STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GARDEN NURSING AND REHABILITATION CENTER	**1579 OLD FREEHOLD ROAD , TOMS RIVER, New Jersey, 08753**

(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 Survey Date: 9/18/25 Complaints: 434541, 434542, 434543 Census: 117 Sample Size: 24 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. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		11/16/2025
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812	Plan of Correction for F812 Date of Survey: 9.11.25 Date of Completion: 10.10.2025 F812, Food Procurement, Store/Prepare/Serve-Sanitary All residents had the potential to be affected by the deficient practice Based on surveyor's observations it was determined that the facility failed to Ensure washed utensils are dried in a manner to prevent contamination from foreign substances and potential for food- borne illness. Maintain the kitchen equipment in a sanitary manner to prevent microbial growth.	10/10/2025

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

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

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F0812 SS = F	Continued from page 1 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure that washed utensils were dried in a manner to prevent contamination from foreign substances and potential for the development of food-borne illness; b.) maintain the kitchen equipment in a sanitary manner to prevent microbial growth; c.) store, label and date potentially hazardous foods to prevent food borne illness; and d.) ensure bottled drinking water supply was stored in a sanitary manner at least six inches from the floor. This deficient practice was evidenced by the following: On 9/11/2025 at 9:08 AM, the surveyor toured the kitchen with the U. S. FOIA (b) (2)) and observed the following: 1. Near the washing area, dinner knives, forks, and teaspoons contained in perforated plastic flatware containers being air-dried by a standing fan with dust build-up at the back grills. The U.S. FOIA stated that the fan was cleaned the previous night. 2. Manual can opener blue plastic slide bar insert with heavy buildup of blackish unidentified substance. A staff member handed the clean blade and stem to the U. S. FOIA who reassembled the parts together. The U. S. FOIA stated that they could not clean the blue plastic insert, so they ordered a new one to come in. On 9/12/2025 at 8:48 AM, the surveyor toured the first-floor pantry with Registered Nurse/ Unit Manager (RN/Um #1) and observed the following: 1. Reach-in refrigerator freezer without an internal thermometer. Six cups of ice cream were observed inside. RN/UM #1 stated that there used to be a thermometer inside the freezer. 2. Reach-in refrigerator contained an unlabeled and undated chicken soup in a covered Pyrex container. The surveyor also observed an undated box of 2 cannoli and box of 2 puff pastries. On 9/17/2025 at 8:30 AM, the surveyor observed the following in the hallway near the kitchen: 1. Three 5-gallon jug water containers inserted horizontally inside blue plastic crates which were in	F0812	Continued from page 1 Store, label and date potentially hazardous foods to prevent food-borne illness. Ensure bottled drinking water supply was stored in a sanitary manner at least 6 inches from the floor. Following the surveyors' observations immediate actions were taken: The fan that was observed by the surveyor near the washing area, that was used for air flow for staff was immediately removed. All dietary staff were in-serviced that fans/personal fans are not permitted in the kitchen. The can opener, identified with a blackish substance, was immediately cleaned by the FSD. All Dietary staff were in-serviced on proper cleaning and sanitizing of can openers. The noted can opener was replaced 9.22.25. The refrigerator in the nourishment room that was noted to be missing a thermometer, the thermometer was immediately replaced; the unlabeled and undated food was immediately removed and discarded. The 5-gallon water jugs were immediately lifted off the floor onto 6inch pallet and cleaned of any noted dust. To ensure the deficient practice is being corrected a daily audit will be implemented for all refrigerators and food storage areas by the IP to ensure proper dating, labeling, and storage, this daily audit will include checking for thermometer/appropriate refrigerator temperatures. All staff were in-serviced on the facilities policy and procedure related to food storage. The facilities designated IP will conduct kitchen, laundry and environmental rounds. The IP will conduct daily refrigeration audits for two weeks, followed by weekly audits for one month. The results of these audits will be reported to the QAPI committee on a quarterly basis for review and analysis. Based on QAPI committee recommendations, the monitoring frequency may be adjusted as needed to ensure sustained compliance. The QAPI team will determine the need for continued compliance.	10/10/2025

