STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON , SHREWSBURY, New Jersey, 07702

(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 New Jersey Department of Health (NJDOH). Complaint: #'s 423980,423981, 423982, 423984, 423985, 423990 Survey Dates: 09/22/25 to 09/25/25 Survey Census: 118 Sample Size: 33 Supplemental Sample: 23 THE FACILITY IS NOT 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		10/25/2025
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F0550	1. Immediate corrective action for residents affected by deficient practice: Resident R53 was NJ Exec Order 26.4b1 . CNA1 received individual re-education on resident NJ Exec Order 26.4b1 by U.S. FOIA (b)(6) . 2. Identify those individuals who could be affected by the deficient practice: All residents requiring toileting assistance have the potential to be affected by this deficient practice. 3. Measures put in place to ensure the deficient practice will not recur for those residents affected: Licensed and Certified Staff were re-educated on the "Promoting/Maintaining Dignity" policy by the Director	10/25/2025

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F0550 SS = E	Continued from page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure one resident of three (Resident (R)53) of 33 sampled residents were treated with dignity in toileting. This failure had the potential to negatively impact the quality of life and self-esteem for the affected resident. Findings include: Review of R53's "Admission Record" located in the resident's EMR section titled "Profile" revealed the resident was admitted to the facility on NJ Exec Order 26 with diagnoses that included NJ Exec Order 26.4b1 Review of R53's annual "MDS" with an ARD of NJ Exec Order 26 located in the resident's EMR tab titled "MDS" revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1 and able to make NJ Ex	F0550	Continued from page 1 of Nursing/Designee. 4. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Director of Nursing or designee will interview 5 residents each week x1 month, then 5 residents per month x2 months who require assistance with toileting to solicit feedback regarding their experiences related to interactions and timely assistance. Results of the audits will be reviewed monthly during QAPI for three months. The QAPI committee will determine, based upon findings if additional monitoring or plan revision is needed.	

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F0550 SS = E	Continued from page 2 NJ Exec Order 26.4b1. The resident was assessed to have an NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 The resident required NJ Exec Order 26.4b1 Review of R53's "Care Plan" with a revision date of NJ Exec Order 26 located in the resident's EMR tab titled "Care Plans" revealed the resident required one person assistance NJ Exec Order 26.4b1 . Observation on NJ Exec Order 26.4b1 revealed R53 was in NJ Exe wheelchair trying to get into NJ Exe room NJ Exec Order 26.4b . Certified Nursing Assistant (CNA)1 told the resident that NJ E could no NJ Exec Order 26.4b1 in NJ Exec room since housekeeping was NJ Exec Order 26.4b1 . CNA1 also stated the resident would have to wait until she finished taking another resident to the shower. The U.S. FOIA further told the resident that she would NJ Exec Order 26.4b1 During an interview on 09/22/25 at 1:55 PM, R53 revealed NJ E had just returned from an appointment and NJ Exec Order 26.4b1 . R53 stated that NJ E was NJ Exec Or by the U.S. FOIA response to NJ Exec Order 26.4b1 . The resident stated this was not a NJ Exec Order 2 response and felt NJ Exec Order 26.4b by the U.S. FOIA (b) statement that NJ E could use the NJ Exec Order 26.4b1 . R53 stated that NJ E had been NJ Exec Order 26.4b1 in a timely manner to NJ Exec Order 26.4b1 . During an interview on 09/22/25 at 2:30 PM, CNA1revealed that she was getting another resident ready for a shower when R53 was attempting to get to the NJ Exec Order 26.4b1 The U.S. FOIA stated that she did not have time to stop what she was doing to assist R53. CNA1 stated the resident is usually NJ Exec Order 26.4b1 and she thought NJ Exec Order 26.4b1 CNA1 stated that she did not realize that she had NJ Exec Order 26.4b the resident by her statements. During an interview on 09/25/25 at 3:30 PM, Licensed Practical Nurse (LPN)3 revealed that CNA1 was a good worker but at times she could be a bit NJ Exec O with the residents without realizing it. The observation and resident interview was explained to LPN3; LPN3 stated that CNA1's response to the resident's request for assistance was a NJ Exec Order 26.4b1	F0550		

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F0550 SS = E	Continued from page 3 Review of the facility policy titled "Promoting/Maintaining Resident Dignity" with a revision date of 03/10/25 directs the staff "…All staff members are involved in providing care to residents to promote and maintain resident's dignity and respect residents' rights…Respond to resident's for assistance in a timely manner…" NJAC 8:39-4.1(a)	F0550		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and review of the Resident Assessment Instrument (RAI) Manual the facility failed to ensure that a Significant Change Minimum Data Set (MDS) was completed for one resident (Resident (R)6) from a total sample of 33 residents. This failure had the potential for residents not to receive appropriate care in timely manner. Finding include: Review of R6's "Admission Record" located in the electronic medical record (EMR) tab titled "Profile" revealed the resident was admitted to the facility on NJ Exec Order 26 with diagnoses that included NJ Exec Order 26.4b1 [redacted] Review of R6's "Physicians' Orders" dated NJ Exec Order 26 located in the resident's EMR tab titled "Orders" revealed NJ Exec Order 26.4b1 was to NJ Exec Order 26.4b1 Review of R6's "NJ Exec Order 26.4b1 Facility Notification of Admission" dated NJ Exec Order 26 located in the resident's EMR	F0637	1. Immediate corrective action for residents affected by deficient practice: A significant change MDS for resident R6 was submitted and accepted on NJ Exec Order 26 to reflect that NJ Exec Order 26 services are being provided. 2. Identify those individuals who could be affected by the deficient practice: All residents who have a significant change defined as a major decline or improvement in a resident's physical or mental condition that meets the following criteria: 1. Non-Self-Limiting, 2. Impact on Multiple Areas or 3. Interdisciplinary Review Required have the potential to be affected. 3. Measures put in place to ensure the deficient practice will not recur for those residents affected: U.S. FOIA (b)(6) [redacted] received education from Regional MDS Coordinator on completing a significant change assessment within 14 days of determining that a significant change has occurred. An audit of all other residents receiving NJ Exec Order 26.4b1 was conducted and confirmed that a significant change MDS reflecting NJ Exec Order 26.4b1 had been submitted and accepted. 4.Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The MDS Coordinator/Designee will complete a monthly audit of all residents receiving hospice services to confirm that a significant change MDS has been completed within 14 days. MDS Coordinator/Designee will report monthly to the QAPI Committee x3 months, the findings of the audits. he QAPI committee will determine, based upon findings if additional monitoring or plan revision is needed.	10/25/2025

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F0637 SS = D	Continued from page 4 tab titled "Miscellaneous" revealed the resident was accepted into the NJ Exec Order 26.4b1 on NJ Exec Order 26. Review of R6's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4 located in the resident's EMR tab titled "MDS" revealed the resident was assessed as receiving NJ Exec Order 26.4b1. Review of R6's quarterly "MDS" with an ARD of NJ Exec Order 26 located in the resident's EMR tab titled "MDS" revealed the resident was not receiving NJ Exec Order 26.4b1. Additional review of R6's MDS section failed to reveal a Significant Change MDS for the resident NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. During an interview on 09/25/25 at 3:00 PM with the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6)) confirmed a Significant Change MDS should have been completed in the allotted time after the resident was started on NJ Exec Order 26.4b1. Review of the RAI Manual revealed a significant change in a resident's status triggers the need for a Significant Change in Status Assessment (SCSA). This assessment, part of the Minimum Data Set (MDS) 3.0, must be completed within 14 calendar days following the determination that a significant change has occurred… A "significant change" in the context of MDS assessments refers to a major decline or improvement in a resident's condition that impacts multiple areas of health and requires intervention….Definition of Significant Change: According to the Centers for Medicare & Medicaid Services (CMS), a significant change is defined as a major decline or improvement in a resident's physical or mental condition that meets the following criteria…1.Non-Self-Limiting: The change will not typically resolve itself without further intervention by staff or through standard clinical interventions. 2.Impact on Multiple Areas: The change affects more than one area of the resident's health status…3. Interdisciplinary Review Required: The change necessitates a review or revision of the resident's care plan by an interdisciplinary team (IDT)." NJAC 8:39-11.2(i)	F0637		
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.	F0641	1. Immediate corrective action for residents affected by deficient practice: All five residents (R44, R9, R133, R6, R80) were reviewed by the MDS Coordinator and Corporate MDS Nurses. Each MDS was corrected and re-submitted to	10/25/2025

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F0641 SS = E	Continued from page 5 The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the "Minimum Data Set (MDS)" was coded accurately for five residents (Residents (R)44, R9, R133, R6, and R80 in a total sample of 33 residents. This failure placed residents at NJ Exec Order 26.4b1 . Findings include: 1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R44 was admitted to the facility on NJ Exec Order 26 with a diagnosis of NJ Exec Order 26.4b1 [redacted]	F0641	Continued from page 5 NJ Exec Order 26.4b1 [redacted] 2. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. 3. Measures put in place to ensure the deficient practice will not recur for those residents affected: Education was initiated by the Corporate MDS Nurses and the DIRECTOR OF NURSING on MDS accuracy per the Oct 2024 RAI Manual. 4. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The DIRECTOR OF NURSING or designee will audit five residents weekly for four weeks, then monthly for two months, to verify assessment accuracy and documentation. Findings will be reviewed and reported to the Administrator, and monitored in QAPI until sustained compliance is achieved.	

