STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE , NEPTUNE, New Jersey, 07753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint #s:NJ #s 2577317, # 2743500 Survey Date: 3/26/26 Census: 119 Sample: 24 + 2 Closed Records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		05/04/2026
F0684 SS = SQC-H	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 observation, interview and record review, it was determined that the facility failed to ensure staff provided care in a manner for residents to attain their highest practicable [NJ Ex Order 26.4] and NJ Ex Order 26.4(b)(1) by ensuring processes were put in place a.) to identify a change in condition in a timely manner, b.) to assess any [NJ Ex Order 26] in the NJ Ex Order 26.4(b)(1) of a resident (Resident #58) who required assistance with [NJ Ex Order 26] and was not provided [NJ Ex Order 26.4(b)] for over [NJ Ex Order 26.4(b)(1)], and c.) to ensure a recommended physician follow-up appointment was scheduled. On 3/25/26, Resident #58 asked the surveyor to assist them in obtaining a	F0684	Element I Resident #58 The Unit Manager immediately assessed R58 from [NJ Ex Order 26.4(b)(1)] and immediately referred to the [NJ Ex Order 26] or to the change in condition related to [NJ Ex Order 26.4(b)] to the Attending Physician (AP). The AP came on the same day and identified NJ Ex Order 26.4(b)(1) . [NJ Ex Order 26.4(b)] treatment was initiated without delay. The responsible party was immediately notified of the sudden change in condition. Director of Nursing and/or designee immediately in-service the nursing staff were re-educated on timely identification of changes in condition and documentation requirements. The Unit Manager and the Certified Nursing Assistant immediately discussed the shower preference of the resident who used to refuse showers which was also reflected in the plan of care of the resident. The Certified Nursing Assistant immediately provided the shower. The resident has since received a complete shower, and a revised	05/15/2026

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: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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F0684 SS = SQC-H	Continued from page 1 NJ Ex Order 26.4 who was then NJ Ex Order 26.4(b)(and the resident had NJ Ex Order assessment completed by the physician who identified NJ Ex Order 26.4(b)(1)) that required NJ Ex Order 26.4(b) treatment. This deficient practice was identified for 1 of 3 residents (Resident #58) reviewed for quality of care. The facility further failed to ensure processes were in place d.) to ensure for twelve days a resident (Resident #7) was provided their wheelchair after a room NJ Ex Order 26.4(b)(1) get out of bed and e.) ensure a physician's order for the application of NJ Ex Order 26.4(b)(1) to a resident's (Resident #8) NJ Ex Order 26.4(b)(1) was followed. This deficient practice was identified for 3 of 3 residents reviewed for quality of care and physician's orders (Resident #7, #8 and #58), and was evidenced by the following: A review of the facility's policy titled "Change in a Resident's Condition or Status," last updated December 2025, included that the facility will promptly notify the resident, his or her representative or his or her physician of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, reside rights, etc.)...1.The nurse will notify the resident's attending physician on call when there has been a (an): Accident or incident involving the resident; Discovery of an injury of unknow origin; Adverse reaction to medications; Needs to alter the resident's medical treatment significantly; Significant change in the resident's physical, emotional/mental condition; Need to transfer the resident to a hospital/treatment center; Discharge without proper medical authority; and or; Specific instructions to notify the physician of changes in the resident's condition. 2. A "significant change" of condition is a major decline or improvement in a resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not "self-limiting"); Impacts more than one area of the resident's health status; Requires interdisciplinary review/or revision to the care plan; and ultimately is based on judgement of the clinical staff and the guidelines in the Resident Assessment Instrument. 3.Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider…6. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or status…8. The nurse will record information in the resident's medical record relative to changes in the resident's medical/ mental condition or status…	F0684	Continued from page 1 bathing schedule has been implemented per resident preference and care needs. The Unit Manager immediately referred to the resident to NJ Ex Orde or NJ Ex Order 26.4(b)(to verify NJ Ex Order 26.4(b) The resident was evaluated and found with NJ Ex Order 26.4(b)(1) at this time and continue to have the ability to NJ Ex Order 26.4(b)(1) with wheelchair and NJ Ex Order 26.4(b)(1). No NJ Ex Order 26 indicated at this time. NJ Ex Order 26 was offered and completed immediately. The Director of Nursing and/or designee immediately in-service the nursing staff on the importance of resident's NJ Ex Order 26 and NJ Ex Order 26 The Unit Manager immediately followed up the missed appointment and immediately set it up to be seen and evaluated the same day, 3/26/26. The resident was last seen by the NJ Ex Order 26.4 Nurse Practitioner in the facility on NJ Ex Order 26.4(b)(1). Scheduled follow up appointment was on NJ Ex Order 26.4(b) and NJ Ex Order 26 for a routine visit, however the NJ Ex Order 26.4(Services cancelled their facility visit as scheduled. The Director of Nursing and/or designee immediately in-service the Unit Manager and nursing staff on the importance of following through resident's appointments. Resident #7 The Unit Manager immediately located the R7 wheelchair outside of the resident's room and resident was assisted out of bed immediately as per resident's request. It was confirmed the resident is on NJ Exec Order 2 services and has exhibited consistent NJ Exec Orde to get out of bed. Care plan was reviewed and updated to reflect NJ Exec Order 2 in the past, NJ Exec Order 2 goals of care, and comfort-focused interventions. Wheelchair access has been ensured and remains available at bedside should the resident accept assistance. The Director of Nursing immediately in-service the U.S. FOIA (b)(6) in reference to plan of care once they move from one unit to another.	05/15/2026

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F0684 SS = SQC-H	Continued from page 2 1.On 3/22/26 at 8:40 AM, the surveyor observed Resident #58 sitting in their room, in a wheelchair, eating breakfast. Resident #58 had no [redacted] on their [redacted] that were placed directly on the floor. [redacted] appeared [redacted]. The [redacted] of the resident's [redacted] had [redacted] that was [redacted] through their [redacted]. Their [redacted] had a [redacted] and appeared [redacted]. The resident asked the surveyor to return after breakfast, and the surveyor exited their room to continue their tour. On 3/22/26 at 10:08 AM, the surveyor returned to Resident #58's room and the resident was sitting in the same position as observed at 8:40 AM, still dressed in their pajamas. On 3/23/26 at 9:15 AM, the surveyor returned to Resident #58's room and observed the resident sitting in their wheelchair by the bed. Their [redacted] again were [redacted] and appeared [redacted] and had some [redacted]. Resident #58 had [redacted] on the floor. The resident had the same pair of pajamas as observed on 3/22/26 at 8:40 AM. Resident #58 informed the surveyor that they wanted to talk with them at another time. The surveyor exited the room and interviewed a Certified Nursing Aide (CNA) regarding where the documentation was located for [redacted] log. The CNA escorted the surveyor to the nursing station and provided the [redacted] logbook for review. According to the log provided, Resident #58 was scheduled to have [redacted] every Sunday during the 7:00 AM-3:00 PM (7-3) shift, and on Thursday during the 3:00 PM-11:00 PM (3-11) shift. The surveyor reviewed the assignment sheets and observed that Resident #58 was scheduled for a [redacted] or [redacted]. A [redacted] assessment was also supposed to be completed on [redacted] days. According to the Treatment Administration Record (TAR), the nurses had signed the TAR indicating that a [redacted] assessment was completed on Resident #58 and there were [redacted] on [redacted]. On 3/24/25 at 8:45 AM, the surveyor observed Resident #58 in their room still eating breakfast and the resident had asked the surveyor to return in thirty minutes. The surveyor returned to the room at	F0684	Continued from page 2 The DON and UMs conducted an audit on all room changes in the last 30 days and all DMEs were transferred. No other residents were affected by this deficient practice. Resident #8 The Unit Manager immediately assessed the resident and reviewed treatment order. On 3/23/26, an updated physician order was obtained for the [redacted] according to the resident's needs. The assigned LPN was educated on the following: timely documentation of treatment and following physician's treatment as ordered. A medication error was completed related to the omission on the Treatment Administration Record (TAR) related to application of ace wrap. [redacted] noted with physician's notification. Element II All residents have the potential to be affected by this practice. Element III 1. The Facility educator and/or designee will in-service all the nurses on Federal Guidelines F 684 related change in condition, ADL delivery expectations, functional status, showers, appointments, treatments, room changes and revaluation of the resident's needs, treatment orders, following physician's orders, and standard of practice in documentation. 2. The Director of Nursing implemented a centralized tracking log for the specialist for all the appointments on each unit. The Unit Managers and/or designee will audit 5 residents with the specialist appointments weekly for 4 weeks then 10 resident's appointment monthly for 3 months. 3. The Director of Nursing created a room change checklist form to be completed. 4. The Unit Manager and/or designee will audit weekly 5 residents that moved or transferred for all the necessary medical equipment they need will always remain accessible to the resident unless contraindicated, then 5 residents monthly for 3 months.	05/15/2026

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F0684 SS = SQC-H	Continued from page 3 9:50 AM, and observed Resident #58 sitting in their wheelchair still wearing the same pair of pajamas observed on 3/22/26 at 8:40 AM. The resident's NJ Ex Order 26.4(b)(1) and appeared to NJ Ex Order 26.4(b)(1) The surveyor interviewed the resident and inquired if they received assistance with care. The resident replied, NJ Ex Order 26.4(b)(1) The resident continued that, NJ Ex Order 26.4(b)(1) The resident stated to the surveyor "NJ Ex Order 26.4(b)(1) ?" The surveyor then asked the resident when the last time they NJ Ex Order 26.4(b)(1) and the resident replied, NJ Ex Order 26.4(b)(1) ." The surveyor then conducted a follow-up review of the TAR, which verified that staff had signed that Resident #58 received NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b)(1) At that time, the surveyor reviewed Resident #58's TAR with the U.S. FOIA (b)(6), who stated that staff "did not report any NJ Exec Order of care" for the resident. The U.S. FO then stated that Resident #58 was NJ Exec Order 26.4b1 with care and required only NJ Exec Order 26.4 assistance with care." According to the TAR, Resident #58 received NJ Ex Order 26.4(b) twice a week on their assigned days, Sunday and Thursday. The surveyor reviewed the electronic medical record for Resident #58. A review of the Admission Face Sheet, an admission summary, reflected that Resident #58 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, reflected that Resident #58 had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, which indicated an NJ Ex Order 26.4(b)(1) A further review of the MDS, revealed for Section NJ Ex Order 26.4(b)(1) " that the resident had NJ Ex Order 26.4(b)(1) and required NJ Ex Order 26.4(b)(1)	F0684	Continued from page 3 5. The DON or designee will conduct weekly treatment record audits for 5 residents for 4 weeks then monthly x 3 months to ensure compliance. Element IV The Director of Nursing and/or designee will submit the audit report to the Quality Assurance and Performance Improvement (QAPI) committee for trend analysis and corrective action quarterly for the next 3 quarters.	05/15/2026

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F0684 SS = SQC-H	Continued from page 4 NJ Ex Order 26.4(b)(1)) for NJ Ex Order 26.4(b)(1) A review of the resident's 12-page Care Plan (CP), provided by the facility on NJ Exec Order2 at 11:42 AM, revealed that resident had an activities of daily living (ADLs) NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1), initiated on NJ Ex Order 26.4. The goal was to maintain current level of NJ Ex Order 26.4 in ADL function and in ADL tasks through the review date, initiated on NJ Ex Order 26.4. The interventions all initiated on NJ Ex Order 26., included for NJ Ex Order 26.4(b)(1) resident can NJ Ex Order 26.4(b)(1) and needs NJ Ex Order 26.4(b)(1) to do so. NJ Ex Order 26. days are Sunday 7-3 and Thursday 3-11, NJ Ex Order 26.4(b)(1) as ordered, and NJ Ex Order 26.4(b) [Resident #58] is able to: NJ Ex Orde [themselves] with staff reminders to NJ Ex Order 26.4(b)(1). All the interventions were initiated on NJ Ex Order 26.4 and the CP had not been revised to make it current. A review of a Consultation Note from the NJ Exec Order 26 Doctor indicated that Resident #58 was last seen on NJ Ex Order 26. Resident #58 had diagnoses of NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1). Resident #58 was seen at that appointment for a NJ Exec Order 26.4b1 follow-up NJ Ex Order 26.4(b)(1) and was scheduled to follow-up with NJ Ex Order 26.4(in NJ Ex Order 26.4(b)(1). A review of the medical record revealed Resident #58 missed their scheduled appointment for their NJ Ex Order 26.4(b)(1) follow-up on NJ Ex Order 26.4. On 3/25/26, the surveyor reviewed the consultation with the U.S. FO and inquired about the follow-up. The U.S. FO reviewed the calendar at the nursing station and informed the surveyor that they could not locate the appointment for the NJ Ex Order 26.4(Doctor. During surveyor observations between 3/22/26 to 3/25/26, the surveyor observed Resident #58 with thei NJ Ex Order 26.4(b)(1) The NJ Ex Order 26.4(b)(1) area was NJ Ex Order 26.4. The NJ Ex Order 26.4(b)(1) appeared NJ Ex Or with some NJ Ex Order 26.4(b)(1) Resident #58 had a NJ Ex O check documented as completed on NJ Ex Order 26.4 which indicated that their NJ Ex O was NJ Ex Order	F0684		05/15/2026

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F0684 SS = SQC-H	Continued from page 5 On 3/25/26, the surveyor accompanied by the U.S. FO went to Resident #58's room, and the U.S. FO confirmed the observation of Resident #58's NJ Ex Order 26.4(b)(1) that were NJ Ex Order 26.4(b)(1) . On 3/25/26 at 10:47 AM, during a telephone interview with the U.S. FOIA (b)(6), who was Resident #58's physician, the surveyor asked if the facility had informed her of the condition of Resident's 58's NJ Ex Order 26.4(b)(1) and she stated that she had not been contacted by the facility regarding Resident #58's NJ Ex Order 26.4(b)(1) On 3/25/26 at 10:53 AM, after surveyor inquiry, the UM documented in the Progress Notes that Resident #58 was noted to have NJ Ex Order 26.4(b)(1) that was more NJ Ex Order 26.4(b)(1) , with NJ Ex Order 26.4(b)(1) . The U.S. FO documented that the U.S. FOIA (b)(6) was notified and ordered for NJ Ex Order 26.4(b)(1) and to re-consult the NJ Ex Order 26.4(b) Doctor. On 3/26/26 at 9:00 AM, the surveyor further reviewed the medical record which included a Physician Note dated NJ Ex Order 26 at 5:04 PM, that revealed the resident had complaints of NJ Ex Order 26.4(b)(1) . The NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) . No NJ Ex Orde NJ Ex Order 26.4(b)(1) Physical examination: Chief Complaint NJ Ex Order 26.4(b)(1) from the NJ Ex Order 26.4(b)(1) ...Assessment: NJ Ex Order 26.4(b)(1) with the NJ Ex Order 26.4(b)(1) . The plan was to start NJ Ex Order 26.4(b)(1)), monitor for changes, and a NJ Ex Order 26.4 consult and NJ Ex Order 26.4(b)(1) were ordered. On 3/26/26 at 11:30 AM, the U.S. FO provided a note dated NJ Ex Order 26 , that the appointment was canceled on NJ Ex Order 26.4 and NJ Ex Order 26.4 "due to a scheduling conflict." The U.S. did not provide any additional information as to why the information was not documented in the medical record and further stated that Resident #58 had an appointment scheduled for NJ Ex Order 26 , as ordered by the U.S. FOIA (b)(6) .	F0684		05/15/2026

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F0684 SS = SQC-H	Continued from page 6 2. During the initial tour of the facility on 3/22/26 at 10:15 AM, the surveyor observed Resident #7 in bed. Resident #7 was [NJ Ex Or] and able to participate in the interview. On 3/23/26 at 8:35 AM, the surveyor observed Resident #7 in bed. The breakfast tray was on the bedside table. The resident asked the surveyor to raise the head of the bed to assist with the meal. The surveyor informed the resident that they would notify the staff. The surveyor left the room and informed a staff member in the hallway. The staff entered the room and assisted the resident. On 3/24/26 at 9:15 AM, the surveyor observed Resident #7 in bed. The surveyor then asked Resident #7 if they ever got out of bed. Resident #7 replied, [NJ Ex Order 26.4(b)(1)] On 3/24/26 at 10:30 AM, the surveyor conducted a brief review of Resident #7's medical record. The record revealed that Resident #7 had a history of [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)]. On 3/24/26 at 10:45 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] and inquired about Resident #7's status. The [U.S. FO] stated that Resident #7 was transferred to this unit on [NJ Ex Order 26.4] The surveyor accompanied the [U.S. FO] to the room, and the resident was able to restate in the presence of the [U.S. FO] that they would like to [NJ Ex Order 26.4(b)(1)], but they do not have a wheelchair. At that time, the [U.S. FO] stated that the resident was transferred from another unit, and the resident's wheelchair was not transferred with the resident (twelve days prior). The [U.S. FO] stated she would inquire about their wheelchair. On 3/24/26 at 11:30 AM, the surveyor interviewed the Certified Nurse Aide (CNA #1) who cared for Resident #7 regarding their [NJ Ex Order 26.4(b)(1)]. CNA #1 informed the surveyor that the [NJ Ex Order 26.4(b)(1)] were [NJ Ex Order 26] The surveyor followed CNA #1 to the room and verified during an [NJ Ex Order 26.4(b)(1)] that the [NJ Ex O] was [NJ Ex Order] The surveyor reviewed Resident #7's medical record. A review of the Admission Face Sheet reflected that	F0684		05/15/2026

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F0684 SS = SQC-H	Continued from page 7 Resident #7 was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1)). A review of the most recent quarterly MDS dated [redacted] revealed that Resident #7 had a BIMS score of [redacted] out of 15, which indicated NJ Ex Order 26.4(b)(1) [redacted] A review of Resident #7's CP provided by the facility on 3/25/26, included a focus area for ADL NJ Ex Order 26.4(b)(1) related to [redacted] and [redacted]. The goal was for Resident #7 to maintain current level of function through the review date with a target date of [redacted]. The interventions included: [redacted] daily NJ Ex Order 26.4(b)(1) initiated on [redacted] Transfer: The resident required NJ Ex Order 26.4(b)(1) [redacted] with (2) staff assistance for [redacted] initiated on [redacted]. Monitor/document /report as needed any potential for improvement, reasons for NJ Ex Order 26.4(b)(1) [redacted], initiated on [redacted]. On 3/24/26 at 11:15 AM, the surveyor interviewed CNA #1, who stated that usually Resident #7 [redacted] to NJ Ex Order 26.4(b)(1), but she did not ask Resident #7 that morning if they would like to NJ Ex Order 26.4(b)(1). On 3/25/26 at 9:15 AM, the surveyor observed the resident out of bed in a wheelchair. The resident was smiling. On 3/25/26 at 9:45 AM, the surveyor interviewed CNA #2, and inquired if the resident was [redacted] with care or [redacted] to NJ Ex Order 26.4(b)(1), CNA #2 stated "no." CNA #2 stated that she worked for [redacted] and she was informed and now provided with a wheelchair for Resident #7 to NJ Ex Order 26.4(b)(1) The surveyor reviewed the resident's Progress Notes from [redacted] through present, which did not include any documentation that Resident #7 [redacted]	F0684		05/15/2026

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F0684 SS = SQC-H	Continued from page 8 to NJ Ex Order 26.4(b)(1). On 3/26/26 at 9:30 AM, the surveyor observed Resident #7 in activities. Resident #7 was NJ Ex Or and actively participating. 3. On 3/22/26 at 9:36 AM, the surveyor observed Resident #8 sitting up in a wheelchair wearing an NJ Ex Order 26.4(b)(1) leg and NJ Ex Order 26.4(b)(1). The surveyor observed NJ Ex Order 26.4(b)(1) to their NJ Ex Orde [redacted] The resident stated the NJ Ex Order 26.4(b [redacted] was only on their NJ Ex Order 26.4 [redacted] because they did not have one for NJ Ex Order 26 [redacted] and NJ Ex Order 26.4(b)(1) lost it." Resident #8 also stated that they previously wore NJ Exec Order 26.4(b [redacted] On 3/23/26 at 8:55 AM, the surveyor observed Resident #8 out of bed sitting in a wheelchair with one NJ Ex Order 26.4(b [redacted] on their NJ Ex Order 26.4(b)(1). The resident was wearing NJ Ex Order 26.4(b)(1) and NJ Ex Order 2 [redacted] was observed to NJ Ex Order 26.4(b)(1). The surveyor then reviewed the medical record for Resident #8 which revealed the following: A review of the Admission Record face sheet reflected that the resident was admitted with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted] A review of the quarterly MDS dated NJ Ex Order 26.4 [redacted] revealed the resident had a BIMS score of NJ E [redacted] out of 15, indicating that the resident was NJ Ex Order 26.4(b)(1) [redacted] A review of the physician's orders (PO) revealed an order dated NJ Ex Order 26 [redacted], for NJ Ex Order 26.4(b)(1) [redacted] one time a day for [redacted] before NJ Ex Order 26.4(b)(1) [redacted] The surveyor reviewed the Treatment Administration	F0684		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE , NEPTUNE, New Jersey, 07753

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F0684 SS = SQC-H	Continued from page 9 Record (TAR) and noted that Resident #8 was scheduled to have their NJ Ex Order 26.4(b)(1) to their NJ Ex Order 26.4(b)(1), one time a day before NJ Ex Order 26.4(b)(1) for NJ Ex Order 26. A review of the NJ Ex Order 26.4(b)(1) TAR revealed that there was no documentation Resident #8 had NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) The TAR was left blank. On 3/23/26 at 12:48 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) regarding the physician's order for NJ Ex Order 26.4(b)(1) on Resident #8's NJ Ex Order 26.4(b)(1). LPN #1 stated that the resident wore NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) because their NJ Ex Order 26.4(b)(1). LPN #1 stated she would "usually" put them on the resident in the morning but today the assigned CNA had the resident up in the chair early, "so I told the CNA I would NJ Ex Order 26.4(b)(1) after lunch." In the presence of the surveyor, LPN #1 then observed that Resident #8 was wearing NJ Ex Order 26.4(b)(1) on the NJ Ex Or and there was NJ Ex Order 26.4(b)(1). LPN #1 then acknowledged that the NJ Ex Order 26.4(b) was only NJ Ex Order 26.4(b)(1). LPN #1 stated, "the NJ Ex Order 26 was not on because NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) " When the surveyor asked LPN #1 if it was facility protocol to NJ Ex Order 26.4(b)(1), LPN #1 stated the resident "had NJ Ex Order 26.4(b)(1), and they NJ Ex Order 26 to NJ Ex Order 26.4(b)(1)." The surveyor asked LPN #1 if the NJ Exec Order 2 and NJ Ex Or was documented in the Electronic Health Record (EHR), and LPN #1 stated it was "not documented, but it should have been documented, and the doctor should have been notified." On 3/25/2026 at 8:30 AM, Resident #8 was observed with NJ Ex Order 26.4(b)(on NJ Ex Order 26.4(b)(1). Resident #8 stated NJ Ex Order 26.4(b were NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1)" The resident further stated, "they were only NJ Ex Order 26.4(b)(1) for a while I guess they NJ Ex Order 26.4(b)(1) but now they are NJ Ex Order 26.4(b)(1)." On 3/26/26 at 10:13 AM, the survey team met with the U.S. FOIA (b)(6) the U.S. FOIA (b)(6)), the U.S. FO the U.S. FOIA (b)(6)), the U.S. FOIA (b)(6) the U.S. FOIA (b)(6) , and the U.S. FOIA (b)(6)) to discuss concerns. The U.S. FO stated that the order for NJ Ex Order 26.4(b)(1) had been discontinued because the resident reported NJ Ex Or and the order was updated or NJ Ex Order 26.4(to NJ Ex Order 26.4(b)(1) to NJ Ex Or	F0684		05/15/2026

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F0684 SS = SQC-H	Continued from page 10 [NJ Ex O] The [U.S. FO] was unable to explain why Resident #8 was observed on [NJ Ex Order 26] at 8:30 AM, with [NJ Ex O] on their NJ Ex Order 26.4(b)(1) if the order was changed to NJ Ex Order 26.4(b)(1) to their [NJ Ex Order 26.4] on [NJ Ex Order 26] (after surveyor inquiry). The [U.S. FO] also acknowledged that there were blanks in the [NJ Ex Order 2] TAR which indicated that the treatment was not administered. A review of the facility's policy "Charting and Documentation," updated 11/2025, included: Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation…2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition…7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was performed; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; f. notification of family, physician or other staff, if indicated; and g. the signature and title of the individual documenting… NJAC 8:39-11.2 (b), 27.1(a)	F0684		05/15/2026
F0689 SS = SQC-H	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	Element I Resident #58 The Director of Nursing immediately comprehensively reassessed the resident for [NJ Ex Order 26] and remained [NJ Ex Order 26]. Resident's BIMS #13. The Director of Nursing immediately updated the [NJ Ex] care plan to include enhanced, individualized interventions, including but not limited to [NJ Ex Order 26.4(b)(1)]	05/15/2026