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F0812 SS = F	Continued from page 2 direct contact with the floor. The mouthpiece up to the neck part of the containers were jutting out of the crates exposed to any activity on the floor. The crates were observed to have heavy buildup of dirt and dust. The [redacted] stated the water jugs should not be there, and they will be relocated. A review of facility-provided undated policy titled "General Sanitation of Kitchen" did not address proper drying of utensils. A review of facility-provided procedure dated 3/22/2024 titled "Can Opener Cleaning Instructions" included the following: 5. Take out blue holding block. Wash, rinse, and sanitize. A review of facility provided policy dated 12/15/2024 titled "Dating and Labeling Policy" included the following: All … food otherwise stored outside their original containers, must be labeled and dated at the time it was put in the container. The label must include the item description, the date stored, opened date and the use by date." A review of facility-provided policy dated 2/3/2024 titled "Food Storage Policy and Procedure" did not include proper storage of water containers. N.J.A.C. 8:39 – 17.2 (g)	F0812		10/10/2025
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based	F0880	F0880: Infection Prevention and Control It was noted that the facility failed to provide residents with appropriate products for hand hygiene during mealtimes and did not implement and maintain (Resident #114) with NJ Ex Order 26, 4B1 [redacted] on NJ Ex Order 26.4(b)(1). Following notification of the deficient practices the hand wipes that did not contain the alcohol percentage on the packaging were discarded and handwipes containing 60% or more of alcohol were immediately purchased are being provided for hand hygiene at mealtimes. (Resident #114) was immediately placed on [redacted] All residents had the potential to be affected by the deficient practice. A facility wide audit was conducted by DON, IP and Unit Managers ensure any resident with chronic wounds was placed on EBP. From 9.17.25- 10.2.25, All nursing staff including the	10/14/2025

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F0880 SS = E	Continued from page 3 upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F0880	Continued from page 3 [redacted] were educated by the DON on infection control practices and facility infection control policies and procedures. DON and IP conducted facility audits on all residents to identify potential infection control concerns. IP updated policies and procedures to reflect with CDC, CMS and state DOH guidance. DON and IP will continue to provide education to new staff upon orientation and annual competency reviews. The IP will perform weekly infection control audits that will include observation of staff performing specific tasks including hand hygiene, PPE usage, PPE signage, sanitizing /cleaning of equipment, and environmental rounding for 6 months. The results of the audits will be reported to the administrator and provided to the QAPI committee on a quarterly basis for review. The IP and QAPI committee will analyze trends and identify any need for further intervention.	10/14/2025

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F0880 SS = E	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of medical record and pertinent facility documentation, it was determined that the facility failed to a.) provide residents with appropriate products for hand hygiene during mealtime identified in 2 of 3 dining room observations (1st floor Tea Rose and the Main dining rooms) and b.) implement and maintain a resident with NJ Ex Order 26, 4B1 on NJ Ex Order 26.4(b)([redacted] in nursing homes identified in 1 of 1 resident (Resident #114) reviewed for NJ Ex Order 26, 4B1, to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of infection control practice. This deficient practice was evidenced by the following: Reference: "Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens." https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html Reference: "Enhanced Barrier Precautions are indicated for residents known to be colonized or infected with an MDRO deemed novel or targeted by the CDC. When Contact Precautions do not otherwise apply, or when the resident has an indwelling medical device or wound." https://www.nj.gov/health/cd/documents/topics/hai/EBP_in_Nursing_Homes_Algorithm.pdf 1.(a) On 09/12/2025 at 11:38 AM, Surveyor #1 observed dining for lunch on the 1st floor Tea Rose dining room. The U. S. FOIA (b) (2) [redacted]) provided the residents in the dining room with lemon-scented moist towelettes for hand hygiene. The lemon-scented moist towelettes were alcohol free. During an interview with Surveyor #1 on 09/12/2025 at 11:50 AM, the U. S. FOIA [redacted] stated that the lemon-scented	F0880		10/14/2025