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F0641 SS = E	Continued from page 6 Review of an [redacted] "Nursing Progress Note" located in the "Progress Notes" tab of the EMR revealed, "…Patient received via stretcher from [hospital name withheld] at approximately [redacted]. Patient is alert and awake. Noted with moments of [redacted] …" Review of a modified quarterly "MDS" located in the "MDS" tab of the EMR with an ARD of [redacted] revealed R44 was not coded for the [redacted]. Review of an [redacted] Order Summary" located in the "Orders" tab of the EMR after R44 returned from a hospital stay revealed, [redacted]." Review of the "5-day PPS [prospective payment system-a required assessment for Medicare A residents]" located in the "MDS" tab of the EMR with an ARD of [redacted]. revealed that R44 was not [redacted]. During an observation on [redacted], R44 was observed wearing [redacted] and was not able to respond to questions due to [redacted]. During an interview on 09/25/25 at 11:23 AM, the [redacted]) stated, "I did not code her [redacted] and I need to make a correction." 2. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed R9 was admitted to the facility on [redacted] with diagnoses that included a [redacted]. Review of the quarterly "MDS" located in the "MDS" tab of the EMR with an ARD of [redacted] revealed R9 had a "BIMS" score of [redacted] which indicated R9 was [redacted] and had received [redacted] during the observation period. Review of the EMR including the "Assessments" tab and "Nursing and Provider Progress Notes" did not show documentation as to why R9 had received [redacted]	F0641		

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F0641 SS = E	Continued from page 7 therapy. During an interview on 09/25/25 at 11:27 AM, the U.S. FOIA (b) stated, "That was coded inaccurately." 3. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed R133 was admitted to the facility on NJ Exec Order 26 with a diagnosis of NJ Exec Order 26.4b. Review of the admission "MDS" located in the "MDS" tab of the EMR with an ARD of NJ Exec Order 26 revealed R133 had a "BIMS" score of NJ Exec Order 26.4b1 which indicated R133 was NJ Exec Order 26.4b1 . Review of the discharge return anticipated "MDS" located in the "MDS" tab of the EMR with an ARD of NJ Exec Order 26 revealed R133 had a weight of NJ Exec Order 26.4b1 and had not NJ Exec Order 26.4b1. Review of the weights located in the "Weights/Vitals" tab of the EMR revealed indicated that on NJ Exec Order 26 NJ Exec Orde was listed as NJ Exec Order 26.4b1 During an interview on 09/24/25 at 10:37 AM, Registered Dietician (RD)2 was asked if she was responsible for coding the MDS for NJ Exec Order 26. RD 2 stated, "Yes." RD2 further stated, "U.S. FO was NJ Exec Order 26.4b1, and the assessment should have reflected the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1. I am not sure that NJ Exec Order 26.4b1 was an NJ Exec Order 26.4b1 4. Review of R6's "Admission Record" located in the EMR tab titled "Profile" revealed the resident was admitted to the facility on NJ Exec Order 26 with diagnoses that included NJ Exec Order 26.4b1 Review of R6's "Physicians Orders" dated NJ Exec Order 26 and located in the EMR tab titled "Orders" revealed an order for NJ Exec Order 26.4b1 to evaluate and treat. Review of R6's NJ Exec Order 26.4b1 Facility Notification of Admission" dated NJ Exec Order 26 located in the EMR tab titled "Miscellaneous" revealed the resident was accepted into the NJ Exec Order 26.4b1 on NJ Exec Order 26.	F0641		

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F0641 SS = E	Continued from page 8 Review of R6's quarterly "MDS" with an ARD [NJ Exec Order 26] located in the EMR tab titled "MDS" documented the resident as not receiving [NJ Exec Order 26.4b1] During an interview on 09/25/25 at 11:13 AM, the [U.S. FOIA] and the two corporate MDS (CMDS)1 and CMDS2 verified that the quarterly MDS for R6 inaccurately documented that [NJ Exec] was not receiving [NJ Exec Order 26.4b1] 5. Review of R80's "Admission Record" located in the EMR tab titled "Profile" revealed the resident was admitted to the facility [NJ Exec Order 26.] with diagnoses that included age related [NJ Exec Order 26.4b1] . Review of R80's [NJ Exec Order 26.4b1] dated [NJ Exec Order 26] located in the EMR tab titled "Assessments" documented that the resident [NJ Exec Order 26.4b1] on [NJ Exec Order 26]. The resident was assessed to have a [NJ Exec Order 26.4b1] indicating the resident was a [NJ Exec Order 26.4b1] Review of R80's quarterly "MDS" with an ARD [NJ Exec Order 26] located in the resident's EMR tab titled "MDS" revealed the resident was assessed as not having [NJ Exec Orde] since admission to the facility. During an interview on 09/25/25 at 11:13 AM, the [U.S. FOIA] and the two Corporate MDS coordinators (CMDS)1 and CMDS2 confirmed the quarterly "MDS" was inaccurate as it did not capture the resident's [NJ Exec Order 26.4b]. Review of the October 2024 "RAI," manual, page 1-5 revealed, "…An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations…It is important to note here that information obtained should cover the same observation period as specified by the MDS (minimum data set) items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) by the IDT (interdisciplinary team) completing the assessment…" NJAC 8:39-33.2(d)	F0641		
F0656 SS = E	Develop/Implement Comprehensive Care Plan	F0656	1. Immediate corrective action for residents affected by deficient practice:	10/25/2025

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F0656 SS = E	Continued from page 9 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F0656	Continued from page 9 Residents R1, R7, R14, R36, and R104 were reviewed by the Interdisciplinary Care Team (IDT), and care plans were updated to include all active diagnoses, treatments, and orders. 2. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. 3.Measures put in place to ensure the deficient practice will not recur for those residents affected: The IDT was re-educated on the “Comprehensive Care Plans” policy, emphasizing inclusion of all active diagnoses, treatments, and orders by the Director of Nursing/Designee. 4. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Minimum Data Set (MDS) Coordinator or designee will audit five residents’ care plans weekly for four weeks, then monthly for two months, to verify all active diagnoses; treatments and orders are accurately reflected. Results will be reviewed with the Administrator and QAPI Committee until sustained compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

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F0656 SS = E	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews, and review of facility policy, the facility failed to ensure care plans were developed and/or implemented for five residents (Residents (R) R1, R7, R14, R36, and R104) from a total sample of 33 residents. This failure had the potential that residents would not receive all necessary care and services. Findings include: 1. Review of R1's "Admission Record" located in the electronic medical record (EMR) tab titled " Profile" revealed the resident was admitted to the facility initially on [redacted] and readmitted [redacted] with diagnoses that included NJ Exec Order 26.4b1 [redacted] Review of R1's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located in the EMR tab titled "MDS" revealed for Active Diagnosis listed the resident with NJ Exec Order 26.4b1. Review of R1's "Care Plan" with a revision date of [redacted] located in the EMR tab titled "Care Plans" revealed the care plan did not address the resident's diagnosis of NJ Exec Order 26.4b1 and the signs and symptoms of this [redacted] During an interview on 09/25/25 at 4:06 PM, Licensed Practical Nurse (LPN)3 stated she was aware of R1's diagnosis of NJ Exec Order 26.4b1 and felt it should have been included in the resident's care plan to make the other care givers aware of the resident's symptoms. 2. Review of R7's "Admission Record" located in the EMR tab titled "Profile' revealed the resident was admitted to the facility [redacted] with diagnosis that included NJ Exec Order 26.4b1 [redacted] Review R7's "Care Plan" with a revision date [redacted] located in the EMR tab titled "Care Plans" revealed the care plan did not reflect the resident's diagnosis of	F0656		