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F0689 SS = SQC-H	Continued from page 11 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent documents, it was determined that the facility failed to a.) provide [redacted] and implement targeted interventions to prevent [redacted] for a resident (Resident #58) who [redacted] between [redacted] and including [redacted] and that required [redacted] Or Resident #58 [redacted] with a [redacted] from an [redacted] This deficient practice was identified for 1of 2 residents reviewed for [redacted] (Resident #58). The facility further failed to b.) have a system in place to identify potential [redacted] of residents to reduce and [redacted] for residents with a history of [redacted] who [redacted] of the facility on pass. On [redacted], Resident #5 [redacted] of the facility on pass at 1:30 PM, did not return, and the facility was notified that the resident was in the [redacted] after [redacted] when they [redacted] and was diagnosed with [redacted] On 3/22/26 at 8:10 AM, Resident #115, who required [redacted] and was [redacted] was observed [redacted] facility [redacted] This deficient practice was identified for 2 of 2 residents reviewed for [redacted] (Resident #5 and Resident #115). The facility also failed to c.) implement a system to ensure residents [redacted] by [redacted] and ensure [redacted] were appropriately disposed of on facility grounds. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's policy titled "Falls- Clinical Protocol," last reviewed and updated 9/2025, included the physician will help identify individuals with a history of falls and risk factors for falling. Cause Identification: For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke, or an adverse drug reaction, or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling.	F0689	Continued from page 11 [redacted], etc. The Facility Educator and/or designee immediately in-serviced the nurses on F689 related to falls, investigation, root cause, and interventions. Resident #5 The resident is [redacted] with BIMS of #15 when the incident with [redacted] happened while out on pass on [redacted] The Unit Manager immediately obtained an order from the attending physician for [redacted] The Director of Nursing immediately informed the resident and educated on the importance of [redacted] process and accountability. The [redacted] report indicated a past medical history of [redacted] and [redacted] Upon review of the hospital records dated [redacted] the physician's assessment and clinical documentation do not indicate any signs, symptoms, or clinical findings consistent with [redacted] or [redacted]. The Administrator immediately educated the [redacted] and nursing staff the importance of sign in/sign out process and accountability. The Administrator immediately put a new process in place for the resident to [redacted] with the receptionist and/or with the nursing staff at the nurses' station. The Administrator immediately updated the Leave of Absence form according to findings of the surveyor, the Administrator took out the #5 section that states, "I release King Manor, its staff, Administrator, and its affiliates from any liability or responsibility for outcomes resulting from my decision to leave the facility under these terms".	05/15/2026

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F0689 SS = SQC-H	Continued from page 12 The staff and the physician will continue to collect and evaluate information until either the cause of the fall is identified, or it is determined that the cause cannot be found or is not correctable. Treatment/ Management: Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent NJ Ex Order 26.4(b)(1) and address the risks of clinically significant NJ Ex Order 26.4(b)(1). If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of NJ Ex Order 2 until NJ Ex Order 26.4(b)(1) or until a reason is identified for its continuation (for example, if the individual continues to NJ Ex Order 26.4(b)(1) Monitoring and follow-up: The staff, with the physician's guidance, will follow up on NJ Ex Order 26 until the resident is stable and delayed complications, such as late NJ Ex Order 26 or NJ Ex Order 26.4(b)(1) or either NJ Ex Order 26.4(b)(1) could occur up to several weeks NJ Ex Order 26.4(b)(1). The staff and physicians will monitor and document the NJ Ex Order 26.4(b)(1) or the NJ Ex Order 26.4(b)(1) or NJ Ex Order 2. If interventions have been successful in NJ Ex Order 26.4(b)(1), the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed. If the individual continues to NJ Ex O the staff and physicians will re-evaluate the situation and reconsider possible causes for the residents' NJ Ex Orde (instead of, or in addition to those that have already been identified) and reconsider the current interventions. 1.On 3/22/26 at 10:00 AM, the surveyor observed Resident #58 seated in a wheelchair in their room. The resident was eating NJ Exec Order 26.4(and observed with their bare feet directly on the floor. There were no NJ Ex Order 26. or NJ Ex Order 26.4(b)(1) on their feet. A pair of NJ Ex Order 26.4(b)(1) were observed on the floor in the corner of the room. Resident #58 answered the surveyor's greetings and stated that they did not want to discuss any concerns at present time. On 3/24/26 at 10:42 AM, the surveyor observed the resident sitting at the bedside not wearing NJ Ex Order or NJ Ex Order 26.4(b)(1) Their feet were NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) During the visit, the resident stated that they used to	F0689	Continued from page 12 Resident #115: The resident was immediately reassessed by the Unit Manager for NJ Ex Order 26.4 safety and NJ Ex Order 26 His BIMS #13 and NJ Ex Order 26.4(b)(1). The Unit Manager immediately referred the resident to U.S. FOIA (b)(6) for evaluation. The Unit Manager immediately discussed with the resident the risk and benefits of NJ Ex Order 26.4(requirements were reinforced, and the care plan was updated to NJ Ex Order that there was no need for the resident to be Order 26.4(b)(1) The Unit Manager immediately confiscated the NJ Ex Order 26.4(b)(1) from the resident and educated on Smoking Policy. The Administrator immediately discussed with the resident the designated area NJ Ex Order 26.4(and reinformed the NJ Ex Order 26.4 policy. The Unit Manager obtained a physician's order that the resident "May Go Out on Pass effective immediately". The Unit Manager immediately referred NJ Ex O to NJ Ex Orde for evaluation related to NJ Ex Order 26.4(b)(1). The Administrator immediately educated the U.S. FOIA (b)(6) and nursing staff the importance of sign in/sign out process and accountability. The Administrator immediately put a new process in place for the resident to NJ Ex Order 26.4(b)(1) with the receptionist and/or with the nursing staff at the nurses' station. The Administrator immediately updated the Leave of Absence form according to findings of the surveyor, the Administrator took out the #5 section that states, "I release King Manor, its staff, Administrator, and its affiliates from any liability or responsibility for outcomes resulting from my decision to leave the facility under these terms".	05/15/2026

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F0689 SS = SQC-H	Continued from page 13 NJ Ex Order 26.4(b)(1) [redacted], they were NJ Ex Order 26.4(b)(1) and were [redacted], and now they could NJ Ex Order 26.4(b)(1). The surveyor then reviewed the medical record for Resident #58 which revealed: A review of the Admission Face Sheet (an admission summary), reflected that Resident #58 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] reflected that Resident #58 had a Brief Interview for Mental Status (BIMS) score of [redacted] out 15, which indicated [redacted] A review of the comprehensive Care Plan (CP), provided by the facility on [redacted] at 10:05 AM, included a focus area for [redacted] related to [redacted] initiated on [redacted] The goal was that Resident #58 will resume usual activities without further incidents through the review date, initiated on [redacted] with a target date of [redacted] The interventions included: Provide and reinforce use of NJ Ex Order 26.4(b)(1) as tolerated, initiated on [redacted]. Place [redacted] to NJ Ex Order 26.4(b)(1) [redacted] initiated on [redacted] Offer assistance with morning care, initiated on NJ Ex Order 26.4(b)(1) on [redacted] window side, initiated on [redacted]. Educate and reinforce to call for assistance with [redacted] and [redacted] initiated on [redacted] Staff will encourage Resident #58 to NJ Ex Order 26.4(b)(1) [redacted] initiated on [redacted] On 3/25/26 at 10:30 AM, the surveyor requested from the U.S. FOIA (b)(6)) any and all investigations for Resident #58, along with any [redacted] risk assessments and a timeline of Resident #58's [redacted] The surveyor reviewed the [redacted] Risk Evaluations that	F0689	Continued from page 13 Element II All residents have the potential to be affected by this practice. Element III 1. The Facility educator and/or designee will in-service all employees on federal guidelines on F689 related to incident and/or accidents, smoking policy, and leaving out on pass. 2. The Social Worker and /or designee will inform all the residents, and their responsible party and educate them on the importance of sign in/sign out process and accountability. 3. The Unit Managers and/or designee will complete a new smoking assessment for all the active smokers and will review the care plan for accuracy. 4. The Regional Clinical Director of Nursing created a new batch order for all the residents with SUD and polysubstance abuse history. There will be an assessment for clinical signs of drugs/substance influence i.e. altered mental status, change in level of consciousness, speech changes, motor impairment, behavioral changes, etc. every shift. 5. The Unit Manager and/or designee will add the polysubstance/SUD evaluation order in the Medication Administration Record of the resident with history of SUD/polysubstance abuse. 6. The Social Worker will meet with the active smokers and discuss the Smoking Policy and Smoking Agreement. 6. The Unit Manager and/or designee will audit weekly 3 residents that had a fall for 4 weeks, then 10 residents monthly. 7. The Administrator and/or designee will audit Leave of Absence/Out on Pass Form for 5 residents for 4 weeks, then 10 residents monthly for 3 months. 8. The Social Worker and/or designee will audit 5 active smokers weekly for 4 weeks and 10 smokers monthly for 3months. Element IV The Director of Nursing and/or designee will submit the audit report to the Quality Assurance and	05/15/2026

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F0689 SS = SQC-H	Continued from page 14 were provided by the U.S. FOIA which revealed the following: -A NJ Ex O Risk Evaluation dated NJ Ex Order 26.4(b), reflected Resident #58 scored a NJ E which indicated NJ Ex Order 26.4(b)(A total score of NJ E or above represented a -A NJ Ex O Risk Evaluation dated NJ Ex Order 26.4(b), reflected that the facility identified Resident #58 as NJ Ex Order 26.4(b)(1) Resident #5 received a score of NJ E -A NJ Ex O Risk Evaluation dated NJ Ex Order 26.4(b), reflected that the facility did not identify Resident #58 as a NJ Ex Order 26.4(b)(1) Resident #58 received a score of NJ E -A NJ Ex O Risk Evaluation dated NJ Ex Order 26.4(b), reflected that the facility did not identify Resident #58 as a NJ Ex Order 26.4(b)(1). Resident #58 received a score of NJ E -A NJ Ex O Risk Evaluation dated NJ Ex Order 26 reflected that the facility identified Resident #58 as NJ Ex Order 26.4(b)(1). Resident #58 received a score of NJ Ex O -A NJ Ex O Risk Evaluation dated NJ Ex Order 26, reflected that the facility identified Resident #58 as NJ Ex Order 26.4(b)(1). Resident #58 received a score of NJ Ex O The following incidents were documented in the Electronic Medical Record, and/or provided by the U.S. FOIA (b)(6) which revealed the following: NJ Ex Order 26.4(b)(1) #1: On NJ Ex Order 26 at 6:28 AM, a Nursing Progress Note (PN) revealed Resident #58 was NJ Ex Order 26.4(b)(1) The PN revealed that the resident was NJ Ex Order 26.4(b)(1) during medication administration. A NJ Ex Order 26.4(b)(1) was observed under the resident's NJ Ex Order 26.4(and a NJ Ex Order 26.4(b)(was noted to NJ Ex Order 26.4(b)(1) Predisposing factors: NJ Ex Ord . The resident was transferred to the Emergency Department (ED) for evaluation and diagnosed with NJ Ex Order 26.4(b)(1). The resident returned to the facility on NJ Ex Order 26.4 The Interdisciplinary Care (IDC) team met on NJ Ex Order 26, and documented that the resident had no recollection of NJ Ex Order 2 and exhibited NJ Ex Order 26.4(b)(1) The team was in agreement to place NJ Ex Ord to the NJ Ex Order 26.4(b)(1) upon return, and for NJ Ex Order 26.4(b)(1) to screen.	F0689	Continued from page 14 Performance Improvement (QAPI) committee for trend analysis and corrective action quarterly for the next 3 quarters.	05/15/2026