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F0880 SS = E	Continued from page 5 moist towelettes are what the facility uses to provide hand hygiene for residents prior to meals. During an interview with Surveyor #1 on 09/15/2025 at 12:35 PM, the U. S. FOIA (b) (2) stated that the facility provides towelettes scented with lemon to residents during mealtimes. She further stated that she was unsure whether the towelettes contain alcohol. During an interview with Surveyor #1 on 09/16/2025 at 1:10 PM, the U. S. FOIA (b) (2)) stated that lemon-scented moist towelettes are currently used by the facility to provide hand hygiene for residents prior to meals. She also stated that the facility plans to purchase alcohol-based hand wipes in the future for resident use. A review of a facility policy dated 05/06/2025 titled, "Resident Health Program", revealed that, "An active Resident Health Program is maintained as part of the overall Infection Control Program of the facility, under the direction of the Infection Control Committee and supervised by the Infection Control Coordinator. Educate resident on proper hand hygiene which includes washing hands with soap and water, utilizing alcohol-based sanitizer rub and to utilize the wipes that are provided with meals." b.) On 9/15/2025 at 11:45 AM, Surveyor #2 observed residents for lunch meal service in the Tea Rose dining room. A total of 17 residents occupied 6 of 11 tables in the dining room. The surveyor observed U.S. FOIA (b) (6) and Certified Nursing Assistant (CNA #1) assist residents wipe their hands using lemon-scented moist towelette packs before eating lunch. U.S. F stated to this surveyor that the towelettes were the only supplies they use to clean the residents' hands before meals. On 9/16/2025 at 1:10 PM, during an interview with the survey team, the U. S. FOIA (b) (6) stated that the lemon-scented moist towelettes are currently used by the facility to provide hand hygiene for residents prior to meals. They also stated that the facility plans to purchase alcohol-based hand wipes in the future for resident use. 2.) On 9/11/2025 at 10:46 AM, the Surveyor #2 observed Resident #114 in bed. The resident was	F0880		10/14/2025

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F0880 SS = E	Continued from page 6 using a [redacted] type of mattress. There was no signage for EBP inside and outside the room. No Personal Protective Equipment (PPE) supplies were immediately available near the room. On 9/12/2025 at 9:29 AM, the surveyor observed Resident #114 in bed. There was no signage for EBP inside or outside the room. No PPE supplies were immediately available near the room. On 9/16/2025 at 10:00 AM, the surveyor observed the resident's [redacted] treatment by Licensed Practical Nurse (LPN #1). LPN #1 wore gloves but did not wear any [redacted] throughout the [redacted] treatment process. The surveyor asked LPN #1 if they should have used [redacted] during the [redacted] treatment. LPN #1 stated that since there was no sign that the resident was on [redacted] along the doorway, they did not wear the [redacted] The surveyor reviewed the electronic medical record (EMR) for Resident #114. A review of the Resident Face Sheet (an admission record) reflected the resident was admitted to the facility with diagnoses which include [redacted] A review of the most recent comprehensive Minimum Data S (MDS), an assessment tool dated [redacted] indicated that the resident had [redacted] A review of the physician orders as of [redacted], included the following treatment orders: Clean [redacted] A review of the comprehensive person-centered care plan revealed a focus for [redacted] with the following interventions: Maintain adequate [redacted] with [redacted] to prevent [redacted] and [redacted], [redacted] consult, [redacted] treatment, and [redacted] supplement as ordered. On 9/16/2025 at 11:22 AM, during an interview with the survey team, the [redacted] stated that the [redacted] process entailed the staff use of gown and gloves during [redacted] activities like [redacted] care for residents with medical devices and [redacted]	F0880		10/14/2025

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F0880 SS = E	Continued from page 7 A review of facility-provided undated policy titled "Enhanced Barrier Precautions" included under Policy: … Enhanced Barrier Precautions (EBP) are an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. aureus (a bacteria) and MDROs. The policy also included under Overview: 3.) EBP may be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization, and infection or colonized with an MDRO. N.J.A.C. 8:39 - 19.4 (a)	F0880		10/14/2025
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints	F0605	F0605: Right to be free from Chemical Restraints Correction Plan for F0605 Based on observation, interview, review of EMR and other pertinent facility documentation it was noted that the facility failed to document NJ Ex Order 26, 4B1 interventions to manage (Resident #37's) NJ Ex Order 26, 4 prior to administration of NJ Ex Order 26, 4B1 medications. Following the notification of the deficient practice the U. S. FOIA (b) (2) was consulted, medication review was conducted by the U. S. FOIA (b)(2) education was initiated and (Resident 37) care plans were updated to include NJ Ex Order 26, 4B1 interventions and preferences. All residents had the potential to be affected by this deficient practice. Facility wide audit was performed on psychotropic documentation for quality assurance. To prevent recurrence inservices were conducted 9.15.25- 10.2.25 by U. S. FOIA titled: NJ Ex Order 26, 4B1 Medications. The inservice included the updated policy on Psychotropics, education on consents, psychotropic education compliance as the facility is to ensure all consents are updated, confirm side effect education has been provided and documented, resident/family understanding and agreement with current plan, monthly medication reviews for GDR or alternative approaches, any residents showing stability or reduction in symptoms, behavioral interventions are in place, IDT recommendations for next steps, care plan & documentation review, all relevant care plans updated to reflect diagnosis, medication use, and risks, ensure clear interventions and resident-centered problems, and review	10/15/2025