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F0656 SS = E	Continued from page 11 NJ Exec Order 26.4b1 . During an interview on 09/25/25 at 4:06 PM, LPN3 revealed that she was aware of the R7's diagnosis of NJ Exec Order 26.4b1 . LPN3 stated that while talking to the resident NJ Exec Order 26.4b1 . LPN3 stated the resident's diagnosis of NJ Exec Order 26.4b1 should be included in the care plan so the staff would know what to expect and how to react. Interview with the U.S. FOIA (b)(6) on NJ Exec Order 26.4b1 revealed the R1 had the diagnosis of NJ Exec Order 26.4b1 and R7's diagnosis of NJ Exec Order 26.4b1 prior to admission to the facility however felt that there was not a need to develop a care plan unless the residents exhibited those signs and symptoms while admitted to the facility. 3. Review of R14's "Admission Record" located in the EMR tab titled "Profile" revealed the resident was admitted to the facility NJ Exec Order 26 with diagnoses that included NJ Exec Order 26.4b1 . Review of R14's admission "MDS" with an ARD of NJ Exec Order 26 located in the EMR tab titled "MDS" revealed the resident was NJ Exec Order 26.4b1 Review of R14's "Physicians Orders" dated NJ Exec Order 26 located in the EMR tab titled "Orders" revealed the resident was to receive NJ Exec Order 26.4b1 . "Monitor NJ Exec Order 26.4b1 Assess site for any changes in skin condition. Report any noted NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Review of R14's "Care Plan" with a revision date of NJ Exec Order 26 located in the EMR tab titled "Care Plans" revealed the resident's NJ Exec Order 2 care interventions failed to include orders not to change the NJ Exec Order 26.4b1 . During an interview on 09/25/25 at 4:06 PM, LPN3	F0656		

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F0656 SS = E	Continued from page 12 revealed the physician's orders not to change the [redacted] on the resident's [redacted] should have been included on the care plan. 4.Review of the "Admission Record" located in the "Profile" tab of the EMR revealed R36 was admitted to the facility on [redacted] with diagnoses that included [redacted]. Review of the quarterly "MDS" located in the "MDS" tab of the EMR with an ARD of [redacted] revealed R36 had a "BIMS" score of [redacted] which indicated R36 was [redacted] and had [redacted] during the observation period. Review of an [redacted] Investigation Report" provided by the [redacted] revealed, "...Writer was alerted that resident [redacted]. Resident [redacted] ...Resident stated, "[redacted] I...." [redacted] Review of the revised [redacted] Care Plan" revealed, "R36 had an [redacted] " The [redacted] During an observation on [redacted], there was [redacted] located on the door side of the bed and there was [redacted] wall side of the bed. During an interview on 09/23/25 at 3:04 PM, LPN 6 confirmed that there [redacted] next to [redacted] bed. During an interview on 09/23/25 at 3:09 PM, LPN/Unit Manager 2 confirmed that there [redacted] next to [redacted] bed and there should have been [redacted] the "Care Plan." 5. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed R104 was admitted to the facility on [redacted] with a diagnosis o [redacted]	F0656		

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F0656 SS = E	Continued from page 13 NJ Exec Order 26.4b1 [redacted]. Review of the admission "MDS" located in the "MD" tab of the EMR with an ARD of NJ Exec Order 26 revealed R104 had a "BIMS" score of NJ Exec Order 26.4b1 which indicated R104 was NJ Exec Order 26.4b1 and received an NJ Exec Order 26.4b1 period. Review of the NJ Exec Order 26.4 "Order Summary" located in the "Orders" tab of the EMR revealed, NJ Exec Order 26.4b1 . Give NJ Exec Order 2 [redacted] Review of the "Comprehensive Care Plan" did not show a focus/goal or interventions for the use of the U.S. FOIA (b)(6) During an interview on 09/25/25 at 1:23 PM, LPN/UM 3 was asked who was responsible for developing the care plans. The LPN/UM 3 stated, "We do the baseline care plan and then add to it to make the "Comprehensive Care Plan." LPN/UM 3 was asked why there was no "Care Plan" for the use of NJ Exec Order 26 since it was a significant medication U.S. Fo verified there was no care plan for NJ Exec Order 26.4b1 Review of the facility's policy titled "Comprehensive Care Plans with a revision date of 03/01/25 directs the staff as follows: "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality…The comprehensive care plan will describe at a minimum the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well…"	F0656		

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F0656 SS = E	Continued from page 14 NJAC 8:39-11.2(e)thru (i) NJAC 8:39-27.1(a)	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews, and policy review, the facility failed to revise care plans for two residents (Residents (R) 137 and R9) from a total sample of 33 residents. This failure had the potential for residents to have unmet care needs. Findings include:	F0657	1. Immediate corrective action for residents affected by deficient practice: Residents R137 and R9 were reviewed by the IDT (Interdisciplinary Care Team) to ensure care plans reflected current needs. R137's plan was updated for NJ Exec Order 26.4b1 [redacted] R9's for NJ Exec Order 26.4b1 [redacted]. 2. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. 3. Measures put in place to ensure the deficient practice will not recur for those residents affected: The IDT was re-educated on the "Care Plan Revisions Upon Status Change" policy, by the Director of Nursing emphasizing updates within seven days or immediately after a change. The Minimum Data Set (MDS) Coordinator implemented a Change in Condition Log to track changes requiring care plan interventions and updates. 4. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The MDS Coordinator or designee will audit five residents weekly for eight weeks, then monthly for two months, to verify timely care plan updates. Results will be reviewed with the Administrator and QAPI Committee until sustained compliance is achieved.	10/25/2025

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F0657 SS = D	Continued from page 15 1.Review of R137's "Admission Record" located in the electronic medical record (EMR) tab titled "Profile" revealed the resident was admitted initially to the facility on [redacted] and readmitted to the facility on [redacted] with diagnoses that included [redacted] Review of R137's "Physicians Orders" dated [redacted] and located in the EMR tab titled "Orders" revealed the resident was to [redacted] The order included for nursing to [redacted] every shift. [redacted]. Notify the [redacted] with any urgent problems every shift. [redacted]." Review of R137's Five Day Medicare "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located in the EMR tab titled "MDS" revealed the resident was [redacted] Review of R137's "Nursing Notes" dated [redacted] located in the EMR tab titled "Progress Notes" revealed the resident was sent to the [redacted] by the resident [redacted] at the [redacted] Review of R137's "Nursing Notes" written by the MDS Coordinator located in the EMR tab titled "Progress Notes" revealed the resident had returned to the facility after hospitalization for a [redacted] caused by the resident's [redacted] at the [redacted] The U.S. FOIA (b)(6) documented plans to revise the resident's care plan to monitor the resident for [redacted]. Review of R137's "Care Plan" with a revision date of [redacted] located in the EMR tab tilted "Care Plans" revealed the care plan interventions had not been revised to reflect the resident's [redacted] Interview on 09/24/25 at 1:45PM with LPN3 revealed the nurses can revise the resident's care plan at the time of an incident or change in the condition and thought	F0657		

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F0657 SS = D	Continued from page 16 it had been revised during the care plan meeting Interview on 09/25/25 at 11:15AM with the U.S. FOIA (b)(6) revealed the resident's care plans are developed during the resident's care plan meeting with the interdisciplinary team. The floor nurses can revise a resident's at the time of the resident's change in condition. 2. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R9 was admitted to the facility on NJ Exec Order 26.4 with diagnoses that included a NJ Exec Order 26.4b1 . Review of the quarterly "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec Order 26.4 revealed R9 had a "Brief Interview of Mental Status (BIMS)" score of NJ Exec which indicated that R9 was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1 . Review of the NJ Exec Order 26.4 "Nutrition Care Plan" located in the "Care Plan" tab of the EMR revealed, "R9 is at risk for NJ Exec Order 26.4b1 which may NJ Exec Or NJ Exec Order 26.4b1 -varied intake R9 has NJ Exec Order 26.4b1 and is NJ Exec Order 26.4b1 , NJ Exec Orde may change due to NJ Exec Order 26.4b1 Significan NJ Exec Order 26.4b1 unplanned. Revised on NJ Exec Order 26.4 Interventions included: 1. Provide NJ Exec as ordered NJ Exec Order 26.4b1 . Dated NJ Exec Order 26.4b 2. Provide NJ Exec Order 26.4b1 as ordered NJ Exec Order 26.4b1 Dated NJ Exec Order 26.4 Revised on NJ Exec Order 26.4b Review of an NJ Exec Order 26 "Nutrition Note" located in the "Progress Notes" tab of the EMR revealed, "…Nutrition follow-up. NJ Exec Order 26.4b1 . NJ Exec had a significant NJ Exec Order 26.4b1 , unplanned, likely NJ Exec Order 26.4b1 .. NJ Exec will be NJ Exec Order 26.4b1 Recommend NJ Exec Order 26.4b1 NJ Exec Order 26 and NJ Exec Or to help meet needs. Recommend changing NJ Exec Order 26.4b1 order from PM to AM to ensure NJ Exec is NJ Exec Order 2 it…"	F0657		