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F0689 SS = SQC-H	Continued from page 15 NJ Ex Order 26.4(b)(1) #2: On NJ Ex Order 26.4(at 5:00 AM, a Nursing PN revealed that the writer was making rounds and observed the resident NJ Ex Order 26.4(b)(1) on their NJ Ex Order 26.4(with their NJ Ex Order 26.4(b)(1) . The resident had over their NJ Ex Order 26.4(b)(1) The resident was noted not wearing any NJ Ex Order 2 Resident #58 was transferred to the ED. Contributing factors: Recent change in condition, NJ Ex Order 26.4(b)(1) . The IDC team met on NJ Ex Order 26.4(, and documented that the resident did not recall how NJ Ex Order 2 happened, the resident was not wearing NJ Ex Order 26.4(b)(1) , and the team agreed to apply NJ Ex Order 26.4(b)(1) . A PN from the Physician dated NJ Ex Order 26.4(b NJ Ex Order 26.4(b)(1) revealed the following: plan discussed with nursing. NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1)). Continue NJ Ex Order 26.4(b)(1) Reinforce call bell use and safe NJ Ex Order 26 techniques. Monitor for NJ Ex Order 26.4(b)(1) symptoms given NJ Ex Order 26.4(b)(1) Recurrent NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) #3: On NJ Ex Order 26.4(at 12:05 AM, a Nursing PN revealed that a Certified Nursing Aid (CNA) found the resident NJ Ex Order 26.4(b)(1) . The resident stated that they NJ Ex Order 26.4(b) The IDC team met on NJ Ex Order 26.4(b NJ Ex Order 26.4(b)(1) and interviewed the resident and staff. As per the resident, they NJ Ex Orde were provided to bed to assist the resident with NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) #4: On NJ Ex Order 26.4(at 8:00 AM, a PN revealed that Resident #58 was NJ Ex Order 26.4(b)(1) . The resident stated they were trying to NJ Ex Order 26.4(b)(1) , and NJ Ex The resident was noted with NJ Ex Order 26.4(b)(1) upon assessment. The IDC team met on NJ Ex Order 26.4(b) to discuss NJ Ex Orde , and the intervention to offer assistance with morning care was added.	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 16 NJ Ex Order 26.4(b)(1) #5: On NJ Ex Order at 11:10 PM, a PN revealed that the nurse observed the resident NJ Ex Order 26.4(b)(1) There was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) noted on the resident's NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) was applied. The resident's clothing was NJ Ex Order 26.4(b)(1), and they reported a NJ Ex Order 26.4(b)(1) Resident #58 was transferred to the ED for evaluation and treatment. Predisposing factors: NJ Ex Order 26.4. Contributing factors: NJ Ex Order 26.4(b)(1) A NJ Ex Order 26.4 of the head NJ Ex Order 26.4(b)) performed and compared with the NJ Ex Order 26.4(b)(1) which revealed NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The IDC team met on NJ Ex Order 2 to review the fall that occurred on NJ Ex Order, and documented the following: "Resident is able to NJ Ex Order 26.4(b)(1) and able to NJ Ex Order 26.4(b)(1) as needed. Staff will educate the resident upon return to use call bell to ask for assistance with NJ Ex Order 26 and NJ Ex Order 26.4(b) On NJ Ex Order 26 at 7:45 AM, a Nursing PN revealed the nurse entered the room to administer medications and observed the resident NJ Ex Order 26.4(b)(1). The resident was trying NJ Ex Order 26.4(b)(1) . Predisposing factors: NJ Ex Order 26.4(b)(1). The IDC team met on NJ Ex Order 2 to review NJ Ex Order 2. Staff will encourage the resident to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) A review of a handwritten "Screen/Referral Form" dated NJ Ex Order 26, revealed the following: "[Resident #58] returned NJ Ex Order 26.4 due to NJ Ex Order 26.4(b)(1) , resident has history of NJ Ex Order 26.4(b)(1) Resident was recently discharged from NJ Ex Order Resident is not a candidate for NJ Ex Order due to having NJ Ex Order 26.4(b)(1). Discussed NJ Ex Order 26.4 with nursing but was not a candidate at this time as resident NJ Ex Order 2 in room and NJ Ex Order 26.4(b)(1) No additional NJ Ex Order 26 notes were provided by the facility for review. The facility could not provide any documentation that the resident received NJ Ex Order 26 for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1), as well as reinforcement for safe NJ Ex Order 26. techniques were implemented as recommended by the Physician on NJ Ex Order 26.4(b	F0689		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = SQC-H	Continued from page 17 A review of the U.S. FOIA (b)(6) note dated NJ Ex O... included the following recommendations: NJ Ex Order 26.4(b)(1) with recommendations for ongoing NJ Ex Order 26. services and reinforced NJ Ex Order 26.4(b)(1) measures. There was no documented evidence that these recommendations were implemented and there were no specific interventions implemented in the Care Plan to prevent NJ Ex Order 26.4(b)(1) On 3/26/26 at 8:58 AM, the surveyor interviewed the U.S. FOIA regarding Resident #58's NJ Ex Order 26.4(b)(1) at the facility including the NJ Ex Order 26.4(b)(1). The U.S. FOIA stated that the resident tended to be NJ Ex Order 26.4(b)(1) and stated, NJ Ex Order 26.4(b)(1)." The U.S. FOIA stated, "what is missing, is more observations. I relied on the staff to be my eyes and ears on the units, but the oversight is lacking." The U.S. FOIA further stated that the IDC team met and discussed the NJ Ex O and implemented interventions after NJ Ex Order 26.4. When asked if the causal factor was identified after each NJ Ex and a specific intervention was implemented to prevent further NJ Ex Or the U.S. FOIA stated that she would have to review the documentation. 2.On NJ Ex Order 26.4 at 9:16 AM, the surveyor observed Resident #5 ambulating in their room independently. On 3/23/26 at 8:38 AM, the surveyor reviewed the electronic medical record (EMR). A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) A review of the comprehensive MDS dated NJ Ex Order 26.4 reflected that the resident had a BIMS score of NJ Ex out of 15, which indicated NJ Ex Order 26.4(b)(1). The MDS also revealed that the resident was independent with all activities of daily living (ADLs) and NJ Ex Order 26.4 A review of the History and Physical (H&P) dated NJ Ex Order 26.4 indicated the resident was NJ Exec Order 26.4(b) from NJ Ex Order 26.4(b)(1) after NJ Ex Order 26.4(b)(1) while out on pass and had an NJ Ex Order 26.4(b)(1),	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 18 NJ Ex Order 26.4(b)(1) done. A Progress Note (PN) dated NJ Ex Order 2, indicated that the resident signed themself out of facility at approximately 1:30 PM. A PN dated NJ Ex Order 2 at 7:47 PM, indicated the resident did not return from NJ Ex Order 2 and went to the [local] ED. A PN dated NJ Ex Order 2 at 10:51 PM, indicated the resident was admitted to [local] NJ Exec Order 2 with NJ Ex Order 26.4(b)(1). A review of the physician's order dated NJ Ex Order 26.4(b) indicated "May go out on pass with family or friends." A review of the "Release of Responsibility for Leave of Absence," from Resident #5's paper medical chart revealed the resident frequently signed themself out of the facility on pass from NJ Ex Order 26.4(b)(through the present. The forms were signed on multiple occasions by the resident as the responsible party and the return date/time and staff signatures were blank on multiple occasions. A review of the resident's leave of absences from the facility for NJ Ex Order 26.4(b)(1) were as follows: On NJ Ex Order 2 at 9:35 AM, the destination of NJ Ex Order was written with a projected return at 3:30 PM. There was no resident or responsible (Rep) party signature, and the return time/date and staff signature upon return were blank. On NJ Ex Order 2 at 3:00 PM, the destination of NJ Ex Order was written with a projected return time of 3:00 PM. There was no resident or Rep party signature, and the resident returned to the facility at 4:00 PM. On NJ Ex Order 2 at 10:15 AM, the destination of NJ Ex Order was written with a projected return time of 4:00 PM. There was no resident or Rep party signature, and the return time/date and staff signature upon return were blank. On NJ Ex Order 2 at 4:38 PM, the destination of NJ Ex Order was written. The was no projected time of return or resident or Rep party signature, and the return time/date and staff signature upon return were blank. On NJ Ex Order 2 at 12:10 PM, the destination of NJ Ex Order was written with a projected return time of 7:00 PM. There was no resident or Rep party signature, and the return time/date and staff signature upon return	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 19 were blank. On [NJ Ex Order] at 12:55 PM, the destination of [NJ Ex Order] was written with a projected return time of 7:00 PM. There was no resident or Rep party signature, and the resident signed in as returned at 10:00 PM. On [NJ Ex Order] at 10:55 AM, the destination of [NJ Ex Order] was written with a projected return time of 7:00 PM. There was no resident or Rep party signature, and the return time/date and staff signature upon return were blank. On [NJ Ex Order] at 11:20 AM, the destination of [NJ Ex Order] was written with a projected return time of 7:00 PM. There was no resident or Rep party signature, and the return time/date and staff signature upon return were blank. On [NJ Ex Order] at 9:25 AM, the resident signed out to the [NJ Ex Order] with a projected time to return at 7:00 PM. The return date/time and staff signature upon return were blank. On an illegible departure date at 9:15 AM, the resident signed themself out with a projected return time of 7:00 PM. The resident returned on [NJ Ex Order 26.4] at 12:30 PM. On [NJ Ex Order 26.4] at 9:15 AM, the resident signed themself out to the [NJ Ex Order] with a projected return time of 7:00 PM. The return date/time and staff signature upon return were blank. On [NJ Ex Order 26] at 9:38 AM, the resident signed themself out to the [NJ Ex Order] with a projected return time of 7:00 PM. The return date/time and staff signature upon return were blank. On [NJ Ex Order 26.4] at 3:30 PM, an illegible signature signed that the resident was at the [NJ Ex Order] with a projected return time of 7:00 PM. The return date/time and staff signature upon return were blank. On 3/23/26 at 1:44 PM, the surveyor asked the [U.S. FOIA (b)(6)] about the process for residents signing out on pass, and he stated if a resident was signing themself out, they needed a specific order that indicated they may sign themself out. The [U.S. FOIA (b)] stated an order for "may go out on pass with friends or family" did not allow the resident to sign themself out. On 3/24/26 at 8:20 AM, the surveyor observed	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 20 Resident #5 ambulating in their room, getting breakfast ready. The surveyor inquired about their [redacted] and Resident #5 stated it was from [redacted] The resident stated they were living here at the time. The resident also stated [redacted] was not here, "[redacted] When asked where the [redacted] was, the resident stated, [redacted] ." On 3/24/26 at 8:38 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated Resident #5 came to the facility not needing [redacted] but was placed on [redacted] after [redacted]. The [redacted] further stated the facility knew there was a [redacted] involved, but they did not have any additional information about the [redacted] On 3/24/26 at 1:21 PM, the surveyor reviewed the facility provided investigation dated [redacted] The investigation summary revealed the resident had signed out on pass and was involved in [redacted] The resident stated they [redacted], and they were with a family member. Notes on what appears to be an incident report indicated the resident was [redacted] [family member] when they [redacted] which prompted them to go to the ED. A review of the hospital records indicated the resident presented to the ED after [redacted]. The resident stated they were [redacted] and they did [redacted] An [redacted] consultation indicated that the resident presented with [redacted] and [redacted] after [redacted] about [redacted] On 3/24/26 at 1:37 PM, the surveyor interviewed the [redacted] and the [redacted] who stated the resident called the facility to let them know they were in the ED. The [redacted] stated they were still under the facility's care, but they did not think to [redacted] report it. They stated they took the resident's statement as to what happened when the resident returned to the facility. On 3/25/26 at 8:25 AM, the Unit Manager (UM #1) was asked how the "Release of Responsibility for	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 21 Leave of Absence" form worked, and she stated the residents signed out, and then nurses signed them back in upon their return. The surveyor showed UM #1 pages of Resident #5's "Release of Responsibility for Leave of Absence" from NJ Ex Order 26.4(b) to present. UM #1 confirmed there were multiple blanks on the documents and that the nurse was supposed to sign them in when they returned. When asked how it worked with residents signing themselves out, she stated it depended on their BIMS and if the resident had a BIMS of NJ Ex they were responsible for themself and could sign themself out. UM #1 stated "they do need orders to go out on pass." When asked if their history, for example NJ Ex Order 26.4(b)(1), had any bearing on someone's ability go out on pass without a family or friend, and UM #1 stated that it came from the front and pointed to the administration area of the facility. On 3/25/26 at 9:43 AM, the surveyor observed Resident #5 NJ Ex Order 26.4(b)(1) in the front lobby on the NJ Ex Order 26.4(b)(facility. On 3/25/26 at 10:05 AM, the surveyor interviewed the U.S. FOIA (b)(6)), who was also responsible for Resident #5. The U.S. FO was aware of Resident #5's NJ Ex Order 26.4(b)(1) history. The surveyor asked about Resident #5's NJ Ex Order 26 that occurred when Resident #5 left the facility and NJ Ex Order 26.4(b)(1) and had the NJ Ex Order 26.4(The U.S. FO stated, "I wasn't aware of that part, I should have been made aware." When asked if the U.S. FO reviewed incidents and accidents at the Quality Assurance meetings and asked if the accident that occurred when Resident #5 left the facility, NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) , the stated, "no" and that should have been investigated as she did not know how the NJ Ex Order 26 occurred. On 3/25/26 at 10:32 AM, the surveyor interviewed the U.S. FOIA (who stated that Resident #5 was not in the building when they NJ Ex Order 26.4(b)(1). The U.S. FOIA again stated the facility was not aware of the NJ Ex Order 26.4(b)(until the incident happened. As far as NJ Ex Order 26.4(b)(1) history, the U.S. FOIA stated that the residents were monitored when they came back from being out on pass. The U.S. FOIA further stated she was not aware of any blanks for the return dates and times and that the form should be signed when the resident returned to the facility so that the staff knew and could observe for any changes. The U.S. FOIA then stated maybe they should have called the NJ Ex Order 26.4(b)(1) and should have investigated	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 22 further. The U.S. FOIA stated she does review hospital records and remembered briefly going through Resident #5's hospital records upon readmission. The U.S. FOIA also remembered discussing what happened with the resident. On 3/25/26 at 11:29 AM, the surveyor interviewed the U.S. FOIA (b) who stated that ultimately the facility was responsible for the residents. When asked about nursing not documenting the resident's returns on the release form, the U.S. FOIA (b) stated it was documented in the medical record in Progress Notes and was checked every morning for compliance. The U.S. FOIA (b) stated there was a team discussion after Resident #5's incident and it was not discussed in the Quality Assurance meeting. The U.S. FOIA (b) further stated the incident with the resident's NJ Ex Order 26.4(b)(1) was a significant event and they should be reviewing significant events to ensure they had a process to prevent future incidents. On 3/26/26 at 10:13 AM, the U.S. FOIA (b) and U.S. FOIA stated Resident #5's incident happened while they were out on pass, and it was their right to go out on pass. They stated, "they were not under our care because they were out on pass." On 3/26/26 at 12:53 PM, the U.S. FOIA (b) stated he has no further information to provide. 3. On 3/22/26 at 8:00 AM, the survey team entered the facility to conduct a survey and at 8:10 AM, while in the lobby, the survey team observed a person [Resident #115] NJ Exec Order 26.4(b)(1) with a NJ Exec Order The person [Resident #115] then NJ Exec Order the facility, placed NJ Ex Order 26.4(b)(1), and proceeded to NJ Exec Order 26.4 down a hill while NJ Ex Order 26.4(b)(1). When asked, the U.S. FOIA (b)(6) confirmed that it was Resident #115. When asked if the resident was supposed to be NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(, the U.S. FOIA (b)(6) stated no, and that Resident #115 "leaves the facility and that was their routine." On 3/22/26 at approximately 8:20 AM, the surveyor NJ Ex Order 26.4(b)(1) Resident #115 in the area the resident was observed and the surveyor NJ Ex Order 26.4(b)(1) the resident. The "Smoking Policy" was provided by the U.S. FOIA (b	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 23 during the entrance conference held on 3/22/26 at 8:55 AM, and revealed that the facility established and maintains safe resident smoking practices and 2. Smoking is only permitted in designated resident smoking area which are located outside of the building … 11. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, "family member, visitor or volunteer worker at all times when smoking." The Smokers Break Times and Location List was provided, and the smoking area was located on the patio near Room #55. The first smoke break was at 9:30 AM, second smoke break was at 1:00 PM, third smoke break was at 4:00 PM, and the fourth smoke break was at 6:00 PM. Resident #115 was observed smoking by the survey team prior to the first scheduled smoking break. On 3/22/26 at 12:18 PM, a review of the electronic medical record (EMR) for Resident #115 revealed the following: A review of the Admission Record, revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) . A review of the comprehensive MDS dated NJ Ex Order 26.4(b)(1), revealed the resident had a BIMS score of NJ Ex out of 15, which indicated NJ Ex Order 26.4(b)(1) A review of Section NJ Ex revealed the resident required NJ Ex Order 26.4(b)(1) A review of the current 15-page Care Plan revealed a focus area for: NJ Ex Order 26.4(b)(1) and need you to NJ Ex Order 26.4(b)(1), dated initiated NJ Ex Order 26.4(b)(1), and the resident has NJ Ex Order 26.4(b)(1) evidenced by a history of NJ Ex Order 26.4(b)(1) use including: NJ Ex Order 26.4(b)(1) Exhibits NJ Ex Order 26.4(b)(1) dated initiated NJ Ex Order 26.4(b)(1). The resident was also at high risk for NJ Ex O due to NJ Ex Order 26.4(b)(1) dated initiated NJ Ex Order 26.4(b)(1) A review of the Active Physician's Orders for Resident #115 dated NJ Ex Order 26 revealed there was no	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 24 physician's order for Resident #115 to go out on pass. The NJ Ex Order 26.4(b)(1) Medication and Treatment Administration Records for Resident #115 were also reviewed and did not include an order to go out on pass. NJ Ex Order 26.4(b)(1) section did not indicate any monitoring related to history of NJ Ex Order 26.4(b)(1) . A review of the Progress Notes (PN), beginning NJ Ex Order 26 through NJ Ex Order 26, revealed the following: A Health Status Note dated NJ Ex Order 26.4 at 9:24 AM, revealed the resident approached the desk and requested to NJ Ex Order 26.4(b)(1) and it was for them to . The resident was advised to NJ Ex Order 26.4(b)(1) verbalized understanding, but still wanted NJ Ex Order 26.4(b) … they signed the release of responsibility form and returned as promised with no complaints. A PN documented by the U.S. FOIA (b)(6) on NJ Ex Order 26.4 revealed Resident #115 left the facility on pass daily. At that time, a review of the document titled "Release of Responsibility for Leave of Absence," revealed the following and was also the same document that was kept in a book located at the front desk: "I, the undersigned resident and/or my assigned responsible party, herby request a Leave of Absence (LOA) from the facility. I understand and agree to the following conditions: …1. I am voluntarily leaving the facility on the date and time listed below and understand that this LOA is temporary and expected to last no more than 24 hours; 2. I acknowledge that if I do not return to the facility within 24 hours of my expected return time, and if I or my responsible party fail to notify the facility of any delay, my absence will be considered as leaving the facility Against Medical Advice (AMA); 3. I understand that failure to return within the specified time frame without notice will result in my being voluntarily discharged from the facility; 4. By signing below, I acknowledge that I have been informed of the risks and consequences of leaving the facility, including the possibility of adverse health effects, loss of bed hold, interruption of care and medical management; 5. I release the facility, its staff, administrators, and affiliates from any liability or responsibility for outcomes resulting from my decision to leave the facility under these terms; 6. I	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 25 confirm that this signed form will serve as both an AMA acknowledgement and a voluntary discharge notice if I fail to return within the specified timeframe." On 3/23/26 at 10:03 AM, the surveyor interviewed the assigned Certified Nurse Aide (CNA #1) for Resident #115 in the resident's room. The resident was out of the facility at that time. The surveyor informed CNA #1 of their observations of the resident ambulating and NJ Ex Order 26.4(b)(1) outside of the facility and also asked what care the resident required from her. CNA #1 stated the resident "leaves all day." CNA #1 stated the resident 'NJ Ex Order 26.4(b)(1) ." The surveyor observed NJ Ex Order 26.4(b)(1) at that time on the resident's nightstand and asked if the resident kept NJ Ex Order 26.4(b)(1) in the cabinet, and CNA #1 did not know because the NJ Ex Order 26.4(b)(1) by the resident. When asked what help or care the resident required from CNA #1, she stated they "didn't need any help." CNA #1 stated they did not eat at the facility, but wanted the meal tray left at the bedside. On 3/23/26 at 10:25 AM, the surveyor interviewed the U.S. FOIA (b)(6)) from where Resident #115 resided. The surveyor asked about the process when residents temporarily left the building for out on pass (OOP). The surveyor observed the "Release of Responsibility" documents in Resident #115's medical record and the U.S. FOIA (b)(6 informed the surveyor that the resident had to sign the paper with the nurse and that the documents must remain in the resident's medical record. On 3/23/26 at 10:28 AM, the surveyor then interviewed a Licensed Practical Nurse (LPN #1) and asked if they provided care to Resident #115. LPN #1 stated they took care of them, "when [they] are here because they go out." LPN #1 stated Resident #115 attended NJ Ex Order 26.4(b) program Monday, Wednesday, and Friday. When asked if residents were supposed to NJ Ex Order 26.4(b)(1) LPN #1 stated they "are not supposed to" they were supposed to get NJ Ex Order 26.4(b) from the NJ Ex Order 2 Department and Resident #115 preferred to NJ Ex Order 2 When asked if Resident #115 required nursing care, LPN #1 stated she gave them NJ Ex Order 2 in the morning, and they came back at 2:30 PM. On 3/23/26 at 10:45 AM, the surveyor interviewed the U.S. FOIA (b)(6)) regarding the NJ Ex Order 26.4	F0689		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = SQC-H	Continued from page 26 process and shared the observations of Resident #115 walking and [NJ Ex Order 26.4] in front of the building. The [U.S. F] stated, "they are not supposed to [NJ Ex Ord] and they are not supposed to be smoking on their own, they cannot smoke on that part of the property." The [U.S. F] stated there were scheduled times and the residents could only smoke when scheduled in the smoking area. The [U.S. F] then showed the surveyor Resident #115's cigarettes, and the surveyor asked if they also NJ Ex Order 26.4(b)(1) and the [U.S. F] stated that Resident #115 goes to the store and could have [NJ Ex Order 26.4(b)(1)] cigars. The [U.S. F] showed the surveyor the smoking log that staff filled out when residents [NJ Ex Order 26.] and was dated [NJ Ex Order 26.], which revealed Resident #115's 9:30 AM [NJ Ex Order 26.4] session was blank as the resident did not [NJ Ex Order 2] at that time. The only documented [NJ Ex Order 26.4] session for Resident #115 that day was for the 1:00 PM [NJ Ex Order 26.4] session, and the 4:00 PM and 6:00 PM [NJ Ex Order 26.4] sessions were also left blank. On 3/23/26 at 12:45 PM, the surveyor interviewed both facility Social Workers (SW #1) and SW #2 regarding their involvement with the residents who attended the [NJ Ex Order] program. When asked, (SW #2 who was assigned to Resident #115), if the resident was allowed to hold their NJ Ex Order 26.4(b)(1) both SWs confirmed "no." On 3/23/26 at 1:38 PM, the surveyor interviewed the [U.S. FOIA (b)] about the admission agreements and asked about the facility's responsibility regarding when residents went OOP. The [U.S. FOIA (b)] stated all residents were supposed to have a special order to go OOP or out independently, and it should be a specific order. The surveyor further reviewed the "Release of Responsibility of Leave of Absence" forms from Resident #115's medical record and the form dated [NJ Ex Order 26] and [NJ Ex Order 26.4] from the front desk book, along with the Progress Notes (PN) which revealed the following: -On 3/19/26 at 8:05 AM and at 5:00 PM, it was documented that the resident went to the food store at 8:05 AM and another store at 5:00 PM. There was no documentation of the resident's returns in the PN. -On 3/20/26 at 8:10 AM, it was documented that the resident went to the store with no return time documented in the PN and the form was not signed	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 27 by staff upon return. -On 3/20/26, the resident signed out of the facility twice at 4:30 PM and at 6:15 PM. There was a note written by the U.S. FOIA (b)(6)) that the resident returned from the store in "good spirits" at 7:10 PM. There was no documentation regarding when the resident returned after signing out of the facility at 4:30 PM. -On 3/21/26 at 8:05 AM, the resident signed out to the NJ Ex Ord and the staff signature upon return was left blank. The OOP was not documented in the PN. -On 3/21/26 at 4:30 PM, the resident signed out to the NJ Ex Ord and the PN indicated that the resident returned from the NJ Ex Ord in "NJ Ex Order 26.4(b)(1)" at 7:10 PM. -A review of the "front desk copy," revealed the resident signed out on 3/22/26 at 8:05 AM. The return date and time and the staff signature upon return were left blank. The same information was documented in the medial record, and the staff signature was also blank. The OOP was not documented in the PN. A review of all of the "Release of Responsibility for Leave of Absence" documents from 12/30/25 through 3/21/26, revealed the facility failed to consistently document in the PN when the resident returned from out on pass. On 3/25/26 at 11:32 AM, the surveyor interviewed the U.S. FOIA (b and asked about the facility's Quality Assurance process and the surveyor reviewed the concerns with Resident #115 NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). The stated that Resident #115 "goes out and buys their NJ Ex Order 26.4(b)(1)." The U.S. FOIA (b stated nursing was responsible to ensure that the resident was signing out and nursing was also responsible to document in the PN when the resident left and returned. On 3/25/26 at 10:47 AM, the surveyor conducted an interview with the U.S. FOIA (b)(6)) regarding her role at the facility. The surveyor asked the U.S. FO if the facility admitted residents with a history of NJ Ex Order 26.4(b)(1), and she stated yes. The surveyor asked the if there were any risks involved with admitting those residents, and the U.S. FO stated "yes, of course there were risks." When asked if there were risks also if the residents with the history of NJ Ex Order 26.4(b)(1) left the facility	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 28 on pass, the U.S. FO stated "yes, for sure, if a patient NJ Ex Order 26.4(b)(1)." When asked if the U.S. FO had ever had a discussion with the facility regarding residents with a history of NJ Ex Order 26.4(b)(1) that were in the facility, she stated, "no." When asked if there was a policy and process in place when residents with a history of NJ Ex Order 26.4(b)(1) were admitted and if there had been a discussion with the facility. The U.S. FO stated she was not asked by the facility about creating a policy or anything related to the risks associated with residents with a history of NJ Ex Order 26.4(b)(1) signing themselves out of the facility. On 3/25/26 at 1:27 PM, in response to the surveyor requesting any policies related to minimizing any risks for residents with a history of substance abuse disorder, the U.S. FOIA provided a "Substance Abuse" policy dated reviewed August 2025, which revealed all residents admitted to the facility will be asked to sign a contract showing they understand that illegal drug use (possession, taking of drugs or possession with intent to sell) is not allowed in the facility. The policy did not address residents with a history of substance abuse disorder who left the facility alone, would be at an increased risk for obtaining illegal or prescription drugs while out on pass. This could result in accidental overdose while residing in the nursing home. The policy also did not include that the facility would assess residents with a history of substance abuse for potential risks and implement care plan interventions to ensure the safety of all residents who resided at the facility. On 3/25/26 at 1:56 PM, the survey team conducted a pre-exit conference with the U.S. FOIA (b) U.S. FOIA (and the facility's corporate staff, and the surveyor informed them of the above concerns. On 3/26/26 at 10:13 AM, the survey team met with the U.S. FOIA (b) U.S. FOIA (and the facility's corporate staff. The facility informed the survey team that the out on pass process form was revised to remove the waiver language and confirmed there was a breakdown between the PACE program and the facility, and they realized the need for integration between both the facility and the PACE program. 4.On 3/22/26 at 9:34 AM, during the initial tour of the facility, the surveyor observed Resident #86 walking down the hallway with NJ Ex Order 26.4(b)(1) who then stated they were NJ Ex Order 26.4(b)(1)	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 29 NJ Ex Order 26.4(b) At 9:35 AM, the surveyor observed the residents walking outside onto a semi-covered patio. There were two Nursing Staff (NS #1 and NS #2) observed assisting the residents in the NJ Ex Order 26.4(. NS #1 handled the individually wrapped NJ Ex Order 26.4(b) with the residents' names, stored in a portable box and handed NJ Ex Order 26.4(b)(1) to each resident. NS #2 was observed NJ Ex Order 26. each resident's NJ Ex Order 26.4(b)(Some of the residents were seated on the patio chairs, others were seated in their wheelchairs, and a few stood around the patio area while they NJ Ex Order 26.4(b)(1). At that time, an open receptable was observed on the cement ground where the residents who NJ Ex Order 26. placed their NJ Ex Order 26.4(b)(1) after NJ Ex Order 26.4(b On 3/24/26 at 9:28 AM, the surveyor observed two Recreational Staff (RS #1 and RS #2) in the NJ Exec Order 26 area. RS #1 lit the residents' NJ Exec Order 26.4(and RS #2 distributed two residents NJ Ex Order 26.4(b) from the portable box to each resident including Resident #1. At 9:40 PM, the surveyor observed Resident #1 put their NJ Ex Order 26.4(b)(1) into the open receptacle. On 3/26/26 at 8:26 AM, the surveyors and the U.S. FOI) toured the designated resident NJ Ex Order 26.4(b)(1). The U.S. FOIA (b confirmed that there was one open receptacle which was the receptacle used for NJ Ex Order 26.4(b)(1) and where the residents NJ Ex Order 2 their b)(1). On 3/26/26 at 8:31 AM, the surveyors and the U.S. FOIA (b followed the path from the designated NJ Ex Order 26.4 area to the ambulance entrance. The U.S. FOIA (stated the ambulance entrance was an emergency entrance and exit and was not part of the designated NJ Ex Order 26.4 At that time, the surveyors did not observe a NJ Ex Order 26.4(b)(1) sign, there were NJ Ex Order 26.4(b)(1) and there were no observed receptacle for NJ Ex Order 26.4(b)(1) At that time, the U.S. FOIA (b stated that the NJ Ex Order 26.4(b)(1) were from the facility's employees. The acknowledged and confirmed that there were no signs to identify the area was a NJ Ex Order 26.4(b)(1) area and there were NJ Ex Order 26.4(b)(1) receptacles in the area. On 3/26/26 at 10:33 AM, during a meeting with the survey team, the U.S. FOIA (b) U.S. FOIA (and the facility's corporate staff, the surveyor discussed the concerns with the opened NJ Ex Order 26.4 receptacles at the designated NJ Ex Order 26.4(b)(1). The surveyor also informed them of the NJ Ex Order 26.4(b)(1) found	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 30 at the emergency entrance/exit that was not a designated [NJ Ex Order 26.4] area which also did not have a sign to indicate that was a [NJ Ex Order 26.4(b)(1)] of the facility. No further information was provided. A review of the facility provided “Smoking Policy,” dated reviewed/updated 10/2025, included the following: smoking is only permitted in designated resident smoking areas which were located outside of the building…Metal containers with self-closing devices are available in smoking areas… A review of the facility provided policy, "Accidents and Incidents - Investigating and Reporting," dated reviewed June 2025, which included: Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. Policy Interpretation and Implementation…2. The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time accident or incident took place…c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; e. The name(s) of the witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; j. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc); k. Any corrective action taken; l. Follow-up information; m. Other pertinent data as necessary or required… A review of the “Out on Pass (OOP) Policy/Leave of Absence (LOA)/ Discharge Against Medical Advise (AMA),” dated 1/2026, revealed it is the policy of the facility...A cognitively intact resident may leave the facility independently...The facility will track the departure and return of a resident on the "Release of Responsibility for OOP/LOA/AMA” form. Procedure: 1. obtain a physician's order for the resident/patient to leave the facility...4. Obtain signature of the resident/patient or the responsible party taking the resident/patient from the facility of the Release of Responsibility for OOP/LOA/AMA form...	F0689		05/15/2026

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F0689 SS = SQC-H	Continued from page 31 A review of the "Care Plans, Comprehensive Person Centered Policy," dated updated 9/2025, revealed: 7. The comprehensive, person-centered care plan. a. included measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...11. Assessments of residents are ongoing, and care plans are revised as information about the residents and residents' condition changes. N.J.A.C. 8:39-4.1(a)25; 27.1(a)	F0689		05/15/2026
F0568 SS = F	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility failed to have a system in place to ensure quarterly financial statements were provided to residents who maintained Personal Needs Account (PNA) funds with the facility. This deficient practice was identified for 7 of 7 residents who attended a resident council meeting, and affected all 84 residents identified as maintaining a facility PNA account. The evidence was as follows: On 3/23/26 at 8:13 AM, the U.S. FOIA (b)(6) provided the surveyor with a list of all Personal Need Account balances as of 3/19/26. The Trial Balance listed 84 total PNA accounts with a NJ Ex Order 26.4(b)(1) held by the facility.	F0568	The Business Office Manager immediately initiated distribution of quarterly Personal needs account (PNA) statements to all residents and/or representatives. On 3/27/26, the social worker went to the store for resident #56 and bought NJ Ex personal items thus bringing NJ Ex Order 26.4(b)(1) . All residents have the potential to be affected by this practice. U.S. FOIA (b)(6) , Social Workers, and U.S. FOIA (b)(6) were in serviced by the Administrator, regarding the facilities responsibility to distribute quarterly statements timely. Quarterly Statements will be generated after each quarter and be distributed to the residents/responsible party. Statements will be hand delivered to alert and oriented residents by the Business Office Manager or designee or mailed to the responsible party of any other resident. Delivery and mailings will be documented. The Administrator or designee will conduct an audit each quarter for the next 3 quarters to ensure all residents/responsible parties received a copy of their quarterly PNA statement. Results will be reported to the QAPI committee for the next 3 quarters.	05/15/2026

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F0568 SS = F	Continued from page 32 On 03/23/26 at 10:28 AM, the surveyor conducted a resident council meeting with 7 residents. When asked if the residents were provided quarterly statements for their PNA accounts, the residents stated "no" and they would have to request a PNA statement from the facility. On 03/24/26 at 10:39 AM, the surveyor met with Resident #56 and the regular U.S. FOIA (b)(6) was present. When asked if the resident needed anything, the U.S. FOIA showed the surveyor the NJ Ex Order 26.4(b)(1) and the U.S. FOIA stated the resident needed NJ Ex Order 26.4 When asked the resident if they knew that they had PNA funds to spend on items that they needed, they stated, “no” they were not aware (Resident #56's PNA balance was NJ Ex Order 26.4(b)(1). The resident showed the surveyor NJ Ex Order 26.4 and stated they would like NJ Ex Order 26.4(b)(1) also. On 03/24/26 at 9:47 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated he worked for the management company that managed the facility. The surveyor asked about the PNA funds and the U.S. FOIA stated that the residents would take out money through the U.S. FOIA (b)(6) as needed and that he provided the U.S. FOIA (b)(6) with a daily report of PNA funds. On 03/24/26 at 10:08 AM, the surveyor conducted a follow-up interview with the U.S. FOIA regarding the PNA process and asked if there was a process in place to send quarterly PNA statements to the residents. The U.S. FOIA stated he did not distribute any statements and also confirmed that he was the person who maintained the access to the PNA management program for the facility. The U.S. FOIA stated he was aware that residents were supposed to be provided with PNA statements and he stated that one family asked for a statement a few months ago. When asked if the process was for residents to request statements, he stated, "no, shouldn't be, they are supposed to get them quarterly." The U.S. FOIA confirmed he had been aware that the facility was not providing residents with quarterly PNA statements. A review of the Resident Funds Management System (PNA) policy last revised 10-2025 revealed a Policy Statement: The facility shall maintain a PNA account for any resident who chooses to deposit funds with the facility. These funds are managed solely for the resident's personal use. The facility will ensure secure handling, accurate accounting, and timely access to funds upon resident request. The policy	F0568		05/15/2026

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F0568 SS = F	Continued from page 33 did not indicate a process for providing quarterly statements. NJAC 8:39-9.5(a)	F0568		05/15/2026
F0569 SS = F	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation interview and document review it was determined that the facility failed to ensure a process was in place to ensure that all residents that maintained a Personal Needs Account (PNA) that approached the limit that could jeopardize a resident's eligibility for [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] were notified. This deficient practice was identified for a resident who had PNA funds in excess of [NJ Ex Order 26.4(b)(1)] (Resident #56) and affected all 84 residents who maintained a facility PNA. The evidence was as follows: On 3/23/26 at 8:13 AM, the U.S. FOIA (b)(6)	F0569	On 3/27/26, the Social Worker notified resident #56 that [NJ Ex Order 26.4(b)(1)] account balance was [NJ Ex Order 26.4(b)(1)] and went to the store and bought [NJ Ex Order 26.4(b)(1)], thus bringing [NJ Ex Order 26.4(b)(1)] PNA account [NJ Ex Order 26.4(b)(1)] All residents have the potential to be affected by this practice. A weekly report will be generated by the Business Office Manager or designee to identify all balances for Medicaid residents. Any resident/responsible party of a resident with a balance of $1,700 or more will be notified immediately by Social Services stating: 1) account has almost reached $200 less than SSI limit, and 2) eligibility may be lost if the account reaches $2,000. Social Worker will meet with resident/representative to develop a spend down plan. Social Worker's were in serviced by the Administrator to discuss and document during quarterly care plan meetings 1) what funds are available in the PNA account, and 2) if the resident chooses to spend down any money during the quarter. The Administrator or designee will audit 100% of Medicaid resident PNA accounts weekly for 4 weeks, then monthly for 5 months, then quarterly for 1 quarter to verify that no accounts exceed $1,700 without documented notice and spend down plan, and that notices were issued at the time the residents balance reaches $1700. Audit results will be reported to the QAPI committee quarterly for the next 3 quarters.	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE , NEPTUNE, New Jersey, 07753

(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
F0569 SS = F	Continued from page 34 U.S. FOIA (b)(6) provided the surveyor with a list of all Personal Need Account balances as of 3/19/26. Resident #56 had a current balance of NJ Ex Order 26.4(b) and the Trial Balance listed 84 total accounts with a NJ Ex Order 26.4(b)(1) balance held by the facility. On 03/23/26 at 12:45 PM, the surveyor interviewed both Social Workers (SW #1 and SW #2) regarding the PNA process to assist residents to use their funds. SW #1 stated that the U.S. FOIA (b)(6) talked to the residents to determine what they needed from the store and the business office would keep "an eye" on the PNA funds to identify who needed to spend down PNA funds. On 03/24/26 at 9:47 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who worked for the management company that managed the facility. The surveyor asked about the PNA funds process. The U.S. FOIA stated that the residents would take out money through the U.S. FOIA (b)(6) as needed and that he provided the U.S. FOIA (b)(6) with a daily report of PNA funds. When asked what he did if resident had a large amount of funds, he stated he would reach out to SW and tell them that the resident needed to spend down the funds. He then stated, he hasn't noticed anyone with the need to spend down. The U.S. FOIA stated that if a resident was over NJ Ex Order 26.4(b) in their PNA they could be "shut down" and become ineligible for NJ Ex Order 26.4(b) Then he stated he would not get involved as it was the SW's responsibility to ensure the residents spent their money. When asked about the policy, he stated he was unsure of the official policy. On 03/24/26 at 10:39 AM, the surveyor met with Resident #56 and the regular U.S. FOIA (b)(6) was present. When asked if the resident needed anything, the U.S. FOI showed the surveyor the NJ Ex Order 26.4(b)(1) and the stated the resident needed NJ Ex Order 26.4 When asked the resident if they knew that they had funds to spend on items that they needed, they stated, “no” they were not aware. The resident showed the surveyor NJ Ex Order 26.4 and stated they would also like NJ Ex Order 26.4(b) The surveyor then reviewed the medical record for Resident #56 which revealed an Admission Record that revealed diagnoses which included, but were not limited to, NJ Ex Order 26.4(b)(1) A review of the quarterly	F0569		05/15/2026