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F0605 SS = D	Continued from page 8 imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs	F0605	Continued from page 8 psychotropic risk/benefit documentation. The DON will conduct weekly audits of psychotropic medication orders and associated documentation for 6 months to ensure compliance. The DON's audits will be presented to the QAPI committee for recommendations and review. The QAPI committee meets quarterly and will determine the need for continued compliance.	10/15/2025

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F0605 SS = D	Continued from page 9 receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of electronic medical records (EMR) and other pertinent facility documentation it was determined that the facility failed to document [redacted] interventions to manage a resident's behavior prior to administration of [redacted] medications. This deficient practice was identified for 1 of 5 residents (Resident #37) reviewed for unnecessary medications and was evidenced by the following: Review of the resident Face Sheet (admission summary) indicated that Resident #37 was admitted to the facility with the diagnoses that included but was not limited to [redacted] Review of the quarterly Minimum Date Set (MDS) an assessment tool that facilitates a resident's care dated [redacted], indicated that Resident #37 [redacted] and was [redacted] The MDS also indicated that the resident required [redacted] with activities of daily living and exhibited [redacted].On 9/11/2025 at 11:15 AM, the surveyor observed Resident #37 sitting quietly in the	F0605		10/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0605 SS = D	Continued from page 10 hallway in front of the nurse's station. The resident was in NJ Ex Order 26, 4B1, clean and dressed appropriately. The resident was unable to be interviewed due to NJ Ex Order 26, 4B1. On 9/12/2025 at 10:22 AM, the surveyor interviewed the U. S. FOIA (b) (2)) who stated that Resident #37 required assistance with NJ Ex Order 26, 4B1 She also stated that resident was NJ Ex Order 26, 4B and required assistance with NJ Ex Order 26.4(b)(1) but was able to NJ Ex Order 26.4(b)(1). She stated that the resident did not have that she was aware of. On 9/12/2025 at 10:27 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that Resident #37 was NJ Ex Order 26.4(b) and required NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) She stated that the resident NJ Ex Order 26, 4B1) and NJ Ex Order 26, 4B1 at times in the NJ Ex Order 26, 4B1. She explained that the resident was NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and that the resident required NJ Ex Order 26, 4B1 at times due to NJ Ex Order 26, 4B1 She stated that the resident NJ Ex Order 26.4(b)(1) when NJ Ex Order 26.4(b)(1) and NJ Ex Order 26, 4B1 when asked by staff members. She stated that the resident was given a NJ Ex Order 26.4(b)(1) but not all the time. The U. S. FOIA continued to add that the staff would try to bring the resident to activities, but the resident would sometimes NJ Ex Order 26.4(b)(1). On 9/12/2025 at 10:34 AM, the surveyor interviewed the U. S. FOIA (b) (2)) who stated that Resident #37 had NJ Ex Order 26, 4B1 and was NJ Ex Order 26, 4B1 but restless in the afternoon and early evening. She stated that the resident NJ Ex Order 26, 4B1 and usually a staff member would have to sit with the resident. She said that staff would sometimes just let the resident NJ Ex Orde or that the activities department would try to read with the resident. She also added that activities department would take the resident NJ Ex Order 26.4(b)(1) provide snacks and have the resident NJ Ex Order 26.4(b)(1). She explained that the NJ Ex Order 26, 4B1 saw the resident on NJ Ex Order 26, 4B1 and started the resident on the NJ Ex Order 26, 4B1 medication NJ Ex Order 26, 4B1. She stated that the NJ Ex Order 26, 4B1 medication NJ Ex Order 2 was only ordered for NJ Ex Order 26, 4B1 until the NJ Ex Orde could get into the resident's system. Review of the NJ Ex Order 26, 4B1 consultation dated NJ Ex Order 2, indicated that the nurses stated that Resident #37 was having episodes of NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 and frequently NJ Ex Order 26, 4B1	F0605		10/15/2025