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F0657 SS = D	Continued from page 17 During an interview on 09/24/25 at 10:30 AM, Registered Dietician (RD) 1 was asked if she was responsible for updating and revising the [redacted] Care Plan." RD1 stated, "Yes." RD1 was asked about the update to R9's [redacted] per [redacted] to R9's [redacted] and should the "Care Plan" be updated to reflect [redacted] current [redacted]. RD1 stated, "Yes, I should have changed that." Review of the facility policy titled "Care Plan Revisions Upon Status Change" with a revision date of 03/01/25 directs staff "…The comprehensive care plan will be reviewed, and revised as necessary when a resident experience a status change…The care plan will be updated with new or modified interventions…" NJAC 8:39-11.2(e)	F0657		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to ensure nursing assessments of a [redacted] were provided for one resident (Resident (R)132) in a total sample of 33. This failure placed residents at [redacted]. Findings include: Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R132 was admitted to the facility on [redacted] with a diagnosis of a [redacted]	F0684	Immediate Corrective Action for Residents Affected by Deficient Practice: Upon identification of the deficient practice, Resident #132 was immediately assessed by nursing and a licensed provider on [redacted] following an [redacted]. The [redacted], the [redacted] were notified, and the resident was transferred to the hospital for [redacted]. Upon return to the facility, physician orders were implemented for ongoing [redacted] monitoring, and licensed nursing staff were instructed to document [redacted] in the EMR and TAR. No other residents were found to have [redacted]. Identification of Other Individuals Who Could Be Affected by the Same Deficient Practice: A facility-wide audit of all current residents with surgical wounds or incisions was conducted by the DON and the Wound Nurse on 09/23/2025 to ensure that appropriate assessment and monitoring were being performed and documented. No other residents were found to have missed or incomplete wound assessments. Measures Put in Place or Systemic Changes to Ensure the Deficient Practice Will Not Recur: 1. DON and designee re-educated All licensed nurses on the facility's "Skin/Wound Management and Assessment" and "Sepsis Protocol" policies, emphasizing:	10/25/2025

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F0684 SS = D	Continued from page 18 Review of the NJ Exec Order 26.4 "Admission Comprehensive Nursing Assessment" located in the "Assessments" tab of the EMR revealed under the 'NJ Exec Assessment" section revealed that R132 had NJ Exec Order 26.4b1 . There was no further documentation to show an NJ Exec Order 26.4b1 Review of the NJ Exec Order 26.4 "Admission Nursing Progress Note" located in the "Assessments" tab of the EMR revealed, NJ Exec Order 26.4b1 patient arrived at facility via wheelchair accompanied by NJ Exec Order 26.4b1 from [hospital name withheld] with primary diagnosis of NJ Exec Order 26.4b1 ... NJ Exec Order 26.4b1 ..." There was no further documentation of an NJ Exec Order 26.4b1 Review of the NJ Exec Order 26.4b1 "Treatment Administration Record (TAR)" and the "Medication Administration Record (MAR)" revealed no documentation of a daily assessment or monitoring of the NJ Exec Order 26.4b1 . Review of the NJ Exec Order 26.4 "Care Plan" located in the "Care Plan" tab of the EMR revealed, "R132 has an actual NJ Exec Order 26.4b1 Interventions included: 1. NJ Exec Order 26.4b1 . 2. NJ Exec Order 26.4b1 3. NJ Exec Order 26.4b1 Review of an U.S. FOIA (b)(6) "Provider Note" located in the "Progress Notes" tab of the EMR revealed, "Resident seen and examined at nursing request for NJ Exec Order 26.4b1 . The resident laying [sic] in bed NJ Exec Order 26.4b1 bu NJ Exec Order NJ Exec Order 26.4b NJ Exec Order 26.4b1 The NJ Exec Order 26.4 r. Told Licensed Practical Nurse/Unit Manager (LPN/UM) 2 and U.S. FOIA (b)(6) to send the resident to the hospital for possible NJ Exec Order 26.4b1	F0684	Continued from page 18 - The requirement to perform and document initial wound assessments upon admission. - Daily monitoring for signs and symptoms of infection (redness, swelling, drainage, warmth, or odor). - Proper use of the Sepsis Protocol upon admission and as indicated. 2. The Wound Care Nurse or designee will complete a 24-hour wound verification for all new admissions and readmissions with surgical incisions. 3. The Admission Nurse will ensure that all new residents with surgical wounds have active monitoring and treatment orders entered into the EMR before the end of the admission shift. 4. The DON or designee will review the EMR within 24 hours of all new admissions to confirm wound documentation is completed and visible on the TAR. 5. A "Post-Surgical Admission Checklist" was implemented to ensure wound orders, monitoring protocols, and documentation requirements are initiated on Day 1. Monitoring of Measures or Systemic Changes to Ensure the Deficiency Will Not Recur: 1. The Wound Care Nurse or designee will conduct weekly audits of all residents with surgical wounds to verify that wound assessments and documentation are completed daily and accurately in the EMR. 2. Audit findings will be reviewed during weekly QAPI meetings for three months, and any identified noncompliance will trigger immediate re-education. 3. The DON will conduct random spot checks of three residents with wounds each week for eight weeks to ensure adherence to documentation requirements. 4. Sustained compliance will be achieved when 100% of residents with surgical wounds have documented daily assessments for three consecutive months. 5. Ongoing monitoring will continue under the QAPI Skin Integrity and Wound Management Performance Improvement Project (PIP) for continuous oversight.	