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F0569 SS = F	Continued from page 35 Interdisciplinary Team Meeting (IDT) Note dated [redacted] did not reveal any documentation regarding any resident needs, or the available PNA. A review of a [redacted] note dated [redacted] and signed by a [redacted] which revealed …the resident was thinking about [redacted] and their [redacted] On 03/24/26 11:27 AM, the surveyor interviewed Resident #56's [redacted] regarding her role in assisting residents with their PNA and asked if Resident #56 needed anything. The [redacted] stated that typically the residents would go to the Activity Department when they needed something from [redacted]. When asked about the [redacted] PNA balance and had that been discussed with the resident, since there was a recent IDT meeting held on 3/11/26. The [redacted] stated the PNA "should have probably been discussed in the quarterly meeting." The [redacted] stated that she may have purchased [redacted] of clothing for Resident #56 one year ago and the surveyor asked for documentation of those purchases. A subsequent review of Resident #56's PNA statement provided by the [redacted] from [redacted] through [redacted] revealed there were no personal needs items or cash withdrawals. After surveyor inquiry regarding Resident #56's PNA, the surveyor reviewed a SW's progress note dated [redacted] at 3:45 PM which revealed SW and Activities met with Resident #56 to discuss spending down some of their PNA. … The third time we asked they said they would like some [redacted] … asked SW to pick out some [redacted] … stated they would like some [redacted]. On 3/25/26 at 1:57 PM, the survey team met with the facility [redacted] and the [redacted] and the facility management company [redacted] and the surveyor discussed the above concerns. On 03/26/26 at 10:13 AM, during the exit conference held between the survey team, the facility administration and management company there was no additional information provided. NJAC 8:39-4.1(3)(8)(10)(12)	F0569		05/15/2026

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F0725 SS = F	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and review of pertinent documents it was determined that the facility failed to ensure that there was sufficient competent staff to ensure a) all residents were provided with appropriate and timely [NJ Ex Order 26.4(b)(1) redacted] and were consistently available to provide appropriate care to maintain residents highest practicable physical, mental, and psychosocial wellbeing and b) the minimum staffing requirements per the New Jersey Department of Health based on acuity of the residents was maintained. The deficient practice was identified for 5 of 5 residents reviewed (Resident #10, #31, # 58,	F0725	1. How the deficient practice was corrected for the affected individual(s) Resident #122 The Certified Nursing Assistant immediately checked the resident and provided the [NJ Ex Order 26.4(b)(1) redacted] care. This resident had a plan of care of refusal to be changed. Educated to the risk and benefit as reflected on his care plan. The Unit Manager immediately completed the [NJ Ex O redacted] assessment and no [NJ Ex Order 26.4(b)(1) redacted] noted. Resident #10 The Certified Nursing Assistant immediately offered the resident to [NJ Ex Order 26.4(b)(1) redacted] and in agreement. No adverse effect noted. Resident #31 The Certified Nursing Assistant immediately offered the resident to [NJ Ex Order 26.4(b)(1) redacted] in agreement. No adverse effect noted. Resident #58 The Certified Nursing Assistant immediately checked the resident and provided the [NJ Ex Order 26 redacted] This resident had a plan of care of [NJ Exec Orde redacted] of care and [NJ Ex Order 26. redacted] Educated to the risk and benefit as reflected on his care plan. Resident #68 The Certified Nursing Assistant immediately checked the resident and provided the [NJ Ex Order 26.4(b)(1) redacted] care. The Unit Manager immediately completed the [NJ Ex O redacted] assessment and no [NJ Ex Order 26.4(b)(1) redacted] noted. The Administrator and the Staffing Coordinator immediately notified the staffing agency to provide additional Certified Nursing Assistant (CNA) to supplement the staffing need of the facility based on the appropriate ratio. The Administrator immediately boosted the rate of	05/15/2026

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F0725 SS = F	Continued from page 37 #68 and #122) and had the potential to affect all residents who resided in the facility. The evidence was as follows: Refer to F677 a)1. On 3/22/26 at 8:30 AM, the surveyor observed Resident #122 in bed, the resident informed the surveyor that they just finished their breakfast meal. The resident had the lid tray in their hand and informed the surveyor that they [NJ Ex Order 26.4(b)(1)], they were [NJ Ex Orde]. The surveyor inquired regarding care, and Resident #122 stated they were [NJ Ex Order 26.4(b)(1)] last night. The resident stated a staff checked them this morning and informed them that [NJ Ex Order 26.4(b)(1)] the staff left the room and did not return. On 3/22/26 at 9:00 AM, the surveyor reviewed the assignment sheet and located the Certified Nursing Aide (CNA) who confirmed she was the resident's aide for the day and stated that she was informed that the resident had not been changed during the 11:00 PM-7:00 AM shift. The surveyor accompanied by CNA and entered Resident #122's room the CNA informed the resident of the procedure and then pulled back the resident's blanket which revealed the resident was NJ Ex Order 26.4(b)(1) and the surveyor observed a NJ Ex Order 26.4(b)(1). The CNA informed the surveyor that she had not yet provided care to that resident. The CNA further stated that she was assisting other residents with the breakfast meal. A review of the 11:00 PM-7:00 AM staffing reflected that the Census was 59 and the facility had 3 CNAs working for the shift. Review of the CNA assignment sheet revealed the unit had a census of 58 Residents with five assigned aides. The CNA had an assignment of 12 residents on that shift. On 3/22/25 at 9:15 AM, the surveyor interviewed the U.S. FOIA (b)(6) she stated that U.S. FOIA (b)(6) care should be completed every two hours during the day shift and every 4 hours on the 11:00 PM-7:00 AM shift. On 3/24/26 at 10:17 AM, the surveyor interviewed the U.S. FOIA (b)(6) who confirmed that incontinent care should be provided every two hours and as needed during the day shift. The [U.S. FO] stated that the CNAs were to inform the nurses if any resident refused care.	F0725	Continued from page 37 the Certified Nursing Assistant (CNA) through an agency. The Director of Nursing immediately in-serviced the U.S. FOIA (b)(6) in reference to the state guideline F725. The Staffing Coordinator immediately called all the aides scheduled for the next shift to come in early. 2. How the facility will identify other residents having the potential to be affected: All residents have potential to be affected by this practice. 3. What systemic changes will be put into place to ensure the deficient practice does not recur: The Director of Nursing will in-service the [U.S. FOIA (b)(6] on federal guidelines F677 and F725 related to sufficient staffing per state guideline necessary to provide the care of the residents i.e ratio 1-8 on 7-3 shift, 1-10 on 3-11 shift and 1-14 on 11-7 shift. The Regional DON reviewed and updated the staffing policy to maintain staffing levels that meet or exceed minimum state staffing requirements while ensuring resident care needs are addressed timely and appropriately. The Administrator and Director of Nursing (DON) shall be responsible for oversight of staffing schedules and daily staffing operations. The Director of Nursing and/or designee will review the staffing schedules weekly and adjusted based on census, acuity, resident care needs, and unexpected changes in resident condition. Unit managers and nursing supervisors shall monitor staff assignments and resident care delivery throughout each shift. The Director of Nursing and the Administrator approved the use of nurses to be called to take the assignments as C N A in the event of challenged staffing.	05/15/2026

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F0725 SS = F	Continued from page 38 2. 03/22/26 at 9:30 AM, Resident #68 for NJ Ex Order 26.4(b)(1) care. Resident #68 was in bed, and their NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1). Resident #68 stated that they were provided with NJ Ex Order 26.4(b)(1) care around 4:00 in the morning. The CNA who assisted the surveyor with the NJ Ex Order 26.4(b)(1) care stated that the resident should have been checked and NJ Ex Order 26.4 before breakfast was served. 3. On 3/22/26 at 9:31 AM, the surveyor observed Resident #31 in bed, when asked about how their stay had been at the facility Resident #31 stated "[redacted]." Resident #31 stated that NJ Ex Order 26.4(b)(1) The surveyor observed al NJ Ex Order 26.4(b)(1) over the NJ Ex Order 26.4(b) with NJ Ex Order 26.4(b)(1). Resident stated that "NJ Ex Order 26[redacted] On 3/23/26 11:18 AM, the surveyor interviewed the CNA regarding NJ Ex Order 26.4(b) and NJ Ex Order 26.4. The CNA stated that Resident #31 required NJ Ex Order 26.4(b)(1). She stated today was their NJ Ex Order 26 day, but they never NJ Ex Order 26.4(b)(1), they received a NJ Ex Order 26.4(b)(1), and they were dressed and assisted out of bed. The CNA stated that NJ Ex Order 26.4(b) should have been included on their NJ Ex Order 26 day. The CNA stated if the NJ Ex Or were NJ Ex Order 26.4 she would NJ Ex Order 26.4 because the resident could NJ Ex Order 26 someone. The CNA stated that Resident #31 never asked to have their NJ Ex Order 26.4. The surveyor and CNA went to Resident #31's room together to observe their NJ Ex Order 26.4(b)(1). The CNA stated "they could NJ Ex Order" but if they had NJ Ex Order 26.4(b) I would not NJ Ex Order 26.4(b)(1) the nurse would NJ Ex Order 26.4(b)(1) if they were NJ Ex Order 26.4(b). When the surveyor asked the CNA if Resident #31 had NJ Ex Order 26.4(b) the CNA was unable to answer. On 3/23/26 at 11:27 AM, the surveyor interview Licensed Practical Nurs (LPN) regarding NJ Ex Order 26.4(b) and NJ Ex Order 26.4. The LPN stated that "only if they asked, we would NJ Ex Order 26.4(b)(1), and their NJ Ex Order 26 usually NJ Ex Order 26.4 nails." The LPN further stated that she didn't notice Resident #31's NJ Ex Or and they had not requested to have their NJ Ex Order 26.4(b) LPN #1 stated the nurses would cut the resident's NJ Ex Or if the resident had NJ Ex Order 26.4 and the CNA should not NJ Ex [redacted] The LPN stated Resident #31 was not NJ Ex Order 26.4 The LPN then stated, "we should offer to NJ Ex the residents' NJ Ex Or when we provided care on their NJ Ex Order 26 days, "they should not have to ask." 4. On 3/22/ 26 at 9:43 AM, the surveyor observed	F0725	Continued from page 38 The Administrator hired a new Human Resources to facilitate efficient hiring of staff. She started NJ Ex Order 26.4(b)[redacted] In the event of staffing shortages, call-outs, increased census, emergencies, or other unforeseen staffing concerns, the facility shall implement contingency staffing measures which may include: Requesting voluntary overtime; Utilizing per diem staff; Utilizing approved agency staffing personnel; Reassignment of management or supervisory nursing staff to resident care assignments as needed; Adjustment of non-essential duties to prioritize direct resident care; Cross-training staff (i.e. rehab), where appropriate and within scope of practice; Resident non-adherence will be managed through education on risk vs benefits, care planning and reinforcement of safety agreements. Shower schedules were reviewed by Unit Managers for their respective units and deemed appropriate. Validation of shower completion is documented in the Medication Administration Record. The Unit Manager and/or designee will audit 10 resident's showers and nail care weekly for 4 weeks the 15 patients monthly for 3 months. The Unit Manager and/or designee will audit the incontinence care of 10 residents weekly for 4 weeks, then 10 residents monthly for 3 months.	05/15/2026

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F0725 SS = F	Continued from page 39 Resident #10 sitting in a wheelchair in the room and was eating the breakfast meal. The surveyor observed Resident #10's [NJ Ex Or] were [NJ Ex Order 26.4(b)(1)] The surveyor asked the resident if they would like their NJ Ex Order 26.4(b)(1) , the resident stated that they would like to. On 3/23/24 at 9:30 AM, the surveyor observed the resident eating breakfast in the room and the resident's [NJ Ex Or] were in the same condition as observed during the initial tour on 3/22/26. The surveyor asked the resident again if they would like their [NJ Ex Or] to be NJ Ex Order 26.4(b)(1) , the resident stated, "yes". On 3/25/26 at 11:30 AM, the surveyor asked the U.S. FOIA (b)(6) when staff were to provide nails care to the residents. The U.S. FOIA (b)(6) stated that [NJ Ex Or] care was to be provided [NJ Ex Order 26.4(b)(1)] The surveyor accompanied the U.S. FOIA (b)(6) to the room, and we both observed that [NJ Ex O] care was not provided on 3/23/26 as scheduled. Resident #10 received [NJ Ex O] care after the surveyor inquiry on 3/25/26. Review of the CNA assignment sheet for 3/23/26 during the day shift revealed the unit had a census of 58 Residents with five assigned aides. The CNA had an assignment of 12 residents on that shift. On 3/25/26 at 10:14 AM Resident #58 informed the surveyor that they had not had [NJ Ex Order 26.4(b] since [NJ Ex Order 26.4] The surveyor reviewed the [NJ Ex Order 26] log and observed that Resident #58 was to receive their [NJ Ex Order 26] on NJ Ex Order 26.4(b)(1) . Resident #58 stated that they had been asking for [Ex Order 26.4(b] and did not receive [NJ Ex Order 26.4(b] on [NJ Ex Order 26.4] The surveyor observed Resident #58 with the same set of pajamas on for 3 days. Resident #58 [NJ Ex Order 26.4(b)(1)] were covered with [NJ Ex Order 26.4(b)(1)] The Physician prescribed a NJ Ex Order 26.4(b)(1) to be NJ Ex Order 26.4(b)(1) daily. Resident #58 had a container of the [NJ Ex Order 26.4(b)(] [NJ Ex Order 26.4] delivered to the facility on [NJ Ex Order 26.4] . The container was still half full, and another container delivered from the pharmacy on [NJ Ex Order 26.4] was unopened. On 3/25/26 at 10:17 AM, the surveyor interviewed the U.S. FOIA (b)(6) who confirmed that [NJ Ex O] care was to be provided on [NJ Ex Order 26.4(b)(1)] and was listed on the daily assignment sheet. The U.S. FOIA (b)(6) confirmed also that [NJ Ex Order 26.4(b)(1)] care should be provided every two hours on the day shift and twice on the night shift. The first [NJ Ex Order 26.4(b)(1)] rounds should be completed between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM.	F0725	Continued from page 39 The Director of Nursing (DON)/Designee will review staffing with the Staffing Coordinator daily for 4 weeks then will audit ratios weekly for 3 month. 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur: The Staffing Coordinator and/or DON will submit the audit report to the Quality Assurance Performance Improvement Committee quarterly for three quarters.	05/15/2026

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F0725 SS = F	Continued from page 40 b) 1. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for 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. Staffing had been calculated for the following time frames and revealed the following: For the 2 weeks of AAS-11 and 2 weeks of AAS-12 staffing from 03/08/2026 to 03/21/2026 the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts and deficient in total staff for residents on 4 of 14 overnight shifts as follows: -03/08/26 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -03/09/26 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/10/26 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/10/26 had 7 total staff for 115 residents on the overnight shift, required at least 8 total staff. -03/11/26 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/12/26 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/13/26 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/14/26 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/14/26 had 7 total staff for 115 residents on the	F0725		05/15/2026

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F0725 SS = F	Continued from page 41 overnight shift, required at least 8 total staff. -03/15/26 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/15/26 had 7 total staff for 119 residents on the overnight shift, required at least 8 total staff. -03/16/26 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/16/26 had 11 total staff for 119 residents on the evening shift, required at least 12 total staff. -03/17/26 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/18/26 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/19/26 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/19/26 had 7 total staff for 119 residents on the overnight shift, required at least 8 total staff. -03/20/26 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/21/26 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. For the 2 weeks of AAS-12 staffing from 03/08/2026 to 03/21/2026, the facility was deficient in staffing for required resident services on 2 of 14 days as follows: For the week of 03/15/26 Required Staffing Hours: 306.75 2. -03/16/26 had 304 actual staffing hours, for a difference of -2.75 hours. -03/19/26 had 296 actual staffing hours, for a difference of -10.75 hours. A review of the facility's "Staffing" policy updated December 2025, included the following: “ Our facility provides sufficient numbers of staff with the	F0725		05/15/2026

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F0725 SS = F	Continued from page 42 skills and competency necessary to provide care and services for all residents in accordance with resident care and facility assessment, staffing numbers and skills requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care A review of the facility's "Activities of Daily Living (ADLs) Supporting" policy dated revised included resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living... NJAC 8:39-5.1(a); 27.1(a)	F0725		05/15/2026
F0730 SS = F	Nurse Aide Perform Review – 12Hr/Year In- service CFR(s): §483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of pertinent facility documents, it was determined that the facility failed to conduct yearly performance reviews of all Certified Nursing Aides (CNA) to provide specific education aligned with the facility assessment and based on staff observed needs for improvement. This deficient practice was identified for 5 of 5 CNAs whose personnel records were reviewed, and was evidenced by the following: On 3/24/26 at 10:30 PM, the surveyor requested the U.S. FOIA (b)(6)) to provide the list of all new hires since the last survey, including employees who were no longer employed by the facility and contracting facility's employees. On 3/24/26 at 10:00 AM, the surveyor interviewed the U.S. FOIA (b)(6) and required the orientation package, the facility assessment and the Performance Evaluation for 5 selected CNAs. The nurse educator informed the surveyor that the U.S. FOIA (b)(6) and the [redacted] were responsible for the employees' Performance evaluation.	F0730	The Director of nursing/Assistant Director of Nursing initiated yearly performance reviews for all certified nursing aides to provide specific education aligned with the facility assessment and based on staff observed needs for improvement. All residents have the potential to be affected by this practice The Administrator created a schedule for when all nurses aides are due for yearly performance reviews The U.S. FOIA (b)(6) U.S. FOIA (b)(6) [redacted] were in serviced by the Administrator on the requirement to perform a review of all nurses aides at least once every 12 months. The administrator will audit 5 certified nurses aides monthly for 3 months and then quarterly for 3 quarters to ensure all certified nursing aides receive a yearly performance review and are provide specific education aligned with the facility assessment and based on staff observed needs for improvement. Audit results will be reported to the QAPI committee quarterly for the next 3 quarters.	05/15/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE , NEPTUNE, New Jersey, 07753

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F0730 SS = F	Continued from page 43 On 3/24/26 at 10:30 AM, the surveyor requested from the [redacted] the performance evaluation for five randomly selected CNAs and one Licensed Practical Nurse for review. On 03/24/26 at 10:22 AM, during an interview with the surveyor, the [redacted] stated that they have not done performance reviews for any the CNAs and nurses recently. The [redacted] further stated, "The facility should have done it. It is important" to ensure the job performance was based on an employees job description. Another surveyor asked the [redacted] why it is important for the facility to evaluate their staff. The [redacted] stated it is important to facilitate communication and make sure that their performance aligned with their standard of practice". The [redacted] stated they "slacked off" regarding the performance reviews and he confirmed that the facility doesn't have them to provide to the survey team. The facility could not provide any employee files for review of performance evaluations. A review of the facility's policy titled, "Staffing" last updated December 2025 revealed the following: Our facility provides sufficient numbers of staff with the skills and competency necessary to provide services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct care services. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. NJAC 8:39-43.17(b)	F0730		05/15/2026
F0836 SS = F	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State	F0836	The interdisciplinary (IDT) team met with the Director of Clinical Services and the IDT team for the Program of all-inclusive Care for the Elderly (PACE) to ensure a process is in place to integrate care and services for residents who regularly attend the PACE program. Resident #115 has since been discharged from the facility.	05/15/2026

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F0836 SS = F	Continued from page 44 and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and review of pertinent documents it was determined that the facility failed to ensure that it maintained responsibility for the care and services provided to residents at all times, and ensure a process was in place to integrate care and services for residents who regularly attended an outside Program of All -Inclusive Care of the Elderly (PACE). This deficient practice was identified for 1 of 3 residents reviewed for accidents (Resident #115) and attended a PACE program, and had the potential to affect all residents who resided in the facility and for 6 of 6 residents who attended a PACE program. The evidence was as follows: On 3/22/26 at 8:00 AM, the survey team entered the facility to conduct a survey and at 8:10 AM, while in the lobby, the survey team observed a person ambulating with a walker, then NJ Ex Order 26.4(b)(1) [redacted] and proceeded to	F0836	Continued from page 44 All residents that attend an outside program have the potential to be affected by this practice After meeting with the IDT team for the PACE program, the following interventions were put into place. The Unit Manager/designee will receive daily updates via phone from a representative at the PACE program on any resident who attends the PACE program. The information provided will be transmitted in the resident's medical chart Any resident which was seen by any physician or clinician, the consult will be sent by PACE via email and will be uploaded to the resident's medical chart. 4.The Administrator will audit weekly for 4 weeks and then monthly for 3 months and then quarterly for 2 quarters, all resident's that attend the PACE program to ensure a process is in place to integrate care and services for residents who regularly attend the PACE program. Audit results will be reported to the QAPI committee quarterly for the next 3 quarters.	05/15/2026

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F0836 SS = F	Continued from page 45 ambulate NJ Ex Order 26.4(b)(1) When asked, the receptionist confirmed that it was Resident #115. When asked if the resident was supposed to be NJ Ex Order 26.4 in that area, NJ Ex Order 26 , she stated “no”, and that Resident #115 NJ Ex Order 26.4(b)(1) and that was their routine.” On 3/22/26 at approximately 8:20 AM, the surveyor NJ Ex Order the facility NJ Ex Order 2 for Resident #115 in the area the resident was observed and the surveyor could not locate the resident. On 3/22/26 at 12:18 PM, a review of the electronic medical record (EMR) for Resident #115 revealed the following: The Admission Record revealed diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) The Admission Minimum Data Set, an assessment tool, dated NJ Ex Order 26.4(revealed the resident was admitted from NJ Ex Order 26.4(b)(1) , The Brief Interview for Mental Status score was out of 15 which indicated the cognition was NJ Ex Order The Discharge Plan was coded "Yes", to indicate active discharge planning already occurring for the resident to return to the community. The current 15 page Care Plan was reviewed and revealed a Focus for: I have chosen to continue to smoke and need you to observe me for safety, Date Initiated: NJ Ex Order 26.4(and Resident has NJ Ex Order 26.4(b)(1) evidenced by a history of NJ Ex Order 26.4(b)(1) Exhibits NJ Ex Order 26.4(b)(, or NJ Ex Order 26.4(b Date Initiated: NJ Ex Order 26.4(b)(1) High risk for NJ Ex Order 26.4(b)(1) problems, NJ Ex Order 26.4(b)(1) Date Initiated: NJ Ex Order 26.4(b)(1) . The Care Plan did not include information regarding attendance at a PACE program, or goals and interventions regarding a discharge plan. A review of the Progress Notes beginning NJ Ex Order 26 through NJ Ex Order 26 revealed the resident was admitted from the PACE at 2:55 PM and NJ Ex Order 26.4(b)(1) . A review of the admission documents from the PACE program revealed the participant was coming from home …with a potential discharge date “no discharge date at this time.” A Health Status Note effective NJ Ex Order 26 at 2:52 PM, and documented by the U.S. FOIA (b)(6)	F0836		05/15/2026

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F0836 SS = F	Continued from page 46 U.S. FOIA (b)(6) revealed: Team met with the PACE via zoom. Clinical and discharge plans updated and the discharge plan is NJ Ex Order 26.4(b)(1), and will continue visits with the [Pace program] every Monday, Wednesday and Friday with transportation. A review of a Release of Responsibility for Leave of Absence document that was in a book at the front desk, and also located in Resident #115's medical record revealed: "I, the undersigned resident and/or my assigned responsible party, herby request a Leave of Absence (LOA) from the facility. I understand and agree to the following conditions: …1. I am voluntarily leaving the facility on the date and time listed below and understand that this LOA is temporary and expected to last no more than 24 hours; 2. I acknowledge that I do not return to the facility within 24 hours of my expected return time, and if I or my responsible party fail to notify the facility of any delay, my absence will be considered as leaving the facility Against Medical Advice; 3. I understand that failure to return within the specified time frame without notice will result in my being voluntarily discharged from the facility; 4. By signing below, I acknowledge that I have been informed of the risks and consequences of leaving the facility, including the possibility of adverse health effects, loss of bed hold, interruption of care and medical management; 5. I release the facility, its staff, administrators, and affiliates from any liability or responsibility for outcomes resulting from my decision to leave the facility under these terms; 6. I confirm that this signed form will serve as both an AMA acknowledgement and a voluntary discharge notice if I fail to return within the specified timeframe. On 03/23/2026 at 12:45 PM, the surveyor interviewed both facility Social Workers (SW) #1 and SW #2 regarding their involvement with the residents who attended the PACE program. Both SWs stated the PACE program had their own SWs. When asked SW #2, who was assigned to Resident #115 what the discharge plan was for Resident #115, SW #2 stated she was not involved in the discharge planning process and that was the responsibility of the PACE program. When asked if the resident was allowed to hold their own cigarettes/lighter the SWs confirmed "no." On 03/23/26 at 10:03 AM, interviewed the assigned U.S. FOIA (b)(6)) for Resident #115 in the resident's room. The resident was out of the facility at that time. The surveyor informed the U.S. FOIA of their observations of the resident ambulating and NJ Ex Order 26.4	F0836		05/15/2026