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F0605 SS = D	Continued from page 11 especially after dinner. The NJ Ex Order 26, 4B1 indicated that the resident was having no signs or symptoms of NJ Ex Order 26, 4B1 at that time, however, was seen in the early morning hours and staff and family had reported NJ Ex Order 26, 4B1 occurred in the afternoon after dinner. The [redacted] recommended starting NJ Ex Order 26, 4B1 [redacted] The surveyor reviewed the physician's orders dated [redacted] for NJ Ex Order 26, 4B1 [redacted] Review of the progress notes prior to the start date of NJ Ex Order 26, 4B1, revealed that there was no documented behavior nor were there interventions documented regarding NJ Ex Order 26, 4B1 interventions to manage NJ Ex Order 26.4(b) such as [redacted] There was also no [redacted] monitoring documented after the medication [redacted] was administered. Review of the Interdisciplinary Care Plan (ICP) revealed that there was a ICP dated [redacted], with the focus on [redacted]. There were no resident specific interventions to demonstrate how the facility was managing the resident's [redacted]. The interventions included the following: · Use NJ Ex Order 26.4(b)(1). · Maintain a safe environment. · Offer choices of two items. · Evaluate medication regimen. Review of the Interdisciplinary Care Plan (ICP) revealed that there was a ICP dated [redacted] with a focus on NJ Ex Order 26.4(b)(1) such as [redacted] NJ Ex Order 26.4(b)(1) with safety education, not utilizing the call bell and NJ Ex Order 26.4(b)(1). There were no resident specific interventions documented on the ICP to demonstrate how the facility was managing these [redacted] The interventions included the following: Document in the progress notes the intensity, duration or frequency of the [redacted] Notify the physician immediate changes in [redacted] Encourage participation in activities. Encourage participation in activities of daily living.	F0605		10/15/2025

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F0605 SS = D	Continued from page 12 NJ Ex Order 26.4(b)(1). Administer medications as ordered by the physician. Review of the Physician's orders (PO) dated NJ Ex Order 26.4 indicated tha NJ Ex Order 26, 4B1 Review of the PO dated NJ Ex Order 26 reflected an order for NJ Ex Order 26, 4B1 Review of the psychiatric medical evaluation dated NJ Ex Order 2 indicated that Resident #37 had the diagnoses of NJ Ex Order 26, 4B1. The NJ Ex Order 26, 4B1 lists the behaviors as NJ Ex Order 26 NJ Ex Order 26.4(b)(1) trying to NJ Ex Order 26.4(b)(1) the wheelchair and NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) documented that these behaviors occurred after dinner. The U.S. FOIA (b) (6) indicated that the NJ Ex Order 26, 4B1 medication NJ Ex Order 26, 4B1 was being given to the resident for NJ Ex Order 26, 4B1. The documentation also indicated that the resident was to be given NJ Ex Order 26, 4B1 as needed NJ Ex Order 26, 4B1 on NJ Ex Order 26 and discontinued on NJ Ex Order 26. There were no documented interventions on the NJ Ex Order 26.4 ICP or NJ Ex Order 26.4(b) ICP that specifically addressed NJ Ex Order 26.4(b) such as NJ Ex Order 26, 4B1 prior to administration of NJ Ex Order 26, 4B1 medications. On 9/12/2025 at 11:06 AM, the surveyor interviewed the U. S. FOIA (b) (2)) who stated that new residents were assessed within 5 days of admission, quarterly and annually. She stated that these assessments were important to perform to assure that all residents activities need, wants and interest were reviewed. She added that these assessments assured that residents NJ Ex Order 26, 4B1 needs were met. She explained that Resident 37 was encouraged to participate in NJ Ex Order 26.4(b)(1) which were held at 1:30 PM every day. This activity included NJ Ex Order 26.4(b)(1) such as NJ Ex Order 26 The stated that she was not aware that the resident had NJ Ex Order 26, 4B1 in the evening hours and was not sure if the staff were supposed to let her know. When the surveyor asked the U. S. FOIA if the nurse should have told her that the resident was a NJ Ex Order 26, 4B1 or had specific NJ Ex Order 26, 4B1 in the evening, she stated that she wasn't sure. She stated she only had access to the progress notes and didn't have access to the care plan. She stated that the U. S. FOIA (b) (2) was taking care of updating the care plan because the U. S. FOIA (b) (2) was out on	F0605		10/15/2025