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F0684 SS = D	Continued from page 19 NJ Exec Order 26.4b1 Review of a NJ Exec Order 26.4b1 Protocol" was completed and documented in the EMR under the "Assessments" tab. The protocol states, "All NJ Exec Order 26 patients will be screened for the possibility of NJ Exec Orde at least daily and as needed." There were no other "NJ Exec Orde Protocols" completed prior to NJ Exec Order 26.4 During an interview on 09/24/25 at 11:32 AM, the U.S. FOIA (b)(6) was asked when a resident entered the facility having had NJ Exec Order 26.4b1 what is the expectation to assess and monitor that NJ Exec Order 26.4b1 for signs/symptoms of NJ Exec Order 26 The U.S. FOIA stated, "First, there should be an order to monitor the NJ Exec Order 26.4b1 ." The U.S. FOIA stated, "The staff should be utilizing the "NJ Exec Orde Protocol." The U.S. FOIA was asked when staff were to implement the "NJ Exec Orde Protocol." The U.S. FOIA stated, "Generally, it should be done on admission for a baseline assessment. In addition, there needs to be a progress note or documentation on the "Comprehensive Nursing Assessment." The U.S. FOIA confirmed that assessing and monitoring of the NJ Exec Order 2NJ Exec should have begun for R132 at the time of admission. Review of the NJ Exec Order 26.4 "Hospital Emergency Room Report" provided by the Administrator revealed that R132 was admitted with NJ Exec Order 26.4b1 NJAC 8:39-27.1	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F0689	1. Immediate corrective action for residents affected by deficient practice: Residents R16 and R69 were reassessed for the use of [redacted] and were found to be appropriate for continued use. 2. Identify those individuals who could be affected by the deficient practice: All residents at risk for elopment have the potential to be affected by this deficient practice. 3. Measures put in place to ensure the deficient practice will not recur for those residents affected:	10/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 20 This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews, and policy review, the facility failed to monitor the effectiveness of NJ Exec Order 26.4b1 and modify interventions for two of 33 sampled residents (Resident (R)16 and R69). This failure had the potential to interfere with the residents' right to NJ Exec Order 26.4b1 and their NJ Exec Order 26.4b1 about NJ Exec Order 26.4b1 in the facility. Findings include: 1. Review of R16's "Resident Face Sheet," located in the electronic medical record (EMR) under the "Resident" tab, revealed an admission date o NJ Exec Order 26.4 with diagnoses of NJ Exec Order 26.4b1 Review of R16's quarterly "Minimum Data Set (MDS)," located in the EMR under the "RAI (Resident Assessment Instrument)" tab with an Assessment Reference Date (ARD) of NJ Exec Order 26, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26 indicating R16 was NJ Exec Order 26.4b1 . This same MDS indicated there were no changes in R16's mental status and there were no NJ Exec Order 26.4b1 . The MDS indicated a NJ Exec Order 26.4b1 was in use daily. Review of R16's "Care Plan," dated NJ Exec Order 26.4b located in the EMR under the "RAI" tab, revealed R16 was an NJ Exec Order 26.4b1 with a history of NJ Exec Order 26.4b1 the facility. A NJ Exec Order 26.4b1 A review of R16's progress notes located in the EMR under the "Progress Notes" tab dated NJ Exec Order 26 indicated R16 was NJ Exec Order 26.4b1 of the facility NJ Exec Order 26.4b1 and stating NJ Exec had a car waiting for NJ Exec The U.S. FOIA (b)(6) was notified, and she placed a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . There were no other NJ Exec Order 26.4b1 documented in R16's EMR. A review of R16's NJ Exec Order 26.4b assessments located under the "Assessment" tab of the EMR revealed an NJ Exec Order 26.4b assessment dated NJ Exec Order 26.4 indicating R16 was a NJ Exec O	F0689	Continued from page 20 Licensed and Certified staff were re-educated by the Director of Nursing on the "Elopement and Wandering" policy. 4. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The DIRECTOR OF NURSING or designee will audit all residents with wander guards weekly for eight weeks, then monthly for two months, to validate device function, documentation, and care plan accuracy. Results will be reviewed in QAPI for the duration of the audits and until substantial compliance is achieved.	

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F0689 SS = D	Continued from page 21 A review of R16's NJ Exec Order 26 tracking dated NJ Exec Order 26.4b1 revealed no documented NJ Exec Order 26.4b1. During an interview on 09/22/25 at 3:29 PM, R16 stated NJ Ex had the NJ Exec Order 26.4b1 on to keep NJ Exec NJ Exec Or because NJ Ex was NJ Exec Order 26.4b1t. R16 stated NJ Ex did not try to go NJ Exec Order because NJ Ex was NJ Exec Order 26.4b1 A review of R16's EMR revealed no discussion of NJ Exe NJ Exec Order 26.4b1 and whether it was effective or if other interventions should be attempted during the care plan meetings on NJ Exec Order 26.4b1. 2. Review of R69's "Resident Face Sheet," located in the EMR under the "Resident" tab, revealed an admission date of NJ Exec Order 26 with diagnoses of NJ Exec Order 26.4b1 . During the initial tour of the facility on NJ Exec Order 26.4b R69 was observed with a NJ Exec Order 26.4b1 in place. R69 declined to talk with the surveyor during the investigation. Review of R69's annual "MDS," located in the EMR under the "RAI " tab with an ARD of NJ Exec Order 26, revealed the resident had a "BIMS" score of NJ Exec Order 26.4b1 indicating R69 was NJ Exec Order 26.4b1. This same MDS indicated there were no changes in R69's NJ Exec Order 26.4b1 and there were no NJ Exec Order 26.4b1. The MDS indicated a NJ Exec Order Review of R69's "Care Plan," dated NJ Exec Order 26, located in the EMR under the "RAI" tab, revealed R69 was an NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1 the NJ Exec NJ Exec O A NJ Exec Order 26.4b1 was placed on NJ Exec Order 26. A review of R69's progress notes located in the EMR under the "Progress Notes" tab dated NJ Exec Order 26 indicated R69 had a NJ Exec Order 26.4b1 . There was no documentation as to why the NJ Exec Order 26.4b1 was placed. Continued review of the EMR revealed a progress note dated NJ Exec Order 26 noting R69 with NJ Exec Order 26.4b1 . The progress note indicated that R69 NJ Exec Order 26.4b1 and stated NJ Exec Order 26.4b1	F0689		

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F0689 SS = D	Continued from page 22 A review of R69's' NJ Exec Order 26.4b1 assessments located under the "Assessment" tab of the EMR revealed an NJ Exec Order 26.4b assessment dated NJ Exec Order 26.4 indicating R69 was a NJ Exec with no reported incidents of NJ Exec Order 26.4b NJ Exec Order 26.4b in the last month. There was no other assessment for R69 located in the EMR indicating why the NJ Exec Order 26.4b1 was placed. A review of R69's EMR revealed there was no NJ Exec Order 26 monitoring or intervention report implemented for the NJ Exec Order 26.4b1 . A review of R69's EMR revealed no discussion of NJ Exe NJ Exec Order 26.4b1 and whether it was effective or if other interventions should be attempted during the care plan meetings or NJ Exec Order 26.4b During an interview on 09/25/25 at 10:45 AM the U.S. FOIA stated that she will be notified of any attempt to NJ Exec Or and will place the NJ Exec Order 26.4b1 . The U.S. FOIA stated that assessments are completed for the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b risk but were not completed prior to or when these NJ Exec Order 26.4b1 were placed. The U.S. FOIA stated NJ Exec Order were discussed during the care plan meeting and if the behavior NJ Exec Order 26.4b1 the risk should be re-evaluated to see if the NJ Exec Order 26.4b1 was effective. A review of the facility policy titled "Elopement and Wandering Residents" dated 03/05/25 indicated that all residents will be assessed for elopement upon admission and throughout their stay. "Additionally, the facility is responsible to establish a systematic approach to monitoring and managing residents at risk for wandering an assessment of the risks, evaluation of the risks, implementing interventions to reduce the risks and monitoring for the effectiveness of the interventions and modifying the interventions when necessary." NJAC 8:39-5.1(a) NJAC 8:39-27.1(a)	F0689		
F0745 SS = D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest	F0745	1. Immediate corrective action for residents affected by deficient practice: A NJ Exec Order 26.4b1 assessment and NJ Exec Order 26.4b1 Assessment were completed by the NJ Exec Order 26.4b1 r for R66.	10/25/2025

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F0745 SS = D	Continued from page 23 practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of the U.S. FOIA (b)(6) job description, the facility failed to ensure the "Comprehensive NJ Exec Order 26.4b1 Assessment" was completed upon admission for one resident (Resident (R)66) in a total sample of 33 residents. This failure placed residents at risk of NJ Exec Order 26.4b1 . Findings include: Review of an undated U.S. FOIA (b)(6) " job description revealed, "...The U.S. FOIA (b)(6)) is responsible for overseeing the development, implementation, supervision and ongoing evaluation of the U.S. FOIA (b)(6) ...The U.S. FOIA (b)(6) will complete and/or delegate the completion of the social services component of the comprehensive assessment..." Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed that R66 was admitted to the facility on NJ Exec Order 26 with diagnoses that included a NJ Exec Order 26.4b1 Review of the "Comprehensive Social Services Assessment" located in the "Assessments" tab of the EMR, dated NJ Exec Order 26.4 was documented as "incomplete." There was no documentation on the assessment to show the US FOIA had completed the "Comprehensive Assessment." Review of the NJ Exec Order 26.4b1 Visit Note" located in the "Progress Notes" tab of the EMR revealed, "Resident presents NJ Exec Order 26.4b1 . NJ Ex notes a past history of NJ Exec Order 26.4b1 including NJ Exec Order 26.4b1 . NJ Ex reports having a NJ Exec Order 26.4b1 . NJ Ex reports NJ Exec Order 26.4b1 The resident NJ Exec Order 26.4b1 Review of the admission "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment	F0745	Continued from page 23 2. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. 3. Measures put in place to ensure the deficient practice will not recur for those residents affected: The Social Services Director was re-educated by the Regional Social Worker on completing Comprehensive Assessments within 14 days of admission or upon significant change, including trauma screening, psychosocial history, and veteran status. 4. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Administrator or designee will audit five new admissions monthly for three months to verify timely completion of social service assessments and trauma screenings. Results will be reviewed in QAPI for sustained compliance and recommendations.	