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F0836 SS = F	Continued from page 47 NJ Ex Order 26.4(b)(1) and asked what care the resident required. The [redacted] stated the resident NJ Ex Order 26.4(b)(1) The U.S. FOIA stated the resident NJ Ex Order 26.4(b)(1) ." The surveyor observed two locked cabinets at that time, on the resident's nightstand and asked if the resident kept NJ Ex Orde and NJ Ex Order 26.4(b) in the cabinet and the U.S. FOIA did not know as the cabinets were locked by the resident. When asked what help or care the resident required from the U.S. FOIA stated, they "didn't need any help." The U.S. FOIA stated they didn't eat at the facility, but wanted the meal tray left at the bedside. On 03/23/26 at 10:28 AM, the surveyor interviewed the U.S. FOIA (b)(6) who was assigned to Resident #115. When asked does she provide care for Resident #115, she stated "when [he/she] is here", they go out and goes to the PACE program Monday, Wednesday and Friday and returned back at 2:30 PM. On 3/23/26 at 1:55 PM, the U.S. FOIA (b)(6)) provided the surveyor with a copy of the PACE contract which revealed a different named PACE and the contract was signed by a former U.S. FOIA (b on 2/6/20. The U.S. FOIA (b confirmed the contract was the current contract. A further review revealed the Program of all-inclusive Care for the Elderly (PACE) which is designed to provide community-based, comprehensive, integrated acute and long-term care healthcare for qualified members of the frail elderly population. 3.1.7 Participate in IDT (Interdisciplinary Team) Meeting. The Provider agrees to participate in the IDT as required by the PACE team… 3.7.7 Provider shall designate an employee with sufficient authority who shall act as liaison between Provider and PACE. Name: (left blank); contact information: (left blank) shall act as Provider's liaison with PACE … On 03/24/26 at 12:57 PM, the surveyor interviewed the U.S. FOIA (b regarding how many current residents were enrolled in the PACE program and the U.S. FOIA (b stated he "did not know", but he would find out. The U.S. FOIA (b then provided the surveyor with a list of 6 residents, that included Resident #115. On 03/25/26 at 11:32 AM, two surveyors interviewed the U.S. FOIA (b and asked about the facility Quality Assurance Process and asked about PACE program	F0836		05/15/2026

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F0836 SS = F	Continued from page 48 process. The U.S. FOIA (b)(6) stated the PACE referred to and also placed residents at the facility and the residents would then attend the PACE day program. When asked about the contract, and the blank areas for the Liaison and the facility integration with the PACE. The U.S. FOIA (b)(6) stated, "I was not aware it was blank" and stated there was a biweekly phone call held with the PACE, and that the discharge plan was the sole responsibility of the PACE program and it was collaborated with the U.S. FOIA When informed that the U.S. FOIA were not involved in the discharge planning, the U.S. FOIA (b)(6) was unaware. When asked who was responsible to ensure care and services were provided for the residents who attended the PACE program. The U.S. FOIA (b)(6) stated it was his responsibility and stated there should be oversight between the PACE program and the facility. When asked if there was a process in place, the U.S. FOIA (b)(6) stated, "no," and stated the "collaboration should be documented in the medical record." On 03/25/26 at 1:56 PM, the survey team conduced a pre-exit conference with the facility U.S. FOIA (b)(6) and U.S. FOIA (b)(6) and the U.S. FOIA (b)(6), U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) from the Management Company for the facility. The surveyor reiterated the above concerns. On 03/26/26 at 10:13 AM, the survey team met with the above individuals with the addition of the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) for the Wedgwood Unit. The facility informed the survey team that the out on pass process form was revised to remove the waiver language and confirmed there was a breakdown between the PACE program and the facility and they realized the need for integration between both the facility and the PACE program. NJAC 8:36-5.1(a); 27.1(a)	F0836		05/15/2026
F0847 SS = F	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any	F0847	The Admissions Director re-explained the terms of the binding arbitration agreement to residents #15,#37, #38, #86, #102, #106, #114 and will re-explain to the responsible party for resident #105 in a manner they understood. All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) and Concierge were in serviced by the Administrator regarding ensuring if	05/15/2026

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F0847 SS = F	Continued from page 49 resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review it was determined that the facility failed to have a process in place to ensure that prior to signing a binding arbitration agreement, that was included within the Admission Packet, the agreement was clearly communicated to the resident or representative in a manner they understood, and they acknowledged they understood the agreement. The deficient practice was identified for 7 of 7 residents (Resident	F0847	Continued from page 49 a new admission is cognitively intact prior to signing the admission agreement. The U.S. FOIA (b)(6) and Concierge were in serviced by the Administrator regarding explaining to residents the content of the binding arbitration agreements in a manner they understand and to ensure the resident/responsible party understand the agreement. Within 2 business days after the resident signs, a printed copy of the signed agreement will be offered to the resident and/or representative for their records. The Admission Director/Designee will audit 3 signed arbitration agreements weekly for 4 weeks, monthly for 3 months, and quarterly for 2 quarters to ensure the residents/responsible party understood the agreement. All results of the audits will be reviewed at the QAPI meeting quarterly for the next 3 quarters.	05/15/2026

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F0847 SS = F	Continued from page 50 #15, #37, #38, #86, #102, #106, and #114) who attended a resident council meeting and a resident with NJ Ex Order 26.4(b)(1) (Resident #105). The evidence was as follows: On 3/22/26 at 10:19 AM, during the facility entrance conference held with the U.S. FOIA (b)(6) [redacted], the surveyor asked the [redacted] if the facility used Arbitration Agreements and asked if any residents had signed the agreements. The [redacted] stated the admission department would handle the Arbitration Agreements and that he would inform the surveyor if anyone had signed the agreement. On 3/22/26 at 11:07 AM, the surveyor interviewed Resident #105 who was unable to elaborate on the care provided and appeared somewhat confused. On 3/22/26 at 11:13 AM, a surveyor reviewed Resident #105's Admission Agreement which revealed the AA was accepted with a signature of the resident that was one line, no signature of a legal representative and a signature of the [redacted] as the "Facility Representative" as being signed by both on [redacted], however, the [redacted] signed the Admission Agreement [redacted]. The Admission Minimum Data Set (MDS) dated [redacted] revealed the resident scored a [redacted] out of 15 on the Brief Interview for Mental Status which indicated the resident had NJ Ex Order 26.4(b)(1) The Care Area Assessment section indicated the resident triggered for NJ Ex Order 26.4(b)(1) On 3/23/26 at 9:03 AM, the [redacted] stated he was unable to provide a list of residents who signed an arbitration document, and he had "somebody working on it." On 03/23/26 at 10:28 AM, a resident council meeting was held with seven residents. The surveyor explained an arbitration agreement and inquired the residents that had recalled signing an arbitration agreement. All seven residents stated they did not recall, because the admission process was completed orally. One resident stated they were [redacted] the agreement on the small tablet and the facility would provide them with a copy and the facility never did. On 3/23/26 at 1:11 PM, the [redacted] provided the surveyor with a list of Arbitration Agreements (AA) which indicated what residents signed the agreements. Residents #38 and #106 were on the list, and Resident #105 was not listed.	F0847		05/15/2026

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F0847 SS = F	Continued from page 51 On 03/23/26 at 1:20 PM, the surveyor interviewed the Admission and Marketing Staff (ADM). The surveyor asked what her responsibilities were regarding admissions. The ADM stated she would get admissions from the hospital and handle referrals and worked on getting the insurance coverage for the residents prior to being admitted into the facility. When asked about the Admission Agreement, the ADM stated that it was completed after the resident was admitted and it was completed using a tablet and was signed electronically. When asked what the review of the AA entailed with the residents, she stated it was "something outside of a courtroom." When asked how she would know if the residents were able NJ Ex Order 26.4(b)(1) the AA, and did she document that information anywhere. She stated that "usually" the U.S. FOIA (b)(6) would let her know if there were concerns about a resident being able to NJ Ex Order 26.4(b)(1) the paperwork themselves. The ADM stated she did not document anything related AA being explained with the residents and when asked if the ADM provided the residents with a copy of the agreement that was signed electronically, she stated the residents don't get a physical copy of the Admission Agreement. The ADM stated that the U.S. FOIA (b) would sign the Admission Agreement. On 03/23/26 at 1:38 PM, the surveyor interviewed the U.S. FOIA (b) about his role with the Admission Agreement process and if her documented in the medical record regarding any questions the residents may have or anything that was reviewed with the residents including the AA. The U.S. FOIA (b) confirmed he did not document in the medical record and he confirmed that the ADM also did not document in the medical record. The U.S. FOIA (b) stated that if a resident had a BIMS of NJ Ex and up that they would be able to sign the Admission Agreement on their own, and if they had a BIMS NJ Ex Order 26.4(b)(1) that a Responsible Party would have to sign the agreement. The U.S. FOIA (b) stated that the ADM could look up the BIMS and that any Admission Agreement with his signature meant that the BIMS was NJ Ex Ord . When asked if he signed the Admission Agreement in the presence of the resident, he said he signed it, but not in the presence of the resident. On 03/25/26 at 1:56 PM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b)(6) and the Management Company: U.S. FOIA (b)(6) U.S. FOI and the U.S. FOI and the U.S. FOIA (b)(6)	F0847		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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F0847 SS = F	Continued from page 52 [redacted] and reviewed the concerns with the AA. On 3/26/26 at 11:37 AM, during the exit conference held with the facility and Management Company representatives, there was no information provided regarding the process of the AA. NJAC 8:39-4.1(a)8; 33 (b)	F0847		05/15/2026
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.	F0865	The facility initiated QAPI plans for all deficient practices identified during annual survey. These plans included tags: F568, F569, F584, F677, F679, F684, F689, F730, F925. Although the facility had systems in place to self-identify potential deficient practices, these systems are now being strengthened to identify potential deficient practices more efficiently. All residents have the potential to be affected by this practice. The Administrator In serviced all department heads regarding self-identifying systems and processes that may negatively affect resident quality of care, quality of life and review significant events and implement data driven QAPI program. Increase QAPI meetings to monthly instead of quarterly to maintain continuity of improvement and routine analyzation of data. Include “standard QAPI plans” to be reviewed at every monthly QAPI meeting. Standard QAPI plans include but are not limited to falls, accidents, incidents, and any significant events. The Administrator or designee will audit QAPI meetings monthly for 6 months to verify that systems that can potentially negatively affect residents are identified by the IDT team. Results will be provided to the QAPI committee quarterly for 3 quarters	05/15/2026

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F0865 SS = F	Continued from page 53 §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.	F0865		05/15/2026

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F0865 SS = F	Continued from page 54 §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility Quality Assurance and Performance Improvement (QAPI) committee failed to self-identify systems and processes that may negatively affect resident quality of care, quality of life and review significant events and implement data driven QAPI program. The deficient practice affected all residents who resided at the facility and was evidenced by the following: Refer to F568, F569, F584, F677, F679, F684, F689, F730, F925 Refer to F568, F569, F584E, F677E, F679E, F684H, F689H, F730F, F925E a. On 3/23/26 at 8:13 AM, the U.S. FOIA (b)(6) [redacted]) provided the surveyor with a list of all Personal Need Account balances as of 3/19/26. Resident #56 had a current balance of [redacted] NJ Ex Order 26.4(b) and the Trial Balance listed 84 total accounts with a [redacted] NJ Ex Order 26.4(b)(1) balance held by the facility. On 03/24/26 at 9:47 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) who worked for the management company and went to multiple facilities. The surveyor asked about the PNA funds and the [redacted] U.S. FOIA stated that the residents would take out money through the [redacted] U.S. FOIA (b)(6) as needed and that he provided the [redacted] U.S. FOIA (b)(6) with a daily report	F0865		05/15/2026

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F0865 SS = F	Continued from page 55 of PNA funds. When asked what he did if resident had a large amount of funds, he stated he would reach out to [U.S. FO] and tell them that the resident needed to spend down the funds. He then stated, he hasn't noticed anyone with the need to spend down. The [U.S. FOIA] stated that if a resident was over [NJ Ex Order 26.4(b] in their PNA they could be shut down for [NJ Ex Order 26.4(b] and become ineligible. Then he stated he would not get involved as it was the [U.S. FOIA] responsibility. When asked about the policy, he was unsure of the official policy. b. On 3/22/26 at 8:57 AM, Resident #54 showed the surveyor a plastic bag with 4 dead cockroach- like insects inside. The resident then stated that when they used the bathroom during the night, and then turned on the light, they would see the cockroaches scatter. On 3/24/2026 at 11:27 AM, the surveyor reviewed the pest control reports provided by the facility which revealed the following:1/14/26, [NJ Ex Order 26.4(b)(1] wing; roach (cockroach) cleanout complete. Treated all cracks and crevices. Activity found coming out of the drop ceiling and molding around the ceiling. On 3/24/2026 at 12:33 PM, the surveyor interviewed the U.S. FOIA (b)(6) who explained the procedure for insect sightings to log the sightings in the book. There was a book in each nurse's station, and then he called the pest control company. He confirmed that Resident #54 had reported to him earlier that month regarding the cockroaches and the pest company came, assessed the room and didn't find anything. He further stated that Resident #54 provided him with a bag with dead insects in it, and he held on to it and showed it to the pest control company. He also stated that lately (this month) the facility has had a "little roach problem." On 3/22/2026 at 10:03 AM, the surveyor entered Resident #13's room, the surveyor observed a large portion of the floor molding between the dresser and the heating/air conditioning unit was in disrepair, the blinds were broken, the hardware on the large dresser were broken and hanging off the furniture, the molding area under the sink was not affixed to the wall and falling off the wall and there was no calking around the sink area/vanity. On 3/22/26 at 10:40 AM, during the initial tour, the surveyor entered Residents #15's bathroom, observed broken tiles behind the toilet, 4 of the 9 ceiling tiles had gaps which also surrounded the sprinkler head and were deteriorated on the corners of the tiles. A piece of plywood on top of the	F0865		05/15/2026

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F0865 SS = F	Continued from page 56 bathtub which was not fastened and was covered with half a mat that positioned lengthwise. On 3/22/26 at 10:45 AM, the surveyor and the CNA entered Resident #19's bathroom and observed blackish-brownish sediment on the tiles toward the left-hand side of the toilet bowl and brownish, rust colored sediment on the bathtub. c.On 3/22/26 at 8:30 AM, surveyor #1 entered Resident #122's room and observed Resident #122 in bed. Upon inquiry, Resident #122 informed the surveyor that they were not provided with NJ Ex Order 26.4(b)(1) care on the 11:00 PM-7:00 AM shift. The surveyor left the room and asked a Certified Nurse Aide in the hallway to assist with an NJ Ex Order 26.4(b)(1) check. The CNA informed the resident of the procedure, the resident agreed to get checked. The resident was covered with a clean blanket. The CNA pulled the cover, and we observed the bedding including the resident's gown, the blanket was NJ Ex Order 26.4(b)(1). The surveyor left the room and accompanied the Licensed Practical Nurse (LPN) in the room. The LPN observed that the resident was NJ Ex Order 26.4(b)(1). The LPN stated that the CNA reported that the resident refused care. The Licensed Practical Nurse confirmed that Resident #122, needed to NJ Ex Order 26.4(b)(1). The surveyor then asked the LPN if she spoke with the resident regarding NJ Ex Order 26.4(b)(1) care, she stated, "No". On 3/22/26 at 9:30 AM, surveyor #1 observed Resident #10 seated at the bedside eating breakfast. Resident #10's NJ Ex Order 26.4(b)(were NJ Ex Order 26.4(b)(1) Upon inquiry, Resident #10 informed the surveyor that they would like their NJ Ex Or to be NJ Ex Order 26.4 and NJ Ex Order 26.4 Resident #10 was to have their NJ Ex Or on their scheduled NJ Ex Order 26 days. Resident #10 received NJ Ex Order 26.4(b) on NJ Exec Order 2 and were observed with NJ Ex Order 26.4(b)(1 in the same condition as observed on NJ Exec Order 26.4b1. d. On 03/25/26 at 10:47 AM, the surveyors conducted a telephone interview with the U.S. FOIA (b)(6) regarding her role at the facility. The surveyor asked if there were residents with a history of NJ Ex Order 26.4(b)(1) at the facility, and the U.S. stated "yes." When asked if that posed any risks, the U.S. F stated, "of course", if they leave the facility and when asked if the U.S. F was involved in any policies regarding NJ Ex Order 26.4(b)(1) history with residents, she stated, "I wasn't asked about that by	F0865		05/15/2026

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F0865 SS = F	Continued from page 57 the facility." When asked if the [U.S. FO] could residents with history of NJ Ex Order 26.4(b)(1) have the potential to NJ Ex Order 26.4(b)(1), currently NJ Ex Order 26.4(b)(1). The [redacted] stated, "yes for sure," and they could NJ Ex Order 26.4(b)(1) the facility. When asked the [redacted] regarding knowing that Resident #5 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1), was involved in NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) The [U.S. FO] stated, "I wasn't aware of that part, I should have been made aware (Re: NJ Ex Order 26.4) When asked if the [U.S. FO] was involved with the residents who attended the PACE program, the [U.S. FO] stated she did not follow up with the PACE program. When asked about developing policies with the facility regarding the PACE program, she stated she did not. When asked if she reviewed the NJ Ex Order 26.4(b)(1) with the facility at QAPI, she stated she did not. On 03/24/26 at 12:57 PM, the surveyor interviewed the U.S. FOIA (b)(6) regarding how many current residents were enrolled in the PACE program and the [U.S. FOIA (b)] stated he "did not know", but he would find out. The [U.S. FOIA (b)] then provided the surveyor with a list of 6 residents, that included Resident #115. On 03/25/26 at 11:29 AM, two surveyors interviewed the [U.S. FOIA (b)] and asked how often he communicated with the [U.S. FOI] The [U.S. FOIA (b)] stated, "primarily at the QAPI meeting." On 03/25/26 at 11:32 AM, two surveyors interviewed the [U.S. FOIA (b)] and asked about the facility Quality Assurance Process and asked about PACE program process. The [U.S. FOIA (b)] stated the PACE referred to and also placed residents at the facility and the residents would then attend the PACE day program. When asked about the contract, and the blank areas for the Liaison and the facility integration with the PACE. The [U.S. FOIA (b)] stated, "I was not aware it was blank" and stated there was a biweekly phone call held with the PACE, and that the discharge plan was the sole responsibility of the PACE program and it was collaborated with the [U.S. FOI] When informed that the [U.S. FOIA] were not involved in the discharge planning, the [U.S. FOIA (b)] was unaware. When asked who was responsible to ensure care and services were provided for the residents who attended the PACE program. The [U.S. FOIA (b)] stated it was his responsibility and stated there should be oversight between the PACE program and the facility. When asked if there was a process in place, the [U.S. FOIA (b)] stated, "no," and stated the "collaboration should be documented in the medical record."	F0865		05/15/2026

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F0865 SS = F	Continued from page 58 Both surveyors asked the [U.S. FOIA (b)(6)] how the facility determined what was reviewed by the QAPI team and how QAPI plans were developed. The [U.S. FOIA (b)(6)] stated every quarter the department heads would present (Performance improvement Plans- PIP) and assessed their departments and determined where they could improve. The surveyor asked what all the current facility QAPI initiatives were. The [U.S. FOIA (b)(6)] stated the facility currently had the following QAPI plans which included: -Activities regarding attendance rates and residents' satisfaction with activities. (Not specific to room visits) -CNA staffing was short at times. -Minimum Data Set (MDS)- improve assessment accuracy, improve communication with team members, reduce number of modifications. -Kitchen ensured food preferences were adhered to. -Call bell audit grievances 3:00 PM-11:00 PM, 11:00 AM-7:00 PM residents and related to a complaint survey. The [U.S. FOIA (b)(6)] confirmed that the facility did not have any QAPIs for the concerns identified during the survey which included, but were not limited to; the lack of staff performance reviews, environmental concerns, pests, activity room visits, smoking and the "waiver" process, PNA, and falls with injuries. In addition, the [U.S. FOIA (b)(6)] stated the facility did not currently review any significant events in QAPI. On 03/25/2026 at 1:56 PM the survey team met with the [U.S. FOIA (b)(6)], the [U.S. FOIA (b)(6)], the [U.S. FOIA (b)(6)], the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] to discuss concerns. No further information was provided. The surveyor reviewed the facility QAPI-Quality Control and Monitoring Plan, revised 7/20/25.	F0865		05/15/2026

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F0865 SS = F	Continued from page 59 How Potential Topics for PIP's will be identified The QAA committee will review data and input monthly to look for potential topics for PIPs. We will monitor and analyze data, and review feedback and input from residents, staff, families…. We will look at issues, concerns, and areas that need improvement as well as areas that will improve the quality of life and quality of care and services for the residents living and staying in our community. Factors we will consider high-risk, high-volume, or problem prone areas that affect health outcomes, quality of care and services, and areas that affect staff…. NJAC 8:39-33.1(a)(c); 33.2(a)	F0865		05/15/2026
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring,	F0867	All current QAPI plans including but not limited to Activities regarding attendance rates and resident satisfaction with activities, Staffing due to CNA staffing was short at times, Minimum Data Set (MDS)- improve assessment accuracy, improve communication with team members, reduce number of modifications. Kitchen ensured food preferences were adhered to, Call bell audit grievances 3pm-11pm, 11am-7pm residents will be revised to include measurable data to monitor improvement. All residents have the potential to be affected by this practice. The Administrator will inservice all department heads regarding facility process to measure and utilize data acquired and develop quantitative and measurable goals Increase QAPI meetings to monthly instead of quarterly to maintain continuity of improvement and routine analyzation of data. 100% of the QAPI plans that are submitted to the QAPI committee will be reviewed monthly for clear measurable goals and documented improvement and the results will be presented to the QAPI committee for the next 3 quarters.	05/15/2026

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F0867 SS = F	Continued from page 60 including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance	F0867		05/15/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0867 SS = F	Continued from page 61 improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, it was determined that the facility Quality Assessment and Performance Improvement (QAPI) committee failed to utilize the facility Performance Improvement Plan (PIP) to follow the facility process to measure and utilize data acquired and develop quantitative and measurable goals, this deficient practice was evidenced by the following: On 3/24/2026 at 11:00 AM, the surveyor reviewed facility provided Performance Improvement Plans (PIPs) for activities regarding resident participation, missed reimbursement related to failure to capture respiratory treatments, CNA staffing, MDS modifications, and baseline care plans. All PIPs reviewed did not include quantitative and measurable goals. In addition, there were no goals and thresholds listed for performance measurements. On 3/26/2026 at 8:42 AM, two surveyors interviewed	F0867		05/15/2026

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F0867 SS = F	Continued from page 62 the [U.S. FOIA (b)(6)]) regarding how the facility determined what was reviewed by the QAPI team and how QAPI plans were developed. The [U.S. FOIA (b)(6)] stated every quarter the department heads would present their (PIPs) and assessed their departments and determined where they could improve. The surveyor asked what all the current facility QAPI initiatives were. The [U.S. FOIA (b)(6)] stated the facility currently had the following QAPI plans which included: Activities regarding attendance rates and resident satisfaction with activities. (Not specific to room visits) Staffing due to CNA staffing was short at times. Minimum Data Set (MDS)- improve assessment accuracy, improve communication with team members, reduce number of modifications. Kitchen ensured food preferences were adhered to. Call bell audit grievances 3pm-11pm, 11am-7pm residents and due to a complaint survey. The surveyor asked the [U.S. FOIA (b)(6)] if he could provide any data from the PIPs that was analyzed to assess whether the PIP was effective or not. The [U.S. FOIA (b)(6)] stated that he confirmed that he did not have any specific quantitative and measurable goals, outcomes and/or audits written down, but he "knows there has been an improvement." The surveyor reviewed the facility QAPI-Quality Control and Monitoring Plan, revised 7/20/25. How Our QAPI Plan Address Key Issues: Identify and use data to monitor our performance; Establish goals and thresholds for our performance measurements; Systematically analyze underlying causes of systematic problems and adverse events; Ensure Planned Changes/Interventions Are Implemented and Effective; To ensure the planned changes/interventions are implemented and effective in making and sustaining improvements, our organization chooses indicators/measures that tie directly to the new action and conducts ongoing periodic measurement and review to ensure that the new action has been adopted and is performed consistently. N.J.A.C. 8:39--33.1(a), 33.2(b), 33.2(d)	F0867		05/15/2026

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F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Complaint # NJ 2577317	F0584	Resident room #15 bathroom tiles behind the toilet were fixed, 4 ceiling tiles were replaced, and cover on top of the bathtub was fastened by the Maintenance Director. Resident room #19 bathroom tiles toward the left hand side of the toilet bowl and bathtub were cleaned by the housekeeping director and all blackish-brownish sediment/rust colored sediment was removed. Resident room #1bathtub was cleaned by the housekeeping director and any brownish colored sediment was removed. Wedgewood shower room was cleaned by the housekeeping director and any blackish brownish sediment, and whitish pinkish sediment was removed from the tiles. Resident room #13 molding on the floor, blinds, dresser hardware, molding under the sink, and missing caulk around the sink was repaired by the maintenance Director. All residents have the potential to be affected by this practice. The facility implemented a preventive maintenance and housekeeping program in which the maintenance director and Housekeeping Director audits 2 rooms per week and documents their findings. The facility implemented an electronic work order system to efficiently track and record all requested maintenance needs. The facility implemented a shower room cleaning daily checklist for housekeeping staff and a weekly maintenance checklist. The Administrator educated the U.S. FOIA (b)(6) [redacted] and U.S. FOIA (b)(6) regarding the updated shower room cleaning process and preventive room rounds. The Maintenance Director or designee will audit 4 resident rooms/bathrooms weekly x 4 weeks, then monthly x 5 months, and then 10 resident rooms quarterly x 1 quarter to ensure all residents have a safe, clean, and homelike environment. Findings will be reported to the QAPI committee quarterly for the next 3 quarters.	05/15/2026