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F0605 SS = D	Continued from page 13 leave. She stated that if the resident was experiencing [NJ Ex Order 26, 4B] later in the day, then it would have been important to have a ICP with interventions that were specific for the resident at the time of the day to address the [NJ Ex Order 26, 4B1] On 9/12/2025 at 11:18 AM, the surveyor interviewed the [U. S. FOIA (b) (2)]) who stated that if Resident #37 was experiencing [NJ Ex Order 26.4(b)] such as [NJ Ex Order 26. 4B1], the staff should have been trying [NJ Ex Order 26, 4B1] approaches to the behaviors before trying [NJ Ex Order 26, 4B1] medications. The [U. S. FO] reviewed the activities notes and admitted that there was no documentation regarding the residents' [NJ Ex Order 26.4(b)] or any specific activities that were being offered to the resident to manage the [NJ Ex Order 26, 4B1]. The surveyor asked the [U. S. FO] regarding [NJ Ex Order 26, 4B] care plans and activities care plans and the [U. S. FO] stated that all resident specific interventions related to behaviors should have been addressed in the ICP. The [U. S. FOIA] confirmed that there were no [NJ Ex Order 26, 4B1] interventions addressed in the resident's care plan for the listed [NJ Ex Order 26, 4B1] On 9/12/2025 at 12:10 PM, the surveyor interviewed the [U. S. FOIA (b) (2)] who all confirmed that there were no documentations in Resident #37's medical record that indicated [NJ Ex Order 26, 4B1] interventions were initiated prior to start of [NJ Ex Order 26, 4B1] drugs. The [U. S. FO] also confirmed that the ICP did not address activities or resident specific intervention for the [NJ Ex Order 26, 4B] care plan. On 9/16/2025 at 10:09 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who reviewed the progress notes in the presence of the surveyor and agreed that there were no nursing notes prior to [NJ Ex Order 2] which addressed resident specific [NJ Ex Order 26.4(b)] or attempted interventions to manage the [NJ Ex Order 26.4(b)] before starting the resident on the [NJ Ex Order 26, 4B1] medication [NJ Ex Order 2] She confirmed that there should have been documented [NJ Ex Order 26, 4B1] approach to effectively manage the resident's behavior of [NJ Ex Order 26, 4B1]. She also agreed that the resident's care plan did not address any [NJ Ex Order 26, 4B1] interventions that were attempted before starting the [NJ Ex Order 26, 4B1] medication [NJ Ex Order 2] The [U. S. FOIA (b) (2)] confirmed that there was no documentation in the MAR for behavior monitoring before starting the resident on a [NJ Ex Order 26, 4B1] medication or after the resident started on a [NJ Ex Order 26, 4B1] medication. She stated that they "dropped the ball on that one".	F0605		10/15/2025

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F0605 SS = D	Continued from page 14 On 9/16/2025 at 12:45 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that it was "nursing 101" that the nursing staff would try NJ Ex Order 26, 4B1 interventions in an attempt to manage behaviors prior to starting the resident on a NJ Ex Order 26, 4B1 medication. The facility policy dated 4/21/25 and titled, "Psychotropic Drugs" indicated that it was the facility policy that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition diagnosed and documented in the clinical record. Residents who use psychotropic drugs receive a gradual dose reduction, behavior interventions, unless clinically contraindicated. The policy specified that the IDT will implement non-pharmacological approaches designed to meet the individual needs of each resident by way of a personalized care plan. The facility policy dated 4/21/25 and titled, "Dementia Care Planning" indicated that the facility would provide person-centered, dignified and safe care for residents living with dementia. All residents with dementia will have a comprehensive care plan developed, implemented and reviewed regularly. Care planning would include a personal history and interest, communication strategies, environmental modifications, triggers and calming techniques, nutritional and hydration support and medication review and management. The policy also indicated that the facility would use non-pharmacological interventions as a first line management of behavior issues. The facility would provide meaningful engagement and activities tailored to cognitive levels and interest. Document all interventions and updates. N.J.A.C. 8:39-27.1(a)	F0605		10/15/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F0641	F641, Accuracy of Assessments 1. (Resident #9) was noted to have an inaccuracy related to NJ Ex Order 26, 4B1 on their MDS. When this deficient practice was brought to the attention of the facility the MDS in question was immediately corrected via modification by the U. S. FOIA (b) (2) and resubmitted to reflect the use of NJ Ex Order 26, 2. All residents had the potential to be affected by this deficient practice. 3. To prevent recurrence on 9.22.25 the Administrator provided a mandatory inservice to all three facility MDS staff members on proper	10/15/2025