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F0745 SS = D	Continued from page 24 Reference Date (ARD) of [redacted] revealed R66 had a "Brief Interview of Mental Status (BIMS)" score of [redacted] which indicated R66 was [redacted], had [redacted] medication during the observation period. During an interview on 09/22/25 at 9:32 AM, R66 was asked about [redacted] and if the facility met [redacted]. R66 stated, [redacted]]." R66 was asked if [redacted] is seeing a [redacted] R66 stated that [redacted] used to see a [redacted] During an interview on 09/24/25 at 8:52 AM, the [redacted] was asked about her incomplete "Comprehensive Assessment" and when this assessment should be completed. The [redacted] stated, 'It should have been done after admission." The [redacted] confirmed that it was not completed. The [redacted] was asked if she was aware that R66 had voiced that [redacted] had [redacted]. The [redacted] stated, "No, I wasn't aware of it." The [redacted] was asked if she performs, upon admission, a [redacted] Informed Care" assessment to determine any [redacted]. The [redacted] stated, "No, I don't do those unless the resident brings it up." NJAC 8:39-27.1(a)	F0745		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F0880	1. Immediate corrective action for residents affected by deficient practice: Residents R6 and R14 were assessed by the [redacted] on [redacted]. Both had active [redacted] place. Signage and PPE carts were verified as stocked and visible. CNA4 and LPN8 were re-educated on proper PPE use by Infection Preventionist. 2. Identify those individuals who could be affected by the deficient practice: All residents/staff/and families have to the potential to be affected by this deficient practice. 3. Measures put in place to ensure the deficient practice will not recur for those residents affected: Licensed, certified and non-licensed staff re-educated on the Infection Prevention and EBP policies, including	10/25/2025

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F0880 SS = D	Continued from page 25 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 25 PPE use, signage, and hand hygiene by the Director of Nursing/Designee. 4. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Infection Preventionist or designee will conduct weekly PPE/EBP audits on five residents for eight weeks, then monthly for two months, to verify compliance with PPE use, signage, and staff awareness. Results will be reviewed in QAPI for sustained compliance and recommendations until substantial compliance is achieved.	

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F0880 SS = D	Continued from page 26 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the facility failed to ensure staff wore the proper Personal Protection Equipment (PPE) when caring for two of two residents (Resident (R)6 and R14) identified as requiring NJ Exec Order 26.4b1 ([redacted] out of a total sample of 33 residents. This NJ Exec Order 26.4b1 [redacted]. Findings include: 1. Review of R6's "Admission Record" located in the EMR tab titled "Profile' revealed the resident was admitted to the facility on [redacted] with diagnoses that include NJ Exec Order 26.4b1 [redacted]. Review of R6's "Weekly [redacted] Review" dated [redacted] located in the EMR tab titled "Assessment" revealed the resident had developed a NJ Exec Order 26.4b1 [redacted] Review of R6's "Physician Orders' dated [redacted] located in the EMR tab titled "Orders" revealed the resident was on NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1. Observation on NJ Exec Order 26.4b1 revealed Certified Nursing Assistant (CNA)4 entering R6's room carrying linen supplies without donning a gown and gloves. There was [redacted] signage posted on the resident's [redacted] and a cart that contained face masks, gloves, and gowns. CNA4 reentered the resident's room again without donning gown and gloves. Upon entering the room CNA4 was observed preparing to give R6 a bed bath. During an interview on 09/24/25 at 8:42 AM, CNA4 revealed that she was an agency CNA and had worked with the resident for the past month and was not aware the resident was on [redacted] and that she should wear personal protective equipment (PPE) when providing resident care.	F0880		

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F0880 SS = D	Continued from page 27 2. Review of R14's "Admission Record" located in the EMR tab titled " Profile" revealed the resident was admitted to the facility on [redacted] with diagnoses that included NJ Exec Order 26.4b1 [redacted]. Review of R14's "Physicians Orders" dated [redacted] located in the EMR tab titled "Orders" revealed the resident required [redacted] related to having a [redacted] and history of NJ Exec Order 26.4b1 [redacted]. Observation during the initial tour on 09/22/25 at 11:35 AM revealed R14's room did not have [redacted] signage or a cart containing PPE outside [redacted] room. Observation on 09/22/25 at 1:10 PM revealed Licensed Practical Nurse (LPN)8 entering R14's room without donning personal protective equipment to administer medications and to check the resident's [redacted]. Observation on 09/23/25 at 9:30 AM revealed R14 was in [redacted] room preparing for NJ Exec Order 26.4b1. During an interview on 09/23/25 at 9:30 AM, R14 revealed staff did not always wear a gown and gloves when entering the room to provide care such as checking NJ Exec Order 26.4b1 or emptying NJ Exec Order 26.4b1 [redacted]. During an interview on 09/23/25 at 1:48 PM, LPN8 stated R14 had been on [redacted] precautions since admission to the facility for NJ Exec Order 26.4b1 [redacted]. LPN8 was also reminded that she was observed entering the resident's room to provide medications on 09/22/25 without donning PPE. LPN8 stated that she was unaware of that this surveyor was observing her on 09/22/25.. Review of the facility's policy titled, ""Infection Prevention and Control Programs," dated 09/01/24, revealed, ". . . This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines." The policy indicated that all staff were responsible for following all policies and procedures related to the program. Review of the facility's policy titled, "Enhanced Barrier Precautions," dated 09/01/24, revealed, "It is	F0880		

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F0880 SS = D	Continued from page 28 the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug organisms . . . ""An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO . . . . PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . . . High-contact resident care activities include a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting . . ." NJAC 8:39-19.4	F0880		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza	F0883	1. Immediate corrective action for residents affected by deficient practice: Residents R12, R82, R89, and R129 were reviewed by the NJ Exec Order 26.4b1 and Director of Nursing on NJ Exec Order 26.4b1. R12 and R129 were offered the NJ Exec Order 26.4b1 with education and documented consent. R89's form was corrected, and R82's prior consent and NJ Exec Order 26.4b1 were verified. 2. Identify those individuals who could be affected by the deficient practice: All residents could be affected by this deficient practice. 3. Measures put in place to ensure the deficient practice will not recur for those residents affected: Licensed nurses were re-educated by the Infection Preventionist and Director of Nursing on the policy "Infection Prevention and Control Program" related to vaccine offering, education, administration and documentation. 4. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Infection Preventionist or designee will audit five resident charts monthly for three months to verify vaccine education, offer, consent, and administration are documented. Findings will be reviewed in QAPI for	10/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON , SHREWSBURY, New Jersey, 07702

(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
F0883 SS = E	Continued from page 29 immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure four of five residents (Resident (R)12, R82, R89, and R129) reviewed for NJ Exec Order 26.4b1 out of a total sample of 33 residents had been offered and/or provided a NJ Exec Order 26.4b1 [redacted]. This failure increased the risk of residents contracting NJ Exec Order 26.4b1. Findings include: 1. Review of R12's electronic medical record (EMR), located under the “Census” tab revealed R12 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses found under the “Medical Diagnosis” tab included encounter for NJ Exec Order 26.4b1 [redacted]	F0883	Continued from page 29 recommendations until sustained compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON , SHREWSBURY, New Jersey, 07702

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F0883 SS = E	Continued from page 30 Review of R12's paper medical record revealed no documentation that the resident had been offered a NJ Exec Order 26.4b1 . 2. Review of R82's EMR , located under the "Census" tab of the EMR, revealed R82 was admitted to the facility on NJ Exec Order 26.4 with diagnoses found under the "Medical Diagnosis" tab included NJ Exec Order 26.4b1 [redacted] Review of R82's paper medical record revealed authorization for the NJ Exec Order 26.4b1 had been signed by NJ Exec Order 26.4b1 on NJ Exec Order 26 . 3. Review of R89's EMR located under the "Census" tab of the EMR, revealed R89 was admitted to the facility on NJ Exec Order 26 with diagnoses found under the "Medical Diagnosis" tab included encounter for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . Review of R89's paper medical record revealed NJ Exec had signed the consent form on NJ Exec Order 26 for a NJ Exec Order 26.4b1 but did not indicate whether NJ Exec had wanted the NJ Exec Order 26.4b1 or not. 4. Review of R129's EMR, located under the "Census" tab of the EMR, revealed R129 was admitted to the facility on NJ Exec Order 26 with diagnoses found under the "Medical Diagnosis" tab included NJ Exec Order 26.4b1 [redacted] . Review of R129's medical record revealed no documented evidence that NJ Exec Order 26.4b1 had been offered. During an interview on 09/23/25 at 2:00 PM, Licensed Practical Nurse (LPN) 2, who was the U.S. FOIA (b)(6) for the NJ Exec Order floor, stated when a new resident was admitted, the admitting nurse was responsible for providing education to the resident and/or representative on the NJ Exec Order 26.4b1 . LPN2 stated the nurse would also have the forms signed with the choice made. LPN2 confirmed the NJ Exec Order 26.4b1 forms	F0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON , SHREWSBURY, New Jersey, 07702