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F0584 SS = E	Continued from page 64 Based on observation, interview and document review, it was determined that the facility failed to maintain the resident's living environment in a clean, comfortable and homelike manner for 4 of 4 resident rooms (#1, #13, #15 and #19) observed on 1 of 2 resident units ([redacted]) and for 1 of 2 shower rooms ([redacted]) The evidence was as follows: a. On 3/22/26 at 10:40 AM, during the initial tour, the surveyor entered Residents room #15's bathroom, observed broken tiles behind the toilet, four (4) of the 9 ceiling tiles had gaps which also surrounded the sprinkler head ,were deteriorated on the corners of the tiles, a plywood on top of the bathtub which was not fastened, and was covered with half a mat, positioned lengthwise. At that time, the surveyor invited the Certified Nurse Aide (CNA) to enter Room 15's bathroom. The CNA confirmed she observed the same and stated she would inform the nurse of the concerns. On 3/22/26 at 10:45 AM, the surveyor and the CNA entered Residents room #19's bathroom and observed blackish-brownish sediment on the tiles toward the left-hand side of the toilet bowl and brownish, rust colored sediment on the bathtub. At that time, the CNA confirmed she observed the same and stated that she would inform the nurse of the concerns. On 3/23/26 at 12:45 PM, during an interview with the surveyor, the [redacted]) stated each nursing station had a book wherein any staff could report a problem (such as broken tiles, malfunctioning equipment…) and he fixed the problems that were logged. The [redacted] stated he conducted rounds and conducted audits but could not provide the surveyor evidence that rounds and audits were conducted. The [redacted] stated he did not audit for mold, and he did not receive any reports of mold like substances. On 3/24/26 at 11:13 AM, during an interview with the surveyor, the [redacted] stated he oversaw the building and visited twice per month, audited the rooms in no specific order. The surveyor requested any documentation of the audits, and the [redacted] stated he could not provide any documented evidence of any previous audits	F0584		05/15/2026

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F0584 SS = E	Continued from page 65 that were conducted. On 3/24/26 at 11:18 AM, the surveyor, the [redacted] and the [redacted] entered Residents' room #1's bathroom and observed brownish colored sediment on the bathtub. At that time, the [redacted] stated that he was not sure if the bathtub could be painted. The [redacted] and the [redacted] stated that the brownish color on bathtub was rust. At that time, the [redacted] confirmed the observation did not reflect a homelike environment. On 3/24/26 at 11:32 AM, the surveyor, the [redacted] and the [redacted] entered Resident #15's room bathroom and observed the plywood over the bathtub that was not fastened. At that time, the [redacted] could not state if the placement of the unfastened plywood was safe and added that he would discuss the concern with the nursing department. At that time, the [redacted] and the [redacted] confirmed observing 4 of the 9 ceiling tiles that surrounded the sprinkler head were deteriorated and had gaps. The [redacted] acknowledged that the condition of the ceiling tiles was not safe and could be a fire hazard. On 3/24/26 at 11:35 AM, the surveyor, the [redacted] and the [redacted] entered Residents' room #[redacted] and observed the brownish-blackish colored tile behind the toilet and confirmed the discoloration on the tub was rust. At that time both acknowledged that the bathroom did not have the appearance of home-like environment. On 3/25/26 at 8:59 AM, in the presence of a surveyor, the [redacted] and the [redacted] the surveyor observed the shower room. At that time, the [redacted] confirmed that the shower stall observed was where the residents who lived in the [redacted] unit took a shower. The shower stall had blackish-brownish colored sediments underneath the tiles, located underneath the shower head, across the shower head and to the corners, a whiteish, pinkish residue was also found on the floor tiles. The [redacted] stated that it did not look like mold. At 9:12 AM, the [redacted] entered the shower room and informed the surveyors, the [redacted] and the [redacted] that all the tiles could be cleaned with bleach to remove the brownish-blacking and whitish-pinkish substance on the tiles. The [redacted] stated that the cleaning schedule for the shower rooms was twice a week and that shower was last cleaned "6 days ago."	F0584		05/15/2026

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F0584 SS = E	Continued from page 66 b. On 3/22/26 at 10:03 AM, during the initial tour, the surveyor entered Resident #13's room, the surveyor observed a large portion of the floor molding between the dresser and the heating/air conditioning unit was in disrepair, the blinds were broken, the hardware on the large dresser were broken and hanging off the furniture, the molding area under the sink was not affixed to the wall and falling off the wall and there was missing calking around the sink area/vanity. On 3/24/26 at 8:42 AM, the surveyor and the Certified Nurse Aide (CNA) entered Resident #13's room, the CNA acknowledged that the blinds should not have been broken, the molding on the floor should have been repaired and around the sink area/vanity should have been repaired. The CNA further stated that if she had noticed something needed to be repaired, she would have called maintenance or gone to the maintenance department to report the issues. The CNA stated that she was "unsure" if the issues had been reported. On 3/24/26 at 11:55 AM, the surveyor interviewed the [redacted] in the presence of the [redacted]. The [redacted] stated each nursing station had a Maintenance logbook available for staff to log maintenance issues. The [redacted] stated that he checked the maintenance logs every day and he fixed the problems that were logged. The [redacted] stated that he "fixed things every day." The [redacted] stated he conducted rounds and conducted audits, but he did not keep documentation. The [redacted] and [redacted] went to Resident #13's room to view the items in disrepair. The [redacted] and [redacted] agreed that all the above mentioned items should be repaired. On 3/24/26 at 12:15 PM, the surveyor reviewed Maintenance log located at the nurse's station reviewed, there were no reports written for Resident #13's room. The last entry that was recorded in the log was [redacted] On 3/25/26 at 1:57 PM, during a meeting with the survey team, the [redacted], the [redacted], the [redacted], the [redacted] and the [redacted], the survey team discussed the above concerns. On 3/26/26 at 10:15 AM, during a meeting with the survey team, the [redacted], the [redacted] the [redacted]	F0584		05/15/2026

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F0584 SS = E	Continued from page 67 the U.S. FOIA the U.S. FOIA (b)(6), and the U.S. FOIA (b)(6) the U.S. FOIA (b) stated the root cause was the age of the building, recognized that they should have a program in place, and had a transition that contributed to the absence of preventative maintenance. Additionally, the U.S. FOIA (b) stated that the repairs were completed in Resident #13's room. A review of the provided facility policy titled, Homelike Environment, reviewed/updated 9/2025 included that the "Residents are provided with safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible". NJAC 8:36-4.1(a)11; 31.8(e)	F0584		05/15/2026
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that residents who were dependent on staff for activities of daily living was provided with a) routine and appropriate NJ Ex Order 26.4(b)(1) care, b) a NJ Ex Order 26.4 that was consistent with their needs and preferences, c) assistance to NJ Ex Order 26.4(b)(1), d) routine and appropriate NJ Ex Order 26.4(in a timely manner This deficient practice was identified for 4 of 4 residents reviewed for activities of daily living (Resident #10, Resident #31, Resident # 58 and Resident #122). The evidence was as follows: 1) On 3/22/26 at 8:30 AM, the surveyor #1 entered Resident #122's room and observed Resident #122 in bed. Upon inquiry, Resident #122 informed the surveyor that they were not provided with NJ Ex Order 26.4(b)(1) care on the 11:00 PM-7:00 AM shift. The surveyor asked a Certified Nurse Aide (CNA) in the hallway to assist with an NJ Ex Order 26.4(b)(1) check. The CNA informed the resident of the procedure, and the resident agreed to get checked. The resident was covered with a clean blanket, and when the CNA removed the blanket, we both observed NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and the resident's NJ Ex Orde were all	F0677	1. Resident #122 The Certified Nursing Assistant immediately checked the resident and provided the NJ Ex Order 26.4(b)(1) care. This resident had a plan of care for NJ Ex Order 26.4(b)(1) . Educated to the risk and benefit as reflected on NJ Ex care plan. The Unit Manager immediately completed the NJ Ex O assessment and NJ Ex Order 26.4(b)(1) noted. Resident #10 The Certified Nursing Assistant immediately offered the resident to NJ Ex Order 26.4(b)(1) No adverse effect noted. Resident #31 The Certified Nursing Assistant immediately offered the resident to NJ Ex Order 26.4(b)(1). No adverse effect noted. Resident #58 The Certified Nursing Assistant immediately checked the resident and provided NJ Ex Order 26.4(b)(1). This resident had a plan of care of refusal of care and NJ Ex Order 26.4 Educated to the risk and benefit as reflected on his care plan. The Unit Manager immediately completed the NJ Ex O assessment and NJ Ex Order 26.4(b)(1) noted except the	05/15/2026

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F0677 SS = E	Continued from page 68 NJ Ex Order 26.4(b)(1) . The surveyor left the room and accompanied the Licensed Practical Nurse (LPN) into the room. The LPN observed also observed that the resident was NJ Ex Order 26.4(b)(1) The LPN stated that the CNA reported that the resident had refused care. The LPN confirmed that Resident #122 needed to NJ Ex Order 26.4(b)(1). The surveyor then asked the LPN if she spoke with the resident after the CNA stated the resident refused NJ Ex Order 26.4(b)(1) care and to follow up on the resident's condition. The LPN she stated, "No", she had not followed up with the resident. On 3/22/26 at 9:00 AM, during an interview with Resident #122, Resident #122 stated that a CNA had checked them this morning and observed they were NJ Ex Order 26.4(b)(1) The CNA informed them the NJ Ex Order 26.4(b)(1) ." The staff then left the room and did not return. Resident #122 was also served breakfast while being NJ Ex Order 26.4(b)(1) . The Resident stated to the surveyor, "What you observed was not over six hours only." The surveyor asked Resident 122, if they NJ Ex Order 26.4(b)(1) , Resident #122 stated, NJ Ex Order 26.4(b)(1) " On 3/23/26 at 10:00 AM, the surveyor reviewed Resident #122's medical record which revealed the following: According to the Admission Minimum Data Set (MDS) dated NJ Ex Order 26 , Resident #122 had a BIMS score of NJ E out of15 which was indicative of NJ Ex Order 26.4(b)(1) After the surveyor's observation on 3/22/26, Resident 122's Care Pan revealed a Care Plan implemented on NJ Ex Order 26.4 , for refusal of care. The Care Plan also a focus for ADL NJ Exec Order 26.4b1 . The interventions were for staff to encourage participation with ADLs care. Initiated NJ Ex Order 26.4(b)(1) 2) On 3/22/26 at 9:30 AM, the surveyor observed Resident #10 seated at the bedside eating breakfast. Resident #10's NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1) . Upon inquiry, Resident #10 informed the surveyor that they would like their NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Resident #10 was supposed to have their NJ Ex Order 26.4(b)(1) on their scheduled NJ Ex Order 26.4(b)(1) days. Resident #10 received NJ Ex Order 26.4(b)(1) on NJ Exec Order 26.4b1 and was observed with NJ Ex Order 26.4(b)(1) in the same condition as observed on 3/22/26 through NJ Exec Order 26.4b1 . Resident #10 had their NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 after the surveyor inquiry on . 3) On 3/22/26 at 10:00 AM, the surveyor entered Resident #58's room. The surveyor observed Resident #58 seated in a wheelchair at the bedside.	F0677	Continued from page 68 NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1). 2. All residents in the facility have the potential to be affected by this practice. 3. The following measures have been put into place to prevent this practice from recurring: A. The Facility educator and/or designee will provide an in-service all the nurses and Certified Nursing Assistance on Federal Guidelines on F677 related to the care of the residents who are unable to carry out their activities of daily living. B. Shower schedules were reviewed by Unit Managers for their respective units and deemed appropriate. Validation of shower completion is documented in the Medication Administration Record. C. The Unit Manager and/or designee will audit 10 resident's showers and nail care weekly for 4 weeks the 15 patients monthly for 3 months. D. The Unit Manager and/or designee will audit the incontinence care of 10 residents weekly for 4 weeks, then 10 residents monthly for 3 months. E. Resident non-adherence will be managed through education on risk vs benefits, care planning and reinforcement of safety agreements. 4. The Director of Nursing and/or designee will submit the audit report to the Quality Assurance Committee quarterly for the next 3 quarters.	05/15/2026

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F0677 SS = E	Continued from page 69 Resident #58's NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1) [redacted]. The surveyor observed Resident #58 with the same pajamas on NJ Exec Order 26 [redacted], seated in the room. On 3/25/26 at 9:45 AM, Resident #58 stated that they had been trying to NJ Ex Order 26.4(b)(1) for so long, and it did not happen. The resident asked the surveyor if they could facilitate NJ Ex Order 26.4(b [redacted] for them. The surveyor asked the resident when they last had NJ Ex Order 26.4(b [redacted]. The resident stated, "the last NJ Ex Order 26 [redacted] was in NJ Ex Order 26.4(b [redacted] The surveyor then reviewed the medical record for Resident #58 which revealed: A review of the Admission Face Sheet (an admission summary) reflected that Resident #58 was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) [redacted] According to the quarterly Minimum Data Set (MDS) dated NJ Ex Order 26.4(b [redacted] Resident #58 had NJ Ex Order 26.4(b)(1) and scored NJ Ex [redacted] out of 15 on the Brief Interview for Mental Status (BIMS). Resident #58 had a care plan for ADL NJ Ex Order 26.4(b)(1) related to NJ Ex O [redacted] and [redacted] Initiated NJ Ex Order 26.4(b [redacted]. The goal was to maintain current level of NJ Ex Order 26.4(b)(1) Initiated NJ Ex Order 26.4(b [redacted]. The interventions included to assist Resident #58 as needed. 4. On 3/22/26 at 9:31 AM the surveyor observed Resident #31 in bed, when asked about how their stay had been at the facility Resident #31 stated "NJ [redacted] " Resident #31 stated that NJ Ex Order 26.4(b)(1) [redacted] The surveyor observed NJ Ex Order 26.4(b)(1) over the NJ Ex Order 26.4(b [redacted] with NJ Ex Order 26.4(b)(1) [redacted] Resident #31 stated that NJ Ex Order 26.4(b)(1) [redacted]." On 3/22/26 at 11:10 AM The surveyor reviewed the medical record for Resident #31. According to the Admission Record (an admission summary) Resident #31 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) [redacted]	F0677		05/15/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0677 SS = E	Continued from page 70 NJ Ex Order 26.4(b)(1) [redacted] ,	F0677		05/15/2026

A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident was [redacted], revealed that Resident #31 was coded as [redacted] or [redacted]

A review of the resident's comprehensive Care Plan effective [redacted] identified a problem area of ADL [redacted] related to [redacted], the goals were maintain current level of [redacted] in [redacted] with assistance, self-propelling in wheelchair through the review date and the interventions included Resident #31 was a [redacted] on Thursday 7:00 AM-3:00 PM and Monday 3:00 PM-11:00 AM date initiated [redacted]

A review of the resident's [redacted], Physician Order Sheet reflected a physician's order dated [redacted] for Bi-weekly [redacted] days, [redacted] Day every day shift every Thursday, and physician order dated [redacted], Bi-weekly [redacted] Day every evening shift every Monday.

On 3/23/26 at 11:18 AM, the surveyor interviewed the CNA regarding [redacted] and [redacted]. The CNA stated that Resident #31 required [redacted]." She stated today was their [redacted] day, but they never took [redacted], they received [redacted] and they were dressed and [redacted] The CNA stated that [redacted] care should have been completed on their [redacted] day. The CNA then stated if the [redacted] were [redacted] she would [redacted] because the resident could [redacted]. The CNA stated that Resident #31 did not ask to have their [redacted] The surveyor and CNA went to Resident #31's room together to observe [redacted]. The CNA then stated "they could [redacted] but if they had [redacted] I would not [redacted] nurse would have to [redacted]. When the surveyor asked the CNA if Resident #31 was [redacted] and the CNA was unable to answer.

On 3/23/26 at 11:27 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding

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F0677 SS = E	Continued from page 71 NJ Ex Order 26.4(b) and NJ Ex O care. LPN #1 stated that "only if they asked, we would NJ Ex Order 26.4(b)(1) Their NJ Ex Order 26 usually NJ Ex Order 26.4(b)(1). The LPN further stated that she didn't notice Resident #31's NJ Ex Ord and they had not requested to have their NJ Ex Order 26.4(b) The LPN stated the nurses would NJ Ex the resident's NJ Ex Ord if the resident was NJ Ex Order 26.4 and the CNA should not NJ Ex if the resident was NJ Ex Order 26.4 The LPN stated Resident #31 did NJ Ex Order 26.4(b)(1). The LPN stated, "we should offer to NJ Ex the resident NJ Ex Ord when we provided care on their NJ Ex Order 26. days, they should not have to ask." On 03/25/26 at 1:56 PM, the survey team met with the U.S. FOIA (b)(6) the U.S. FOIA (b)(6) the U.S. FOIA (b)(6)), the U.S. FOIA (b)(6)), the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6)) to discuss concerns. No further information was provided. A review of the facilities policy updated 10/25 titled "Activities of Daily Living (ADL), Supporting" revealed Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene" Policy Interpretation and Implementation 2. Appropriate care and services will be provided for residents who are unable to carry our ADLs independently … a. hygiene (bathing, dressing, grooming, and oral care). NJAC 8:39-27.1 (a)2(g)(h)	F0677		05/15/2026
F0679 SS = E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by:	F0679	On 3/27/26 the U.S. FOIA (b)(6) was in serviced by the Administrator on ensuring resident activity preferences and attendance are addressed including NJ Ex Order 26.4(b)(1) documentation. On 3/27/26 Resident number #56 was visited by the activity director and social worker to discuss activity preferences including shopping, activity programs and trips. Resident #56 requested items and were purchased by social worker. NJ Ex O was offered the current NJ Exec Order 26.4b1 . Resident #56 will continue to be offered to join activity programs and shopping trips. NJ Exec Order 2 and attendance will be documented. All residents have the potential to be affected by the deficient practice. A review was done of resident activity preferences, participation and documentation	05/15/2026

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F0679 SS = E	Continued from page 72 Based on observation, interview and document review it was determined that the facility failed to ensure a process was in place to provide an ongoing program to support a resident's individual activity preferences to [NJ Exec Order 2] the [NJ Exec Order 26.4b1] needs of the residents. The deficient practice was identified for 1 of 1 resident (Resident # 56) reviewed for activities and was evidenced by the following: On 03/24/26 at 10:39 AM, the surveyor interviewed Resident #56 and asked Resident #56 regarding what they liked to do for activities, and Resident #56's regular certified nurse aide was also present. The resident stated they loved [NJ Ex Order 2] and showed the surveyor their [NJ Ex Order 26.4(] When asked if the resident attended the trips, the resident stated they were never asked about the trips and would go on trips. When asked if the resident walked, the resident stated they could dance and the Certified Nurse Aide (CNA) stated the resident liked to [NJ Ex Order 2] On 03/24/26 at 11:00 AM, the surveyor reviewed the medical record for Resident #56 which revealed the following: A Quarterly Minimum Data Sheet (assessment tool) dated [NJ Ex Order 26] which revealed a Brief Interview for Mental Status score of [NJ E] out of 15 which indicated the resident had NJ Ex Order 26.4(b)(1). The Resident Mood Interview revealed the resident had experienced episodes of NJ Ex Order 26.4(b)(1) on [NJ Exec Order 26.4b1] during the [NJ Exec Order 26.4b1] prior to the assessment. The resident was coded as having NJ Ex Order 26.4(b)(1) The Care Plan revealed a Focus area for Resident #56 was dependent on staff for meeting [NJ Ex Order 26.4(b)(] At risk for [NJ Ex Order 26.4(b)(1)] Initiated [NJ Ex Order 26]. The Goal was to maintain [NJ Ex Order 26.4(] in NJ Ex Order 26.4(b)(1) as desired through review date and reduce the risk of [NJ Ex Order 26.4(b)(1)], with a Target date of [NJ Ex Order 26.4] Interventions included: All staff to converse while providing care, Initiated [NJ Ex Order 26]; Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary, Initiated [NJ Ex Order 26]; Invite/ encourage to scheduled activities, Initiated [NJ Ex Order 26.4]; Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility Initiated [NJ Ex Order 26.4] Provide with activities calendar. Notify of any changes to the calendar of activities. Initiated	F0679	Continued from page 72 of attendance and refusals. Any residents who have been refusing have documentation entered in their record. The activity policy and procedure were reviewed, a new form was created to document the date, time spent, and employee assigned for room visits. All recreation staff were re-educated by the Activities Director on activity policy and procedure including the new room visit form. Activity director/designee will conduct chart reviews of activity documentation of 3 residents weekly x4 weeks and monthly x2 months to ensure that residents are being provided with the opportunity to engage in activities and documentation of attendance and refusals is complete as well as 1:1 room visits are complete. The results of these audits will be reported to the QAPI committee x 3 months to ensure ongoing compliance.	05/15/2026

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F0679 SS = E	Continued from page 73 NJ Ex Order 26.4(b) Enjoys watching NJ Ex Order 26.4(b)(1). Initiated NJ Ex Order 26.4 Loves listening to NJ Ex Order 26.4(b)(1) Initiated NJ Ex Order 26; Resident needs NJ Ex O . Initiated Preferred activities are: NJ Ex Order 26.4(b)(1) , Initiated NJ Ex Order 26.4 An Activity Assessment dated NJ Ex Order 26.4 revealed the resident was coded as "Yes" for on occasion NJ Ex Order 26.4(b)(1) "Yes" for NJ Ex Order 26.4(b)(1) (the If yes, specific dated and the activity section was blank); "Yes" for NJ Ex Order 26.4(b)(1) (the If yes, specific dated and the activity section was blank). On 03/24/26 at 11:07 AM, the surveyor interviewed the U.S. FOIA (b)(6)) regarding the activities and how often trips were scheduled. The U.S. F stated trips were scheduled once per month, and that she asked residents if they wanted to attend. When asked if Resident #56 went on trips, the U.S. F stated Resident #56 wanted NJ Ex Order 26.4(b)(1) and when they went on shopping trips, there would be other residents and Resident #56 NJ Ex Order 26.4(b)(1). The surveyor asked were the trip refusals documented? The U.S. F "it was a long time ago" and confirmed that she did not document refusals and when asked what activities were provided for Resident #56 and the U.S. F stated, room visits were provided to Resident #56 three times per week and the surveyor asked if that was documented. On 03/24/26 at 11:49 AM, the U.S. F provided the surveyor with one-page handwritten document with Resident #56's name on the top, with Date of Room Visit, and a section for brief description of visit with resident. The document did not indicate the time spent with the resident, or staff signature that identified the staff. When asked how long the visits were supposed to be. The U.S. F stated they should be NJ Ex Order 26.4(b)(1) long. When asked if the information was documented anywhere else, the U.S. F stated "no." When asked how she could confirm how long the visits were, or what happened when a refusal was documented? The U.S. F could not confirm the staff who documented the visits, or the time spent with the resident and no additional information was provided. The document revealed NJ Ex Order 2 offered NJ Ex Order 26.4(b)(1)] and refused, NJ Ex Order 26 talked about NJ Ex Order 26.4(b)(1) offered trips-refused, NJ Ex Order 26 offered to take a walk- refused, NJ Ex Order 26 refused visit, NJ Ex Order 26 offered NJ Ex Order 2 (no specific). Three visits per week were not documented for NJ Ex Order 26.4(b)(1) On 03/25/26 at 1:56 PM, the survey team met with	F0679		05/15/2026

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F0679 SS = E	Continued from page 74 the U.S. FOIA (b)(6) and the facility management company staff U.S. FOIA (b)(6), U.S. FOIA (b)(6), and the U.S. FOIA (b)(6) and informed them of the above concerns. No additional information was provided. NJAC 8:39-7.3(a)(g)	F0679		05/15/2026
F0756 SS = E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she	F0756	Element I Resident #95 The Licensed Practical Nurse immediately notified the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) on how to prepare the medication related to residents on modified. The Unit Manager immediately notified the physician related to pharmacy recommendation on how to administer the NJ Ex Order 26.4(b)(1). The Director of Nursing immediately assessed the resident following the medication pass with no adverse effect noted. The Director of Nursing immediately educated the Licensed Practical Nurse on cautionaries for medication administration for residents on modified diet. The Director of Nursing initiated a facility-wide audit of all residents with puree, honey and nectar thick diet and their medication formulation. All residents were noted in compliance with safe administration and no adverse effect noted. The Director of Nursing immediately completed related to a medication error report. Element II All residents in the facility have the potential to be affected by this deficient practice. Element III	05/15/2026

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F0756 SS = E	Continued from page 75 identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Refer to 759. Based on observation, interview, and record review, it was determined that the facility failed to ensure the recommendation made by the [redacted] was acted upon in a timely manner for one (1) of two (2) residents (Resident #95) with a physician ordered diet of [redacted] and was evidenced by the following: On 3/23/26 at 9:45 AM, the surveyor began the Medication Observation Pass for Resident #95. The Licensed Practical Nurse (LPN) began to prepare the medication that included a physician order (PO) of [redacted] ; give [redacted] by mouth every 12 hours for [redacted] The order started on [redacted] and scheduled for administration at 9:00 AM. No additional instruction was reflected on the PO. At that time, the surveyor observed an order on the electronic Medication Administration Record (eMAR) that indicated the resident had a [redacted] diet. On 3/23/26 at 9:52 AM, the LPN requested assistance from another staff to retrieve a pre thickened nectar liquid for Resident #95 since she did not have one in her medication cart. At 9:53 AM, the other staff member brought the LPN a [redacted] that was [redacted]. At that time, the LPN randomly poured an unmeasured amount of [redacted] into the medication cup that contained the [redacted] and stated that she did not have [redacted] in her cart. On 3/23/26 at 9:55 AM, the LPN confirmed with the surveyor that she was ready to administer the medications to Resident #95, turned and walked toward the Resident's door threshold. At that time, the surveyor asked to speak with the LPN to review the electronic Medical Record (eMR). On 3/23/26 at 9:59 AM, the surveyor and the LPN reviewed the eMR together. The LPN informed the	F0756	Continued from page 75 The Facility Educator and/or designee will in-service all nurses on Federal Regulation F 756 related to residents on modified diet and following up the pharmacy recommendation in a timely basis. The Pharmacy consultant will do monthly, admission and as needed medication review. Unit manager and/or designee will complete Pharmacy recommendation on a timely basis per policy. The DON and/or designee will do an audit of 5 residents to verify completion of pharmacy recommendation weekly x 4 weeks then, 10 residents monthly x 3 months. The Facility Educator and/or designee will do the Med Pass Competency for 4 nurses weekly x 4 weeks, then 6 monthly x 3 months. The Pharmacy consultant will complete a Med Pass Competencies for 2 nurses monthly x 3 months. Element IV The Director of Nursing and/or designee will submit the audit findings to the Quality Assurance and Performance Improvement (QAPI) committee for trend analysis and corrective action quarterly for 3 quarters.	05/15/2026

