right away." When the surveyor asked about what should be done when there was an NJ Exec Order 26.4 of NJ Exec Or of a resident, the US FOIA (b) responded "First, make sure they are not NJ Exec O The US FOIA (b) further stated that "if the NJ Exec Orde is a visitor it's technically the same as staff and they need to be NJ Exec Order 26.4b1 The US FOIA (b) also that at the time, the resident was on the property premises, NJ Exec Order and that the NJ Exec Order 26.4b1 US FOIA (b) (6 was on the other side of the facility parking lot. The US FOIA (b) stated that he wrote a statement about the claim and did not write an incident report since the resident had a BIMS of NJ Ex and that the resident NJ Exec Orde the NJ Exec Orde When asked if an incident report should have been filed, the US FOIA (b) replied, "I would have to check our NJ Exec Or policy." On 08/07/2025 at 10:40 A.M., during a follow-up interview with UM #1, she stated that she was not asked to provide a statement regarding the NJ Exec Order 26.4 or instructed to collect any statements from any potential witnesses. UM #1 acknowledged that there was no NJ Exec assessment conducted for Resident #8, and that she would try to complete one. UM #1 also stated that US FOIA (b) was in the facility that morning when she arrived at work on NJ Exec Order 26.4b1.	F0835		

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F0835 SS = J	Continued from page 21 On 08/07/2025, at 11:29 A.M., during a follow-up interview with the [US FOIA (b)(6)] he re-stated that the [NJ Exec Ord] were at the US FOIA (b)(6) area when he walked into the lobby. Per the [US FOIA (b)(6)] the [NJ Exec Ord] acknowledged his presence but continued to talk with the US FOIA (b)(6) The [US FOIA (b)] confirmed that he did not inquire from the [NJ Exec Ord] specific details regarding the [NJ Exec Order 26.4] because he assumed that the [NJ Exec Ord] were unable to [NJ Exec Order 26.4b1] the [NJ Exec Order 26.4b] The [US FOIA (b)] also stated that [US FOIA (b)] [NJ Exec Order 26.4b1] was not [NJ Exec Order 26.4] from Resident #8 because he [NJ Exec Order 26.4b1] as resident is [NJ Exec O] and [NJ Exec Order] The [US FOIA (b)] stated "I feel like if we were doing an assessment, all these measures would need to be taken into account. I was able to rule out [NJ Exec Ord] instantaneously." At that time, the [US FOIA (b)] stated "The thought process was these measures are typically taken to rule out [NJ Exec Orde] they had a BIMS of [NJ Exe] I thought once ruled out the other steps weren't necessary." When the surveyor asked if that was the facility's policy, the [US FOIA (b)] responded, "Per the policy all these steps are part of an investigation and should have been done." The [US FOIA (b)] further confirmed that nursing staff did not perform a body check on the resident to check for [NJ Exec Order] The [US FOIA (b)] also confirmed that there were no staff interviews conducted. The [US FOIA (b)] stated that he felt that he initiated an investigation by talking with Resident #8 because the resident was [NJ Exec O] and [NJ Exec Order 2] and stated they felt [NJ Exec O] When questioned about protection for Resident #8 from the [NJ Exec Order 26.4b1], the [US FOIA (b)] stated that the [NJ Exec Order 26.4] [US FOIA (b)(6)] was not [NJ Exec Order 26.4] from the resident because he felt that he ruled out [NJ Exec Ord] since the resident was [NJ Exec O] and [NJ Exec Ord] and "had a BIMS of [NJ Exe] The [US FOIA (b)] acknowledged that an assessment should have been done. An acceptable Removal Plan (RP) was received on 08/11/2025 at 10:27 A.M., indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the Administration attempted to [NJ Exec Orde] [US FOIA (b)] from the premise pending an investigation, but Resident #8 did [NJ Exec Order 26] The [US FOIA (b)] educated the US FOIA (b)(6) to check Resident #8 every [NJ Exec Order 26.4b1] to ensure no [NJ Exec Ord] while the investigation was being concluded. The [US FOIA (b)] received education from the US FOIA (b)(6) about [NJ Exec Ord] prevention oversight, reporting, and compliance timelines. The facility's abuse prevention program was reviewed and revised to reflect appropriate reporting timeframes in addition to	F0835		

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F0835 SS = J	Continued from page 22 the requirement of mandatory reporting and proper investigation. The [redacted] was additionally educated by the [redacted] regarding regulatory requirements for F 600 and F 610. The survey team verified the implementation of the Removal Plan on-site on 08/12/2025 at 12:45 P.M. NJAC 8:39-9.2(a) NJAC 8:39-9.3(a) NJAC 8:39-27.1(a)	F0835		

New Jersey State Department of Health

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S0000	Initial Comments Complaint #: 2582137 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each 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		

Office of Primary Care and Health Systems Management

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

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F0000	INITIAL COMMENTS A revisit was conducted on 09/25/2025 in relation to the 08/12/2025 Complaint 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 A revisit was conducted on 09/25/2025 in relation to the 08/12/2025 State of New Jersey Complaint 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