(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
F0883 SS = E	Continued from page 31 for the above residents had not been signed and/or no choice had been made. During an interview on 09/23/25 at 3:30 PM, the U.S. FOIA (b)(6) stated the admitting nurse was responsible for offering the NJ Exec Order 26.4b1 and for completing the consent form. The U.S. FOIA stated the U.S. FOIA (b)(6) followed up with an audit of the records to ensure the forms had been signed and the residents had chosen whether or not to receive the NJ Exec Order 26.4b1 During an interview on 09/24/25 at 1:16 PM, the U.S.F stated her role was to ensure the NJ Exec Order 26.4b1 forms had been filled out completely. The U.S.F confirmed the staff were not ensuring the resident and/or their representatives had been offered the NJ Exec Order 26.4 Review of the facility's policy titled, "Infection Prevention and Control Program," dated 09/01/24, revealed, ". . . "Residents will be offered the pneumococcal vaccines recommended by the Centers for Disease Prevention and Control (CDC) upon admission, unless contraindicated or received the vaccines elsewhere . . ." NJAC 8:39-19.4	F0883		
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident	F0887	Immediate corrective action for residents affected by deficient practice: Residents R12, R82, R89, and R129 were reviewed by the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 and consents were verified. R12 and R129 were NJ Exec Order 26.4b1 with education documented. R82's NJ Exec Order 26.4b1 was completed on NJ Exec Order 26.4b1, and R89's consent form was corrected. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. Measures put in place to ensure the deficient practice will not recur for those residents affected: All licensed nurses, and agency staff were re-educated on the COVID-19 Immunization Policy, focusing on vaccine education, offering, and documentation. The	10/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON , SHREWSBURY, New Jersey, 07702

(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
F0887 SS = D	Continued from page 32 or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure four of five residents (Residents(R) 12, R82, R89, and R129) reviewed for NJ Exec Order 26.4b1 out of a total sample of 33 were offered a NJ Exec Order 26.4b1 and/or chose to have the NJ Exec Order 26.4b1 but had not received it. Failure to	F0887	Continued from page 32 Admission Checklist was updated to verify offer, education, and consent, with standing orders for on-site vaccination once consent is obtained. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Infection Preventionist or designee will audit five residents weekly for four weeks, then monthly, to ensure COVID-19 vaccine education, consent/refusal, and documentation are complete. Results will be reviewed in QAPI for review Monthly and quarterly recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

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F0887 SS = D	Continued from page 33 offer and administer could result in the residents acquiring NJ Exec Order 26.4b1 Findings include: 1. Review of R12's electronic medical record (EMR) "Census" tab revealed R12 was admitted to the facility on NJ Exec Order 26 with diagnoses found under the "Medical Diagnosis" tab included encounter for NJ Exec Order 26.4b1 [redacted]. Review of R12's paper medical record revealed no documentation to show that the NJ Exec Order 26.4b1 was offered. 2. Review of R82's EMR "Census" tab of the EMR, revealed R82 was admitted to the facility on NJ Exec Order 26 with diagnoses found under the "Medical Diagnosis" tab included NJ Exec Order 26.4b1 [redacted]. Review of R82's paper medical record revealed authorization for a NJ Exec Order 26.4b1 had been signed by NJ Exec Order 26.4b1 on NJ Exec Order 26.4 3. Review of R89's EMR "Census" tab of the EMR, revealed R89 was admitted to the facility on NJ Exec Order 26 with diagnoses found under the "Medical Diagnosis" tab included NJ Exec Order 26.4b1 [redacted]. Review of R89's paper medical record revealed NJ Exec had signed the consent form on NJ Exec Order 26 for NJ Exec Order 26.4b1 [redacted] but did not indicate whether NJ Exec had wanted the NJ Exec Order 26.4b1 or not. 4. Review of R129's EMR "Census" tab of the EMR, revealed R129 was admitted to the facility on NJ Exec Order 26.4 with diagnoses found under the "Medical Diagnosis" tab included NJ Exec Order 26.4b1 [redacted]. Review of R129's medical record revealed no documentation to show the NJ Exec Order 26.4b1 was offered.	F0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

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F0887 SS = D	Continued from page 34 During an interview on 09/23/25 at 2:00 PM, Licensed Practical Nurse (LPN) 2, who was the [NJ Exec Order 26.4b1] for the [NJ Exec Order] floor, stated when a new resident was admitted, the admitting nurse was responsible for providing education to the resident and/or representative on the [NJ Exec Order 26.4b1] LPN2 stated the nurse would also have the forms signed with the choice made. She confirmed the [NJ Exec Order 26.4b1] forms for the above residents had not been signed or no choice had been made for the [NJ Exec Order 26.4b1] During an interview on 09/23/25 at 3:30 PM, the [U.S. FOIA (b)(6)] stated the admitting nurse was responsible for ensuring the [NJ Exec Order 26.4b1] had been offered and the form completed with their choice and signature. The [U.S. FOIA] stated the [U.S. FOIA (b)(6)]) followed up with an audit of the records to ensure the forms had been signed and the residents had made a choice related to [NJ Exec Order 26.] During an interview on 09/24/25 at 1:16 PM, the [U.S] stated her role was to ensure the [NJ Exec Order 26.4b1] forms had been filled out completely. She confirmed the staff were not ensuring the resident and/or their representatives had been asked about [NJ Exec Order 26.4b1] Review of the facility's policy titled, ""Infection Prevention and Control Program," dated 09/01/24, revealed, ". . . "Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance . . ." NJAC 8:39-5.1(a)	F0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON , SHREWSBURY, New Jersey, 07702

(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
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		10/25/2025
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.	S0560	1.Immediate corrective action for residents affected by deficient practice: Upon identifying the staffing deficiency, the Administrator and DIRECTOR OF NURSING reviewed schedules from December 29, 2024, to September 20, 2025. Ongoing recruitment includes wage adjustments, incentives, job fairs, shift differentials, and referral bonuses. Additional agency contracts were secured for coverage. The Administrator and Staffing Coordinator meet regularly to monitor staffing. 2.Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice; therefore, this plan applies to all current and future residents. 3.Measures put in place to ensure the deficient practice will not recur for those residents affected: Additional staffing agency contracts were secured to ensure coverage. Recruitment efforts include wage adjustments, experience-based pay, job postings, fairs, shift differentials, and referral bonuses. The Administrator and DIRECTOR OF NURSING meet regularly with the Staffing Coordinator to monitor CNA ratios, review schedules, and address callouts within 24 hours. 4.Monitoring of measures or systemic changes to ensure	10/25/2025

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: 061326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON , SHREWSBURY, New Jersey, 07702

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S0560	Continued from page 1 One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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 12/29/2024 to 01/04/2025, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -12/29/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. -01/04/25 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. 2. For the week of Complaint staffing from 01/12/2025 to 01/18/2025, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -01/13/2025 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. 3. For the week of Complaint staffing from 02/02/2025 to 02/08/2025, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -02/02/25 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. 4. For the week of Complaint staffing from 02/16/2025 to 02/22/2025 the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -02/16/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/17/25 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.	S0560	Continued from page 1 that the deficiencies will not recur: The Director of Nursing / designee will review staffing logs weekly to ensure all shifts meet required ratios. The Administrator and Director of Nursing will conduct weekly audits for 3 months to validate ratios and attempts to meet ratios. Findings will be reviewed in QAPI for recommendations until sustained compliance is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

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S0560	Continued from page 2 -02/20/25 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. 5. For the 2 weeks of Complaint staffing from 03/09/2025 to 03/16/2025, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -03/09/25 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -03/10/25 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -03/16/25 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -03/21/25 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. 6. For the week of Complaint staffing from 05/25/2025 to 05/31/2025, there were no deficient practices identified for staffing as submitted. 7. For the 2 weeks of staffing prior to survey from 09/07/2025 to 09/20/2025, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -09/07/25 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -09/12/25 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -09/14/25 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -09/19/25 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs.	S0560		