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F0756 SS = E	Continued from page 76 surveyor that the NJ Ex Order 26.4(b)(1) was not something she had in her cart. The LPN stated that administering NJ Ex Order 26.4(b)(1) to a resident with a NJ Ex O could cause the resident to NJ Ex Order 26.4(b)(1)). At that time, after reviewing the resident's eMR, LPN stated that the administration of the NJ Ex Order 26.4(b)(1) was not appropriate for Resident #95 who had a NJ Ex Order 26.4(b)(1), and she would call the physician for an alternative. On 3/23/26 at 10:24 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) stated that residents with diet changes were reviewed by the U.S. FO and the nurses, who also notified the physician. The surveyor reviewed the medical record for Resident #95. According to the Admission Record, face sheet, an admission summary reflected that Resident #95 was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) A review of the quarterly Minimum Data Set (qMDS) dated NJ Ex Order 26.4 , reflected Resident #95 had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26 out of 15 which indicated Resident #95's NJ Exec Order 26.4 was NJ Ex Order 26.4(b)(1). Further review of the MDS section NJ E under NJ Ex Order 26.4(b)(1) revealed that the resident was administered NJ Ex Order 26.4(b)(1) On 3/23/26 at 11:55 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) informed the surveyor that the resident was admitted with NJ Ex Order 26.4(b)(1) The stated the resident had been admitted with NJ Ex Order 26.4(b)(1) and was upgraded to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26	F0756		05/15/2026

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F0756 SS = E	Continued from page 77 which allowed Resident #95 more time to [redacted] and [redacted]. The [redacted] also stated that [redacted] was shared with the [redacted] the dietary staff and the nursing staff. On 3/23/26 at 1:29 PM, during a follow-up interview with the surveyor, the [redacted] stated that the expectation was that the [redacted] would notify "us" of medication irregularities. The [redacted] could not recall if the [redacted] made recommendations. At that time, the surveyor requested for all of the [redacted] recommendations report for Resident #95. On 3/24/26 at 10:27 AM, during an interview with the surveyor, the [redacted] provided the surveyor with the previously requested [redacted] recommendations report for Resident #95. The surveyor and the [redacted] reviewed the [redacted] recommendations together which included a recommendation to notify the prescriber of the [redacted] and to ask the prescriber if the current consistency was safe for administration. A facility staff signed the [redacted] recommendations report. At that time, the [redacted] acknowledged and confirmed that the [redacted] recommendation was signed and was not acted upon. The [redacted] informed the surveyor that the resident was assessed after the medication pass observation, the physician was notified, and the medication orders were updated. On 3/25/26 at 1:57 PM, during a meeting with the survey team, the [redacted], the [redacted], the [redacted]), the [redacted] and the [redacted]), the surveyor discussed the concern with the [redacted] recommendation was signed and not acted upon. On 3/26/26 at 10:15 AM, during a meeting with the survey team, the [redacted] the [redacted] the [redacted] the [redacted] the [redacted], and the [redacted], the [redacted] stated that a Quality Assurance Performance for Improvement (QAPI) was started after surveyor inquiry, the interdisciplinary team which included the [redacted] and the [redacted] would review the [redacted] and medications to ensure safe administration.	F0756		05/15/2026

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(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
F0756 SS = E	Continued from page 78 A review of the facility provided document titled, Pharmacist Recommendations Review, Nursing Protocol dated 12/2025, included the following under Notify the Attending Physician/APN [Advanced Practical Nurse]: Pharmacist-identified irregularities must be acted upon. The attending physician must review, decide on action, and document justification if no change is made. Nursing staff contact the provider within 24 hours for urgent issues (e.g. high-risk drug interactions, missing monitoring.) NJAC 8:39-29.3	F0756		05/15/2026
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Refer to 756. Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation on 3/23/26 and 3/24/26, the surveyor observed six (6) nurses administer medications to six (6) residents. There were 26 opportunities, and three errors were observed which resulted in a medication error rate of 7.69%. This deficient practice was identified for two (2) of six (6) residents (Resident #84 and #95), that was administered by two (2) of six (6) nurses. This deficient practice was evidenced by the following: a. On 3/23/26 at 8:46 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) prepare medications for Resident #84. The medications included a physician's order (PO) of NJ Ex Order 26.4(b)(1) [redacted] one time a day for NJ Ex Order 26	F0759	Element I Resident 84 The Unit Manager immediately verified the order of NJ Ex Order 26.4(b)(1), discontinued, and changed to NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1). The Unit Manager immediately completed the Medication Error form related to the NJ Ex Order 26.4(b)(1) that was almost given by LPN #1. Director of Nursing and/or designee immediately in-serviced LPN #1 on importance of verifying physician orders for accuracy and completeness. The Facility Educator completed the Med Pass Competency for LPN #1. Resident 95 The Unit Manager immediately verified that medication was not administered and was immediately discarded. The Unit manager and Director of Nursing immediately educated the nurse on importance of reading the cautionary label. Director of Nursing and/or designee immediately in-serviced LPN #2 on importance of verifying	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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F0759 SS = E	Continued from page 79 NJ Ex O and was to be removed per schedule. The PO started on NJ Ex Order 26.4(b) At 8:52 AM, LPN #1 confirmed she was ready to administer NJ Ex Order 26.4(b)(1) medications to Resident #84. At that time, the surveyor observed Resident #84 NJ Exec Order 26.4b1 in their wheelchair in their room toward the doorway and stated that they were scheduled for NJ Ex Order 26.4(b)(1) that morning. LPN #1 administered NJ E medications to Resident #84 and LPN #1 returned to their medication cart. On 3/23/26 at 8:55 AM, LPN#1 informed the surveyor and Resident #84 that the NJ Ex Order 26.4(b)(1) was not in her medication cart and was going to retrieve it from her treatment cart. At 9:02 PM, LPN #1 returned and stated to Resident #84 and the surveyor, that she could not find the NJ Ex Order 26.4(b) in the treatment cart, was not aware if it was stocked in the facility as "house stock" and the U.S. FO was going to call the physician for an alternative. At 9:07 AM, LPN #1 saw the new PO of NJ Ex Order 26.4(b)(1) every "day" shift for NJ Ex Orde The PO started that morning NJ Ex Order 26.4 At 9:09 AM, LPN #2 NJ Ex Order 26.4(b) onto a NJ Ex Order 26.4(b)(1) and turned to administer the NJ Ex Order 2 to Resident #84. At that time, the surveyor stopped the medication pass observation to review the PO with LPN #1. On 3/23/26 at 9:12 AM, during an interview with LPN #1, the surveyor asked how she knew how much to administer when it was not specified on the PO. At that time, LPN #1 acknowledged and confirmed that the PO for NJ Ex Order 26.4(b)(1 did not have a dosage and that she should have clarified the order prior to administration. b. On 3/23/26 at 9:45 AM, the surveyor began the Medication Observation Pass for Resident #95. LPN #2 began to prepare the medication that included a physician order of NJ Ex Order 26.4(b)(1) give 1 table by mouth one time a day for NJ Ex Order 26.4(b)(1) "DO NOT NJ Ex Order 26.4(b)(1) if needed. The order started on 2/6/26 and scheduled for administration at 9:00 AM. At that time, the surveyor observed an order on the electronic Medication Administration Record (eMAR)	F0759	Continued from page 79 physician orders for accuracy and completeness. The Facility Educator completed the Med Pass Competency for LPN #2. Director of Nursing and Regional Clinical Director of Nursing immediately completed a facility wide audit on all residents on thickened liquids and reviewed their medication cautionary label. No other residents are affected by this practice. Element II All residents in the facility have the potential to be affected by this practice. Element III Director of Nursing and/or designee will in-serviced all licensed staff on Federal Guideline F759 regarding medication administration policies emphasizing verifying physician orders for accuracy and completeness and reading the medication-specific cautionary label. The Facility Educator and/or designee will do the Med Pass Competency for 4 nurses weekly x 4 weeks, then 6 monthly x 3 months. The Pharmacy consultant will complete a Med Pass Competencies for 2 nurses monthly x 3 months. Director of Nursing and/or designee will review pharmacy consultant's medication pass competency audit and address findings in real time Element IV The Director of Nursing and/or designee will submit the audit findings to the Quality Assurance and Performance Improvement (QAPI) committee for trend analysis and corrective action quarterly for the next 3 quarters.	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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F0759 SS = E	Continued from page 80 that indicated the resident had NJ Ex Order 26.4(b)(1) . On 3/23/26 at 9:50 AM, the surveyor observed LPN #2 remove one (1) tablet of NJ Ex Order 26.4 from the bingo card (a multidose card containing individually packaged medications) that included a cautionary NJ Ex Order 26.4(b)(1) At that time, LPN #2 NJ Ex Order 26.4 the NJ Ex Order 26.4 and mixed the NJ Ex Order 26.4(b)(1) into NJ Ex Order 26.4(b) On 3/23/26 at 9:55 AM, the LPN confirmed with the surveyor that she was ready to administer the medications to Resident #95, turned and walked toward the Resident's door threshold. At that time, the surveyor asked to speak with the LPN to review the electronic Medical Record (eMR). On 3/23/26 at 10:00 AM, during an interview with the surveyor, LPN #2 stated she missed the cautionary of on the bingo card of "NJ Ex Order 26.4(b)(1) "and the special instructions on the eMAR of NJ Ex Order 26.4(b) if needed". At 10:04, LPN #2 stated she would inform the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) of the concern. On 3/23/26 at 10:24 AM, during an interview with U.S. FOIA (b)(6) , the surveyor discussed the concerns that occurred during the medication pass observation. The U.S. FOIA (b)(6) stated she would contact the physician and place a request for the U.S. FOIA (b)(6) to review Resident #95's medications. On 3/25/26 at 1:57 PM, during a meeting with the survey team, the U.S. FOIA (b)(6) the U.S. FOIA (b) the U.S. FOIA (b)(6) , the U.S. FOIA), the U.S. FOIA) and the U.S. FOIA , the surveyor discussed the concern with the administration of Resident #84's NJ Ex O medication NJ Ex Order without dosing to ensure that the resident's NJ Ex O would be adequately managed and the concern with the administration of Resident #95's NJ Ex Order 26 medication against the pharmacy cautionary label and specified physician's order for administration.	F0759		05/15/2026

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F0759 SS = E	Continued from page 81 On 3/26/26 at 10:15 AM, during a meeting with the survey team, the U.S. FOIA (b) the U.S. FOIA (the U.S. FOIA (b)(the U.S. FOIA the U.S. FOIA (b)(6) , and the U.S. FOIA (b)(6) the U.S. FOIA (b)(6) stated that a Quality Assurance Performance for Improvement (QAPI) was started after surveyor inquiry, the interdisciplinary team which included the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) would review the NJ Ex Order 26.4(b)(1) and medications to ensure safe administration. A review of the facility provided policy titled, Administering Medications, reviewed and updated on 7/2025, included Medications are administered in accordance with prescriber orders… Further review reflected that the individual administering the medication checks the label three (3) times to verify the right resident, the right dosage, right time, and right method (route) of administration before giving the medication. NJAC 8:39-11.2(b), 29.2(d)	F0759		05/15/2026
F0925 SS = E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Complaint NJ #2743500 Based on observation, interview and document review, it was determined that the facility failed to maintain an effective pest control program to ensure the facility was free of cockroaches. The deficient practice had the potential to affect all residents who resided in the facility and was evidenced by the following: On 3/22/26 at 8:57 AM, Resident #54 approached surveyor and stated that they had been in the facility approximately NJ Ex Order 26.4(b)(1) and they resided in the NJ Ex Or room since they had been admitted. The resident then proceeded to show the surveyor a plastic bag with 4 dead cockroach- like insects inside. Resident #54 then informed the surveyor the dead bugs were cockroaches. The resident then stated that when they used the bathroom during the night, and then turned on the light, they would see the cockroaches scatter. The resident also stated that they reported this to the facility, and when they	F0925	Maintenance Director and Housekeeping Director inspected Resident #54's room and fixed the gap between the door molding and the floor, deep cleaned the room and bathroom and scheduled a treatment by pest control contractor. All residents have the potential to be affected by this practice Concerns related to pest activity will be a focus question during resident council for the next 6 months council meetings. The facility initiated a schedule with the contracted pest company to do a preventative spray throughout all resident rooms in addition to rooms specified in the pest log. The facility increased pest control visits from once a week to two times per week to ensure the facility remains free of any pests. The Administrator educated the U.S. FOIA (b)(6) to monitor rooms for overall cleanliness to prevent pests.	05/15/2026

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F0925 SS = E	Continued from page 82 sprayed for the cockroaches the last time, the U.S. FOIA (b)(6) was also present with the exterminator. The resident further stated this was the second bag they had with examples of dead cockroaches and stated the first bag was given to the facility. On 3/24/26 at 8:26 AM, the surveyor interviewed Resident #54, who stated when awake around 3:00 AM to use the bathroom, they saw them (cockroaches) and showed the surveyor a gap between the door molding and the floor. Resident #54 stated that the cockroaches would come in and out of that gap. On 3/24/2026 at 11:27 AM, the surveyor reviewed the pest control reports provided by the facility which revealed the following: -1/14/26, NJ Ex Order 26.4(b)(1 wing; roach (cockroach) cleanout complete. Treated all cracks and crevices. Activity found coming out of the drop ceiling and molding around the ceiling; -1/12/26, Room # NJ E treated the bathroom and heater for general pests. Treated entire kitchen, replaced glue traps due to roach activity on them; -1/7/26, Inspected and treated for initial roach clean out. Unit wasn't fully prepared, there were cabinets that had items inside of them; -1/5/26, Follow- up in room # NJ E for roaches; -12/15/25, Treated rooms # NJ E and # NJ due to roach sightings throughout any accessible floorboards and bathrooms ... Replaced any visible glue boards and monitors throughout the kitchen area due to wet traps or roach activity on them; -11/10/25, Replaced any glue traps in the kitchen due to roach activity on them or wet traps; -10/13/25, Replaced most glue boards and monitors throughout each area due to roach activity on them or wet traps. Kitchen and dishwasher areas roach activity seen on glue traps; -9/22/25, Kitchen prep station, dishwasher areas, changed insect monitor by dishwasher area due to minor roach activity. -9/15/25, Replaced the glue boards and monitors throughout the kitchen and basement due to minor roach activity or ineffective glue traps.	F0925	Continued from page 82 The Administrator educated the U.S. FOIA (b)(6) to monitor the facility for potential entry points for pests. Administrator or designee will audit resident satisfaction regarding pest control 5 residents weekly for 4 weeks, then monthly for 5 months, and then quarterly for 1 quarter. Results will be presented to the QAPI committee for the next 3 quarters.	05/15/2026

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F0925 SS = E	Continued from page 83 On 3/24/26 at 12:01 PM, the surveyor toured with the U.S. FOIA (b)(6)) and showed him the gap between the molding and floor in Resident #54's room. He stated he was not aware of roaches in that room. He further stated that he completed environmental rounds, however didn't document the rounds. The U.S. FO stated if he observed something, he would fix it, and stated the pest company came in every Monday. He stated the procedure to report a pest sighting would be that after an insect would be reported to staff, the staff was supposed to put it in a the pest log. The U.S. FO stated there was one at each nursing station and one was also located in the kitchen. The pest company was responsible to checks the books and treat accordingly. On 3/24/26 at 12:33 PM, the surveyor interviewed the U.S. FOIA (b)(6) who explained the procedure for insect sightings was to log the sightings in the book. There was a book at each nursing station, and then he would call the pest control company. He confirmed that Resident #54 reported to him, sometime earlier that month regarding the cockroaches, and the pest company came, assessed the room and didn't find anything. He further stated that Resident #54 provided him with a bag with dead insects in it, and he held onto it and showed it to the pest control company. He also stated that lately (this month) the facility has had a "little roach problem." The pest control company came, sprayed and also fumigated the section that had a problem. On 3/25/26 at 9:03 AM, the surveyor reviewed Resident #54's electronic medical record (EMR) which revealed the resident had a Brief Interview for Mental Status score of NJ Ex out of 15, dated NJ Ex Order 26 which indicated NJ Ex Order 26.4(b)(1). On 3/25/26 at 12:32 PM, the surveyor reviewed the Commercial Pest Control Service Agreement between [name redacted] Services and the facility which was dated 2/3/25, and which indicated treatment would be on a weekly basis. On 3/25/26 at 12:47 PM, the surveyor reviewed the facility provided policy, "Pest Control Program", with a revised date of November 2025, which included:	F0925		05/15/2026

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F0925 SS = E	Continued from page 84 Policy: Facility will maintain an effective pest control program that eradicates and contains common household pests. Policy Explanation and Compliance Guidelines: 3. Facility will maintain a report system of issues that may arise i between scheduled visits with the outside pest service and treat as indicated. On 3/25/26 at 1:56 PM, the surveyor notified the facility leadership of above concerns. On 3/26/26 at 10:13 AM, the U.S. FOIA (b)(6) [redacted] stated that every resident or employee who sees a bug called it a roach, and he did not believe it was a widespread concern. No further information was provided NJAC 8:36-4.1(a)11; 31.5(a)(1)	F0925		05/15/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F0755	Element I Resident #58 The Unit Manager confirmed that the Licensed Practical Nurse (LPN) immediately went back to Resident #58 regarding meds left at the bedside and validated that medication was not taken by the resident and not administered. The LPN confirmed that the medications due for the resident were given as scheduled. All licensed nursing staff were immediately re-educated on medication administration policies including prohibition of leaving medications at bedside without a physician order. Element II All residents have the potential to be affected by non-adherence according to standard of practice. Element III	05/15/2026

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F0755 SS = D	Continued from page 85 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and review of facility's documentation, the facility failed to ensure that medications were administered according to standards of practice. This deficient practice was identified for 1 of 1 resident observed with medication left unattended at the bedside (Resident #58). The evidence was as follows: On 3/22/26 at 10:00 AM the surveyor entered Resident #58's room and observed a medication cup with [redacted] tablets inside the cup and a cup of water on the bedside table. The surveyor observed the resident seated in the room by the bed. Upon inquiry, the resident informed the surveyor that the nurse left the medications at the bedside for them to take. The surveyor exited the room at 10:28 AM, and the medications were still at the bedside. The surveyor did not observe any other residents wandering in the hallway. On 3/22/26 at 10:30 AM, the surveyor observed the Licensed Practical Nurse (LPN) on the medication cart in the hallway and inquired regarding Resident #58's medications. The LPN stated that Resident #58 received their medications at 9:00 AM, and the surveyor asked the LPN to elaborate on the facility's policy regarding medication administration. The LPN stated the process was as follows: Check the identification bracelet to ensure this is the right patient, ensured the resident swallowed the medication prior to exiting the room, then signed the medication administration record after the medications were administered. The surveyor then asked the LPN if she observed Resident #58 [redacted] their medications this morning. The LPN then stated she observed Resident #58 took their medications, drank the water prior to leaving the room. The surveyor showed the nurse the tablets in the cup and the cup of water still at the bedside 90 minutes later, the nurse stated" [redacted] " The nurse then ran to the room and had a conversation with Resident #58 regarding the	F0755	Continued from page 85 The Facility Educator and/or designee will in-service all licensed nurses on federal guideline F755 related to standard of practice in nursing and medication administration policies including prohibition of leaving medications at bedside without a physician order. The Facility Educator and/or designee will do the Med Pass Competency for 4 nurses weekly x 4 weeks, then 6 monthly x 3 months. The Pharmacy consultant will complete a Med Pass Competencies for 2 nurses monthly x 3 months. Element IV The Director of Nursing and/or designee will submit the audit reports to the Quality Assurance Committee quarterly for the next 3 quarters.	05/15/2026

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F0755 SS = D	Continued from page 86 medications left at the bedside. On 3/24/26 at 11:00 AM, the surveyor reviewed Resident #58' medical record. A review of the Admission Face Sheet (an admission summary) reflected that Resident #58 was admitted to the facility with diagnoses which included but was not limited to: NJ Ex Order 26.4(b)(1) [redacted]. The Quarterly Minimum Data Set (MDS), an assessment tool, o[redacted], indicated that the resident's BIMS (Brief Interview for Mental Status) was [redacted] out of 15 which indicated that the resident had [redacted]. On 3/22/26 at 11:30 AM, the surveyor interviewed the [redacted] regarding Resident #58 and requested a printed copy of the Medication Administration Record (TAR) The surveyor then inquired if staff should leave medications unattended at the bedside. The [redacted] stated that the nurses were to ensure that residents took their medications prior to leaving the room. The following medications were scheduled to be administered at 9:00 AM and were observed by the surveyor as left at the bedside: NJ Ex Order 26.4(b)(1) medication to control NJ Ex Order 26.4(b)(1) [redacted] medication to control NJ Ex Order 26.4(b)(1) [redacted] medication to prevent NJ Ex Order 26.4(b)(1) medication to treat NJ Ex Order 26.4(b)(1). The LPN signed the MAR that the above medications were administered at 9:00 AM. On 03/24/2026 at 12:35 PM, during an interview with the U.S. FOIA (b)(6) [redacted], she stated, "nurses were not to leave medications at the bedside for safety. This is standard of practice". On 3/25/26 at 2:00 PM, during a pre-exit meeting held with the survey team and the administrative staff ([redacted] U.S. FOIA (b)(6) [redacted] and the U.S. FOIA (b)(6) [redacted] the surveyor reviewed the concerns regarding Resident #58's medications left at the beside unattended and requested any additional information. The [redacted] stated that the staff had been educated.	F0755		05/15/2026

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F0755 SS = D	Continued from page 87 On 3/26/26 at 1:30 PM, the facility provided in-service education regarding the above concerns, and no other information was provided. A review of the facility's policy titled, "Administering Medications" provided by the [redacted] last updated 7/2025, reflected the following: Policy: Medications are administered in a safe and timely manner, and as prescribed. The facility will maintain appropriate system to ensure medications are available and that residents receive their medications in a timely manner. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. NJAC: 8:39-29.2(d)	F0755		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061341	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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S0000	Initial Comments Complaint #s:NJ #s 2577317, # 2743500 Survey Date: 3/26/26 Census: 119 Sample: 24 + 2 Closed Records 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		05/04/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined the facility failed to a) maintain the required minimum direct care staff-to-resident ratios for 14 of 14-day shifts, in total staff for residents one (1) of 14 evening shifts and four (4) of 14 overnight shifts as mandated by the state of New Jersey and b) ensure that employees are vaccinated for influenza and those who have not received the influenza vaccine due to a medical exemption wear a surgical or procedural mask when in direct contact with patients and in common areas as mandated by the state of New Jersey. a)Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised	S0560	Staffing coordinator was reeducated on the proper staffing guidelines as mandated by the state of New Jersey. (Day shift= 1:8, Evening shift- 1:10. Night shift 1:14). b. The Infection Preventionist/immediately implemented masking requirements for all employees who have declined the influenza vaccination. All employees were immidiately educated on the masking requirement for unvaccinated employees. No adverse effecte observed from this deficient practice. All residents have the potential to be affected by the practice of not meeting the NJ Staffing requirement ratios. 3. a. The following measures have been put into place to prevent the deficient practice from recurring: Advertisement / Job postings for CNAs have been posted on social media websites that we are hiring and offering generous sign on bonus for new hires.	05/15/2026

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: 061341	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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S0560	Continued from page 1 Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including	S0560	Continued from page 1 Will initiate an incentive to promote CNA attendance in the form of a bonus and/or raffle Facility will increase bonus amount for referral bonuses to increase applicant flow. facility has updated and increased sponsorships of advertisements on job search platforms. Facility hired a new Human Resource Director to assist with aggressively pursuing and hiring certified nurses aides. Facility initiated process to increase starting rates for CNA and to help with recruiting new employees. The Director of Nursing and or Administrator has reinforced masking requirements for unvaccinated employees during influenza season. The Infection preventionist had the unvaccinated employees re-sign the masking acknowledgement. Non compliance will result in work schedule removal. Education will be provided to all staff annually and upon hire regarding by IP or designee: Influenza vaccination expectations, Masking requirements for unvaccinated staff and Consequences for non-compliance. Signage reminding staff of masking requirements will be posted in designated staff areas. Supervisors and department heads will be responsible for real-time monitoring of staff compliance. Failure to comply will result in removal from resident care and progressive disciplinary action per facility policy. The Administrator/Designee will review the staffing schedule weekly for 3 months to monitor the staffing ratio on the day, evening, and night shift The Infection Preventionist or designee will conduct weekly audits during influenza season to monitor: Vaccination status documentation, Proper mask use by unvaccinated staff, Compliance across all shifts and departments.	05/15/2026

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S0560	Continued from page 2 certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... a) A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 3/8/2026 and ending 3/21/2026 for the Standard survey on 3/26/2026, revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements. The facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 1 of 14 evening shifts and deficient in total staff for residents on 4 of 14 overnight shifts as follows: -03/08/26 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -03/09/26 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/10/26 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/10/26 had 7 total staff for 115 residents on the overnight shift, required at least 8 total staff. -03/11/26 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/12/26 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/13/26 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/14/26 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -03/14/26 had 7 total staff for 115 residents on the overnight shift, required at least 8 total staff. -03/15/26 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/15/26 had 7 total staff for 119 residents on the overnight shift, required at least 8 total staff. -03/16/26 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs.	S0560	Continued from page 2 All results of the monitoring will be presented to the QAPI committee for review and any additional monitoring or modification of this plan monthly for 3 months.	05/15/2026