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COMPLETE CARE AT SHREWSBURY LLC	**89 AVENUE AT THE COMMON , SHREWSBURY, New Jersey, 07702**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 1/12/2026 in relation to the 9/25/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 1/12/2026 in relation to the 9/25/2025 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: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - RELOCATION FACI... B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON , SHREWSBURY, New Jersey, 07702

(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
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 09/25/25 and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Complete Care at Shrewsbury LLC is a three-story building with partial basement built in 2006. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator powers 100% of the building per the U.S. FOIA (b)(6). The current occupied beds are 117 of 140.	K0000		10/27/2025
K0311 SS = F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined	K0311	Immediate Corrective Action for Residents Affected by the Deficient Practice: The Maintenance Director immediately sealed the ¾-inch by 42-inch gap above stairway door #3 near Room NJ Exit using approved fire-rated materials in accordance with NFPA 101 requirements. Identification of Other Individuals Who Could Be Affected by the Same Deficient Practice: A facility-wide inspection of all stairwell doors and vertical openings was conducted to ensure that all penetrations were properly sealed with approved fire-rated materials. No additional unsealed openings were identified. Measures Put in Place or Systemic Changes to Ensure the Deficient Practice Will Not Recur: Maintenance staff were re-educated on NFPA 101 (2012), Section 7.2.1.7.2, regarding stairway shaft enclosures and the proper use of fire-rated sealing materials. A Quarterly Life Safety Audit Tool was implemented to proactively identify and address any future	10/25/2025

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: 315136	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 02 - RELOCATION FACI... B. WING	09/25/2025

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K0311 SS = F	Continued from page 1 that the facility failed to ensure stairway shaft penetrations were sealed with fire rated material in accordance with NFPA 101 Life Safety Code (2012 Edition) section 7.2.1.7.2 for one of 11 stairway fire doors in the nursing home. This deficient practice had the potential to affect all 117 residents and was evidenced by the following: An observation on 09/25/25 from 11:30 AM to 5:00 PM revealed that an area above stairway door number three on the first floor near room [redacted] had a ¾ - inch by 42-inch-long gap above the door frame that was not sealed with fire rated material. During an interview at the time of observations, the [redacted] confirmed that the gap was not sealed above the door frame. NJAC 8:390-31.1(c), 31.2(e)	K0311	Continued from page 1 deficiencies. Monitoring of Measures or Systemic Changes to Ensure the Deficiency Will Not Recur: The Administrator or designee will review Quarterly Life Safety Audit results during monthly QAPI meetings and the Environment of Care Committee for a period of 12 months. Any identified findings will be addressed immediately through corrective action and documented follow-up.	
K0351 SS = F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined	K0351	Tag K0351 – Mixed Sprinkler Head Types in Same Compartment Immediate Corrective Action for Residents Affected by the Deficient Practice: The standard-response sprinkler head in the main entrance foyer was replaced with a quick-response head to ensure uniformity per NFPA 13. Identification of Other Individuals Who Could Be Affected by the Same Deficient Practice: A complete facility-wide sprinkler inspection was completed to verify that all compartments contain only one type of sprinkler head. Measures Put in Place or Systemic Changes to Ensure the Deficient Practice Will Not Recur: The facility's contracted fire protection vendor updated the inventory of sprinkler head types by location. Maintenance staff were retrained on proper sprinkler installation standards. Monitoring of Measures or Systemic Changes to Ensure the Deficiency Will Not Recur: The Maintenance Director or designee will conduct semi-annual spot checks to confirm sprinkler head consistency throughout the facility and document findings in the Life Safety Log. Results of these	10/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 02 - RELOCATION FACI... B. WING	09/25/2025

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K0351 SS = F	Continued from page 2 that the facility failed to ensure the fire sprinkler heads were the same throughout a compartment in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2012 Edition) Section 8.3.3.2. This deficient practice had the potential to affect all 117 residents and was evidenced by the following: An observation on 09/25/25 at 12:19 PM revealed a quick response sprinkler and a standard response sprinkler in the same compartment in the foyer of the main entrance. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the quick response sprinkler and the standard response sprinkler were installed in the same compartment. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K0351	Continued from page 2 audits will be reviewed during monthly QAPI meetings for a period of 12 months. Any identified variances will result in immediate corrective action and follow-up documentation.	
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 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 observations and interview, it was determined that the facility failed to ensure the sprinkler piping	K0353	Tag K0353 – Sprinkler Piping Penetration and Painted Sprinkler Head Immediate Corrective Action for Residents Affected by the Deficient Practice: The 2-inch unsealed hole around the 4-inch sprinkler pipe in stairway #1 was immediately sealed with approved fire-rated material. The painted quick-response sprinkler in the Maintenance Office was replaced. Identification of Other Individuals Who Could Be Affected by the Same Deficient Practice: A full building inspection was conducted for any unsealed sprinkler penetrations or painted sprinkler heads; none were identified. Measures Put in Place or Systemic Changes to Ensure the Deficient Practice Will Not Recur: Maintenance and contracted fire safety personnel were retrained on NFPA 25 standards for sprinkler system maintenance and inspection. Fire protection vendor checklists were updated to include verification of non-painted heads and sealed penetrations. Monitoring of Measures or Systemic Changes to Ensure the Deficiency Will Not Recur: The Administrator or designee will review monthly Life	10/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 02 - RELOCATION FACI... B. WING	09/25/2025

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K0353 SS = F	Continued from page 3 in the elevator shaft was sealed with fire rated material in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 8.6.5. and failed to ensure quick response sprinklers were not painted in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) section 5.2.1.1.2 These deficient practices had the potential to affect all 117 residents and were evidenced by the following: An observation on 09/25/25 at 3:04 PM revealed a 4-inch sprinkler pipe in stairway number one to the foyer in the rehabilitation room had a 2-inch hole completely around the pipe that was not sealed with fire rated material. An observation on 09/25/25 at 2:36 PM revealed a quick response sprinkler in the maintenance office was painted. During an interview at the time of observations, the U.S. FOIA (b)(6) confirmed the 4-inch sprinkler pipe was not sealed in the stairway and that the quick response sprinkler was painted in the maintenance office. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K0353	Continued from page 3 Safety inspection reports, with findings trended and formally reviewed during monthly QAPI meetings for a period of 12 months. Any identified variances will result in immediate corrective action and documented follow-up.	
K0712 SS = F Bldg. 02	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on record review and interview, it was determined	K0712	Tag K0712 – Fire Drill Transmission of Alarm Signal Immediate Corrective Action for Residents Affected by the Deficient Practice: The facility immediately conducted a fire drill including transmission of an alarm signal to the monitoring company to verify functionality and staff response. Identification of Other Individuals Who Could Be Affected by the Same Deficient Practice: All staff responsible for fire drills were identified and retrained on proper fire drill procedures, including documentation of alarm signal transmission. Measures Put in Place or Systemic Changes to Ensure the Deficient Practice Will Not Recur: The fire drill policy was revised to include mandatory	10/25/2025

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K0712 SS = F Bldg. 02	Continued from page 4 that the facility failed to ensure the fire alarm included the transmission of a fire alarm signal in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.1.4. This deficient practice had the potential to affect all 117 residents and was evidenced by the following: A review of the facility's untitled fire drill records revealed the facility failed to transmit an alarm signal to the fire alarm system monitoring company for 10 out of 12 months. During an interview at the time of document review the U.S. FOIA (b)(6) confirmed that the fire alarm signal was not transmitted to the fire alarm monitoring company. NJAC 8:39-31.2(e)	K0712	Continued from page 4 documentation of alarm signal transmission verification by both facility staff and the monitoring company. Monitoring of Measures or Systemic Changes to Ensure the Deficiency Will Not Recur: The Maintenance Director or designee will audit all fire drill records monthly for 12 months to ensure alarm signal transmission documentation is present and complete. Audit findings will be reviewed by the Safety Committee monthly and reported to the QAPI Committee monthly and quarterly for recommendations and concerns to ensure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

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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) on 09/25/25. The facility was found to be in compliance with 42 CFR Subpart 483.73.	E0000		10/27/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - RELOCATION FACI... B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

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K0000 Bldg. 02	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 1/12/2026 in relation to the 9/25/2025 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.

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