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S0560	Continued from page 3 -03/16/26 had 11 total staff for 119 residents on the evening shift, required at least 12 total staff. -03/17/26 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/18/26 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/19/26 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/19/26 had 7 total staff for 119 residents on the overnight shift, required at least 8 total staff. -03/20/26 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/21/26 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. On 3/23/26 at 10:00 AM, during an interview with the surveyor, the Staffing Coordinator (SC) stated she was aware of the staffing regulation that the 7:00 AM to 3:00 PM shift required one (1) CNA to every 8 residents, the 3:00 PM to 11:00 PM shift required one (1) CNA to every 10 residents and the 11:00 PM to 7:00 AM shift required one (1) CNA to every 14 residents. When asked if she was meeting the required staffing ratios, the SC stated that she met the required ratios “most of the time”. At that time, the SC stated that when someone could not make their shift, she would ask the staff on duty if they could stay; the facility did not offer a bonus. The SC also stated the facility used one (1) staffing agency to supply the facility with staff. The SC stated she did not receive any complaints from Residents’ family regarding staffing. On 3/23/26 at 10:15 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that she was aware of the staffing ratio, she posted the shift when there was a shortage, asked staff to cover a shift, and offered an alternate day off; the facility did not offer bonuses as an incentive for staffing. The DON stated she had the most shortage of shift coverage during the day shift. At that time, the DON stated that she had not received any complaint from any family regarding delay in care that could be attributed to staffing shortage. On 3/23/26 at 10:27 AM, during an interview with	S0560		05/15/2026

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S0560	Continued from page 4 the surveyor, the Licensed Nursing Home Administrator (LNHA) admitted that “staffing could be a struggle; we always try our best”. The LNHA stated they offered bonuses however it was “not a set bonus”. The LNHA also stated he had not received a complaint from a family member, however received reports from staff when there was a shortage of coverage for a shift. A review of the provided facility policy titled, Staffing-Contingent reviewed/updated on 1/2025, included under Purpose: Maintain resident care standards and compliance with CMS and state regulations which is 1 CAN per 8 residents on 7-3 shift, 1 CAN per 10 residents o 3-11 shift and 1 CAN per 14 residents on 11-7 shift. No further information was provided. b) Reference: On January 13, 2020, Governor Murphy signed P.L. 2019 c. 330 (codified at N.J.S.A. 26:2H-18.79 and referred to hereafter as "the Statute"). The Statute requires certain healthcare facilities to establish and implement an annual influenza vaccination program. The New Jersey Department of Health (Department) is required by the Statute to promulgate rules and designate a medical exemption form to be distributed to the covered healthcare facilities. This memo and the attached form are intended to assist general or special hospitals, nursing homes (long-term care facilities licensed pursuant to N.J.A.C. 8:39), and home health care agencies, collectively referred to as "facility" or "facilities," in understanding and meeting their obligations under the Statute, until the rules and the medical exemption form can be adopted through rulemaking. All facility employees are required to be vaccinated, including employees who are not responsible for direct patient care. Per diem and contract employees are to be considered facility employees and are required to be vaccinated. Facilities are required to review and confirm each medical exemption to ensure the exemption is consistent with standards enumerated by the Advisory Committee on Immunization Practices, which can be found at: https://www.cdc.gov/vaccines/hcp/acip-recs/vac	S0560		05/15/2026

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S0560	Continued from page 5 c-specific/flu.html. Facilities must maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee. The Department will address through rulemaking proper procedures for submitting data to the Department. The facility must require any employee who does not receive an influenza vaccination to wear a surgical or procedural mask when in direct contact with patients and in common areas, as specified in facility policy, or to be removed from direct patient care responsibilities during influenza season. On 3/23/2026 at 8:36 AM, the surveyor observed a list of "unvaccinated staff required to wear a mask" at the Rosewood unit nurse's station. No date was noted on list. Certified Nurse Assistant (CNA) #1, was on the list and was noted yesterday during multiple observations to be wearing a mask. On 3/23/2026 at 9:48 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 at a medication cart in the hallway without a mask. Survey team has seen her on multiple occasions since entrance without a mask on. On 3/23/2026 at 9:52 AM, the surveyor observed CNA #2 on multiple occasions in Rosewood hallway and in and out of multiple resident rooms without a mask. On 3/23/2026 at 9:55 AM, the surveyor observed CNA #3 in the Rosewood dayroom at the vending machine without a mask. On 3/23/2026 at 10:14 AM, the surveyor interviewed the Infection Preventionist (IP) nurse and the Assistant Director of Nursing (ADON). The ADON stated that all staff required to have the influenza vaccine, and they have a handful with medical issues. If they have an exemption, they have to mask. She stated the list observed on the Rosewood unit was this year's list.	S0560		05/15/2026

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S0560	Continued from page 6 On 3/23/2026 at 10:58 AM, the surveyor observed various forms of physician documentation for flu vaccine exemption. None of them had the New Jersy mandated form completed. The ADON was unaware of state required documentation. The IP stated she was aware and stated she will obtain it and start using. The ADON stated the facility policy states employees without vaccine must wear a mask during flu season while in the facility. On 3/23/2026 at 11:20 AM, CNA #2 was noted wearing a mask in the hallway of Rosewood. On 3/23/2026 at 12:25 PM, LPN #1 noted to be wearing a surgical mask. When asked why by the surveyor, she stated she's coughing a little. When asked if it has anything to do with the flu vaccine, she stated she did not receive the flu vaccine as she is allergic. She also stated she should be wearing a mask at all times during flu season. On 3/23/2026 at 12:29 PM, CNA #3 was noted with a surgical mask on and stated when the surveyor had seen her previously, she had forgotten to put it back on. She further stated she is not vaccinated for the flu and she wears the mask at all times. On 3/23/2026 at 12:45 PM, Social Worker (SW) #1 was noted wearing a surgical mask. She stated she is wearing the mask because she is not vaccinated for the flu. She also admitted that she had not been wearing a mask yesterday. She stated she didn't think about a mask yesterday On 3/24/2026 at 8:16 AM, LPN #1, was noted on the med cart wearing a surgical mask. On 3/24/2026 at 8:44 AM, the surveyor interviewed the Director of Nursing (DON) who stated some staff declined the influenza vaccine without a medical exemption and they have been allowed to work. She further stated they are supposed to wear a mask, but some are noncompliant with masking. She further stated they educated about the policy and they started a QAPI yesterday and they started an audit. The surveyor reviewed the facility provided list of employees who declined or have a medical exemption for the influenza vaccine. 26 employees did not receive the flu vaccine. Out of the 26, only 4 are documented as having a medical exemption,	S0560		05/15/2026

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S0560	Continued from page 7 although none of the medical exemptions have the New Jersey mandated medical exemption form filled out and signed by a physician. On 3/25/2026 at 1:56 PM, the facility leadership was notified about the concern regarding employee influenza vaccines. The surveyor reviewed the facility provided policy "Influenza vaccination", revised January 2026, which included: Policy: It is our policy to offer our residents, staff members, and volunteer workers annual immunization against influenza. Policy Explanation and Compliance Guidelines: 7. Staff reserve the right to decline the influenza vaccine related to medical exemption. A proof of medical exemption should be submitted to Human Resource or Designee. 8. Staff who does not receive an influenza vaccination should wear a surgical or procedural mask when in direct contact with patients and in common areas during influenza season.	S0560		05/15/2026
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day	S1680	Staffing coordinator was reeducated on the proper staffing guidelines as mandated by the state of New Jersey. All residents have the potential to be affected by the deficient practice of not meeting the minimum staffing level. The following measures have been put into place to prevent the deficient practice from recurring: Advertisement / Job postings for RN’s, LPN’s and CNA's have been posted on social media websites as well as flyers posted in local supermarkets and stores that we are hiring. Incentives are offered to RN’s, LPN’s and CNA's to work extra shifts in form of bonuses. Administrator has reached out to RN’s, LPN’s and CNA's schools to advise we are hiring and willing to	05/15/2026

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S1680	Continued from page 8 Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day	S1680	Continued from page 8 train new graduates. Facility updated and increased sponsorships of advertisements on job search platforms. The Administrator/Designee will review the staffing schedule weekly to monitor the staffing levels for 3 months. All results of the monitoring will be presented to the QAPI committee for review and any additional monitoring or modification of this plan monthly for 3 months.	05/15/2026

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S1680	Continued from page 9 Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This STANDARD is NOT MET as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 03/08/2026 to 03/21/2026, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days. The required staffing hours and actual staffing hours are as follows: For the 2 weeks of AAS-12 staffing from 03/08/2026 to 03/21/2026, the facility was deficient in staffing for required resident services on 2 of 14 days as follows: For the week of 03/15/26 Required Staffing Hours: 306.75 -03/16/26 had 304 actual staffing hours, for a difference of -2.75 hours. -03/19/26 had 296 actual staffing hours, for a difference of -10.75 hours.	S1680		05/15/2026

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S0000	Initial Comments Survey Date: revisit for survey conducted on 5/15/26 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. The facility is not in compliance with the Standards in the New Jersey	S0000		07/14/2026
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 for 1 of 9 day shifts as mandated by the state of New Jersey a) Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct	S0560	1. What corrective action was accomplished for the resident found to have been affected by the deficient practice? There were no known or confirmed negative outcomes to residents on the shift identified as not meeting the NJ staffing requirements for the day shift (7-3) on 5/5/26 2. How will other residents who may have the potential to be affected be identified? All residents have the potential to be affected by the deficient practice of not meeting the NJ staffing requirement ratios. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur? The following measures have been put into place to prevent the deficient practice from recurring: A. Advertisement / Job postings for RN's, LPN's and CNA's have been posted on social media websites as well as flyers that we are hiring. B. Incentives are offered to RN's, LPN's and CNA's to work extra shifts such as raffles. C. Facility increased sign on bonuses and referral	07/14/2026

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: 061341	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0560	Continued from page 1 care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... a) A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 3/8/2026 and ending 3/21/2026 for the Standard survey on 3/26/2026, revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements.	S0560	Continued from page 1 bonuses to increase applicant flow. D. Facility updated and increased sponsorships of advertisements on job search platforms. E. Administrator and HR began pursuing alternative hiring methods to take a more proactive hiring approach such as agency conversions, networking platforms, and job fairs. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put in place? The Administrator/Designee will review the staffing schedule weekly to monitor the staffing levels for 3 months. All results of the monitoring will be presented to the QA committee for review and any additional monitoring or modification of this plan monthly for 3 months.	07/14/2026

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S0560	Continued from page 2 For the 9 days of staffing prior to survey from 05/05/2026 to 05/13/2026, the facility was deficient in CNA staffing for residents on 1 of 9 day shifts as follows: -05/05/26 the facility had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. No further information was provided	S0560		07/14/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061341	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 8/20/2026 in relation to the first onsite revisit of 5/15/2026 in association with the 3/26/2026 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		08/20/2026

Office of Primary Care and Health Systems Management

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/25/26 and 03/26/26 and King Manor was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. King Manor is a single-story, Type I Fire Resistant building with a basement area that was built in January 1967. The facility is divided into 7 smoke zones. The facility has one Diesel emergency generator with an above ground tank. King Manor has 2 dumbwaiters.	K0000		05/20/2026
K0321 SS = F Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K0321	The facility immediately ordered hardware to secure the left leaf of the housekeeping chemical closet door and the right leaf of the soiled linen closet door, to ensure the self-closing mechanism functions properly. This was completed on 04/01/26. All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) [redacted] were in-serviced by the Administrator on the importance of ensuring that all chemical storage rooms and soiled linen rooms are equipped with doors that automatically close and latch in accordance with NFPA 101 Life Safety Code requirements. The Director of Maintenance or designee will audit all storage rooms throughout the facility to ensure doors are automatically closing and latching in accordance with NFPA 101 Life Safety Code. Audits will be conducted monthly for six months, with findings reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for three quarters.	04/19/2026

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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K0321 SS = F Bldg. 01	Continued from page 1 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 03/25/2026 in the presence of the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6), it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Section 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following: Observation at 10:05 AM revealed that the left leaf for house-keeping chemical storage room set doors was not self-closing. Observation at 1:29PM revealed that the right leaf for soiled linen receiving room set doors was not self-closing. In an interview at the time, the U.S. FO and the U.S. FOIA (b confirmed the findings. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 03/26/2026 at 2:15 PM. N.J.A.C 8:39-31.9(e).	K0321		04/19/2026
K0363 SS = F Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K0363	1.The doors to resident rooms 14, 36, 52, 66, and the Dietary Office were immediately inspected. Repairs and adjustments were completed to eliminate excessive gaps between the tops of the doors and the frames. Measures included realignment of doors, hinge adjustments, and installation of appropriate materials to ensure compliance with NFPA standards.	04/19/2026

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K0363 SS = F Bldg. 01	Continued from page 2 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 03/25/2026 in the presence of the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that doors in the corridor were able to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.2 and 19.3.6.3.5. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:41 AM revealed resident room 14 contained a ½ -inch space between the top of the door and the door frame. An observation at 11:09 AM revealed resident room 36 contained a ½ -inch space between the top of the	K0363	Continued from page 2 All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) was in-serviced by the Administrator on the importance of ensuring that all corridor doors resist the passage of smoke in accordance with NFPA 101 Life Safety Code requirements. A preventive maintenance program has been implemented to inspect door gaps, door closures, and the overall integrity of corridor doors. This program will be fully implemented by 05/09/26. The Maintenance Director, or designee will conduct monthly audits of a sample of corridor doors to ensure ongoing compliance. Findings will be documented, and corrective actions will be taken as necessary. Audits will be conducted monthly for six months, with findings reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for three quarters.	04/19/2026

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K0363 SS = F Bldg. 01	Continued from page 3 door and the door frame. An observation at 11:18 AM revealed resident room 52 contained a ½ -inch space between the top of the door and the door frame. An observation at 11:41 AM revealed resident room 66 contained a ½ -inch space between the top of the door and the door frame. An observation at 1:49 PM revealed Dietary office contained a ½ -inch space between the top of the door and the door frame. In an interview at the time, the MD and the VPES confirmed the findings. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 03/26/2026 at 2:15 PM. N.J.A.C 8:39-31.9(e).	K0363		04/19/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 03/25/2026 in the presence of the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that Packaged Terminal Air Conditioner (PTAC) units in residents' rooms were maintained in accordance with NFPA 101:2012 Edition, Section 19.5.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations conducted between 9:10 AM and 2:37 PM revealed that the Filters for PTAC units in residents' rooms on the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1 wings were dirty and clogged. In an interview at the time, the U.S. FO and the U.S. FOIA (b confirmed the findings.	K0521	Upon identification on 03/25/2026, the facility immediately initiated corrective actions to address the deficient practice. All Packaged Terminal Air Conditioner (PTAC) unit filters in resident rooms on the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1 wings were cleaned or replaced, as needed, to ensure proper airflow and compliance with NFPA. This was completed on 4/10/26 All residents have the potential to be affected by this practice . The U.S. FOIA (b)(6) and maintenance staff were in-serviced by the administrator on the importance of maintaining PTAC units, including routine inspection and cleaning of filters, to ensure proper operation and compliance with NFPA 101 Life Safety Code requirements. The Director of Maintenance or designee will implement a preventive maintenance program for all PTAC units. Filters will be inspected and cleaned or replaced on a routine schedule (at least monthly). Audits will be conducted monthly for three months to ensure compliance, and any identified deficiencies will be corrected immediately. Findings will be documented and reported to the Quality Assurance and Performance Improvement (QAPI) Committee as appropriate.	04/19/2026

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K0521 SS = F Bldg. 01	Continued from page 4 The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 03/26/2026 at 2:15 PM. N.J.A.C 8:39-31.2 (e) NFPA 90A.	K0521		04/19/2026
K0532 SS = F Bldg. 01	Escalators, Dumbwaiters, and Moving Walks CFR(s): NFPA 101 Escalators, Dumbwaiters, and Moving Walks 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2 This STANDARD is NOT MET as evidenced by: Repeated Deficiency: Based on documentation review and interview on 03/26/2026 in the presence of the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that existing dumbwaiters were inspected annually in accordance with NFPA 101:2012 Edition, Section 9.4.2.2 and ASME A17.3, Safety Code for Existing Elevators and Escalators. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed the following: two (2) of two (2) dumbwaiters were last inspected on 11/07/2024, and the certificates of occupancy/compliance expired on 11/30/2025, which was 117 days after the last compliance date. No further documentation was provided regarding	K0532	The facility immediately contacted a licensed elevator inspection vendor to schedule the required annual inspections for both dumbwaiters. The inspections will be completed, and current certificates of compliance/operation will be obtained and maintained on-site upon completion. All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) was in-serviced by the Administrator on the importance of ensuring that all dumbwaiters are inspected annually and maintained in compliance with applicable codes and regulations, and that current certificates of compliance are kept on file and readily available for review. The Director of Maintenance or designee will implement a tracking system to monitor inspection due dates for all dumbwaiters to ensure timely completion. Audits will be conducted monthly for three months to verify compliance, and any identified deficiencies will be corrected immediately. Findings will be documented and reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for 3 quarters.	04/19/2026

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K0532 SS = F Bldg. 01	Continued from page 5 current annual elevator inspections. In an interview at the time, the [redacted] and the [redacted] confirmed the findings. The facility's [redacted] was notified of the deficient practice during the Life Safety Code survey exit conference on 3/26/26 at 2:15 PM. N.J.A.C 8:39-31:2(e) ASME A17.3 This deficient practice was cited during the facility's previous standard recertification survey on 10/23/2024.	K0532		04/19/2026
K0741 SS = F Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by:	K0741	Upon identification of this practice on 03/25/2026, the facility immediately initiated corrective actions. A metal container with a self-closing cover device was obtained and placed in the designated smoking courtyard to ensure safe disposal of smoking materials. The area around the ambulance entrance was cleaned, and all dried grass, leaves, and cigarette butts were removed. Signage was reinforced to clearly identify designated smoking areas, and staff were instructed to prohibit smoking in non-designated areas. All residents have the potential to be affected by this practice. The [redacted] , [redacted] and staff were in-serviced by the Administrator on the importance of maintaining safe smoking practices in accordance with NFPA 101 Life Safety Code requirements. This includes ensuring approved metal containers with self-closing covers are readily available in designated smoking areas, maintaining grounds free of combustible materials, and enforcing smoking only in designated areas. The Director of Maintenance or designee will conduct environmental rounds twice daily to monitor designated and non-designated smoking areas for compliance. Audits will be conducted weekly for four weeks and monthly thereafter for 6 months to ensure that smoking receptacles are in place, combustible materials are removed, and non-designated areas remain smoke-free. Any deficiencies identified will be corrected immediately. Findings will be documented and reported to the Quality Assurance and Performance Improvement	04/19/2026

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(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
K0741 SS = F Bldg. 01	Continued from page 6 Based on observation and interview on 03/25/2026 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) it was determined that the facility failed to A) ensure that metal containers with self-closing cover devices were readily available to all areas where smoking is permitted B) ensure that None designated smoking area was maintained free from combustible dried grass, leaves and cigarette butts, and failed to prohibit the practice of smoking in none designated smoking areas in accordance with NFPA 101:2012 Edition, Section 19.7.4 These deficient practices had the potential to affect all residents and were evidenced by the following: An observation at 1:30 PM revealed a metal container with a self-closing cover device into which ashtrays can be emptied was not provided nor readily available to the smoking area courtyard. In an interview at the time, the U.S. FO and the U.S. FOIA (b confirmed the finding. An observation at 1:58 PM revealed that there was dried grass and leaves at the outer perimeter of the ambulance entrance. The surveyor observed 100-plus cigarette butts littered in that area. In an interview at the time, the U.S. FO and the U.S. FOIA (b confirmed the finding. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 03/26/2026 at 2:15 PM. N.J.A.C 8:39-31.9(e).	K0741	Continued from page 6 (QAPI) Committee quarterly for 2 quarters.	04/19/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K0918	Upon identification of the deficiency on 03/26/2026, the facility immediately contacted a certified generator maintenance vendor to obtain and test diesel fuel samples for the emergency and standby power generator. Fuel testing was completed and results were obtained on 04/07/26. All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) will be in-serviced by the Administrator on the requirement to ensure that emergency and standby generator diesel fuel is tested annually in accordance with NFPA 110 standards, and that all required documentation is	04/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315299	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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K0918 SS = F Bldg. 01	Continued from page 7 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on documentation review and interview on 03/26/2026 in the presence of the [redacted] and the [redacted] it was determined that the facility failed to ensure that the emergency and standby power generator diesel fuel quality was tested annually and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's generator annual service reports dated 8/22/2025, and 3/9/2026, provided by the [redacted] revealed no record on diesel sample analysis test had been conducted. No further documentation was provided regarding diesel fuel sample analysis test that had been conducted. During an interview with the surveyor on 3/26/26 at 12:20 PM, the [redacted] and [redacted] confirmed the findings. The facility's [redacted] was notified of the deficient practice at the Life Safety Code survey exit conference at 2:15 PM. N.J.A.C 8:39-31:2(e) NFPA 99, 110	K0918	Continued from page 7 properly maintained and readily available for survey review. The Director of Maintenance or designee will implement a compliance tracking system to ensure annual diesel fuel testing is completed and documented. Audits will be conducted monthly for three months and then quarterly for 2 quarters to verify compliance, and any deficiencies identified will be corrected immediately. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for 3 quarters.	04/19/2026

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K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed	K0222	The Director of Maintenance immediately contacted a vendor to inspect the delayed egress system on the doors. The issue with Door #4 was identified as a dead battery, which was replaced on 03/30/26. For Door #11, new hardware was ordered, with an estimated completion date of 04/10/26. A sign was placed on door #11 indicating the 15-second delayed egress system All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) was in-serviced by the Administrator on the importance of ensuring that the 15-second delayed egress system activates in accordance with NFPA 101 Life Safety Code requirements. The Director of Maintenance or designee will conduct checks weekly for four weeks, and then monthly for 3 months, to ensure the 15-second delayed egress system is functioning properly. All findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for three quarters.	04/19/2026

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K0222 SS = E Bldg. 01	Continued from page 9 in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/25/2026 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that the 15-second delayed egress feature on 2 of 9 exit discharge doors would activate in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1. This deficient practice had the potential to affect 52 of 116 residents and was evidenced by the following: At 10:45 AM, the surveyor, the U.S. FO and the U.S. FOIA (b observed that the exit/egress door # 4 was provided with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds." The U.S. FO tried to activate the door delayed device as indicated on the sign, but the door did not open. At 11:27 AM, the surveyor, the U.S. FO and the U.S. FOIA (b observed that the exit/egress door # 11 was provided with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds." The U.S. FO tried to activate the door delayed device as indicated on the sign, but the door did not open. In an interview at the time, the U.S. FO and the U.S. FOIA (b confirmed the findings. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 03/26/2026 at 2:15 PM. N.J.A.C 8:39-31.9(e).	K0222		04/19/2026

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K0372 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/25/2026 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that penetrations through smoke/fire barriers are protected by a system or materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6,8.3.5, This deficient practice had the potential to affect 22 of 116 residents and was evidenced by the following: An observation at 9:18AM, revealed that the smoke barrier wall above the door set adjacent to room #1 contained unsealed penetrations around wires and piping. In an interview at the time, the U.S. FO and the U.S. FOIA (b) confirmed the finding. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 03/26/2026 at 2:15 PM. N.J.A.C 8:39-31.9(e).	K0372	The Director of Maintenance immediately sealed the penetration in the smoke barrier above the door following adjustments to Room #1. The repair was completed on 03/27/26 using NJ Ex Fire Barrier Sealant CP 25WB. All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) will be in-serviced by the Administrator on the importance of ensuring that all penetrations through smoke and fire barriers are properly sealed with materials capable of restricting the transfer of smoke, in accordance with NFPA 101 Life Safety Code requirements. The Director of Maintenance or designee will audit all smoke barriers to ensure compliance with NFPA standards. Audits will be conducted monthly for three months, and any identified deficiencies will be corrected immediately. All findings of the audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for the next 3 quarters.	04/19/2026
K0374 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors	K0374	The facility immediately ordered hardware to ensure the smoke barrier door by Wedgewood nurses station to the lobby closes fully into the frame and resists the passage of smoke in accordance with NFPA 101 Life Safety Code requirements.	04/19/2026

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K0374 SS = D Bldg. 01	Continued from page 11 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/25/2026 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) , it was determined that the facility failed to ensure smoke barrier doors closed into their door frame to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3,19.3.6.3.3 to 19.3.6.3.17,8.5.4 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect 32 of 116 residents and was evidenced by the following: An observation at 9:20 AM revealed the smoke barrier door located by Wedgewood Nurses' station to the front lobby was not completely closing to its frame. A ½ inch gap was observed along the top of the door. In an interview at the time, the U.S. FO and the U.S. FOIA (b confirmed the finding. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 03/26/2026 at 2:15 PM. N.J.A.C 8:39-31.9(e).	K0374	Continued from page 11 All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) will be in-serviced by the Administrator on the importance of ensuring that smoke barrier doors fully close and latch into the frame to resist the passage of smoke in accordance with NFPA 101 Life Safety Code requirements. The Director of Maintenance or designee will audit all smoke barrier doors to ensure they close completely into the frame and function properly. Audits will be conducted monthly for 6 months, and any identified deficiencies will be corrected immediately. All findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for two quarters.	04/19/2026

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/25/26 and 03/26/26. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		05/20/2026

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