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F0641 SS = D	Continued from page 15 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to accurately code a resident's NJ Ex Order 26.4(b)(1) on the quarterly Minimum Data Set (MDS) an assessment tool for 1 of 24 residents (Resident #9) reviewed and was evidenced by the following: Review of the Face Sheet (admission summary) indicated that Resident #9 was admitted to the facility with the diagnoses that included but was not limited to NJ Ex Order 26, 4B1 [redacted] Review of the quarterly Minimum Data Set (MDS) an assessment tool that facilitates a resident's care dated [redacted] indicated that Resident #9 scored an [redacted] on the Basic Interview for Mental Status (BIMS) which indicated NJ Ex Order 26, 4B1 [redacted]. The MDS also reflected that Resident #9 required NJ Ex Order 26.4(b)(1) with [redacted] of activities of daily living. The MDS did not reflect that the resident was being NJ Ex Order 26.4(b)(1) On 9/11/2025 at 10:50 AM, during initial tour, the surveyor observed Resident #9 lying in bed on [redacted] at	F0641	Continued from page 15 procedures for completing and coding the MDS titled MDS coding and oxygen use. 4. The administrator will audit 5 MDS assessments per month for the first 3 months. Findings from these audits will be reported to the QAPI committee. The QAPI committee will analyze data from the audits to identify patterns and determine if additional training or systemic changes are necessary. The QAPI committee meets quarterly and will determine the need for continued monitoring and or training for the MDS team.	10/15/2025

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F0641 SS = D	Continued from page 16 NJ Ex Order 26, 4B1 [redacted]. The surveyor was unable to interview the resident at this time because the resident was sleeping. The surveyor did not observe that the resident was NJ Ex Orde [redacted]. The surveyor reviewed the residents EMR which revealed the following information: A review of the physician's orders (PO) dated NJ Ex Order 26 [redacted], reflected a PO to administer NJ Ex Order 26, 4B1 [redacted]. A review of quarterly MDS with an assessment reference date of NJ Ex Order 26, 4 [redacted] reflected that the resident was not administered NJ Ex O [redacted]. The surveyor reviewed the nursing progress note date NJ Ex Order 26, 4 [redacted] which indicated that the resident in fact was administered NJ Ex Order 26 [redacted]. On 9/17/2025 at 9:50 AM, the surveyor interviewed the U. S. FOIA (b) (2) [redacted] who explained that the resident's quarterly MDS dated NJ Ex Order 26 [redacted], had a look back was to NJ Ex Order 2 [redacted]. The U. S. FOIA (b) (2) [redacted] confirmed that the documentation in the progress notes indicated that the resident received NJ Ex Order 26, 4B1 [redacted]. The U. S. FOIA (b) (2) [redacted] stated that the MDS had to be modified to include that the resident was on NJ Ex [redacted] at the time the MDS was completed. The U. S. FOIA (b) (2) [redacted] stated that this was an error in documentation. A review of the facilities undated policy titled, "MDS Coordinator Policy" indicated that the Resident Assessment Instrument (RAI) assist skilled nursing facility staff to consistently and accurately gather information regarding residents' strength which provides the foundation for an individual interdisciplinary plan of care. The MDS Coordinator conducts a comprehensive assessment of residents to determine their healthcare needs, functional ability and psychosocial status. To ensure that the MDS is accurately completed to reflect each resident's clinical status. N.J.A.C 8:39-33.2 (d)	F0641		10/15/2025
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F0656	F0656: Develop/Implement Comprehensive Care Plan It was noted that the facility failed to implement a comprehensive, person-centered care plan for pain	10/15/2025

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F0656 SS = D	Continued from page 17 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and review of pertinent facility documentation, it was determined that the facility failed to implement a comprehensive, person-centered care plan (CPCCP)	F0656	Continued from page 17 that was consistent with professional standards of practice and included measurable objectives and timeframes to meet a resident's medical needs for (Resident # 129). Following being notified of the deficient practice the facility immediately initiated a person-centered [redacted] plan for (Resident #129). All residents had the potential to be affected by this deficient practice; therefore a facility wide pain care plan audit was conducted to ensure the deficient practice did not recur. 9.22.25 - 10.10.25, The [redacted] was inserviced on the topic Comprehensive Care Plans, which was conducted by the [redacted] the inservice included the following: Updated Care Planning policy and procedure Education on comprehensive assessments, significant changes, and baseline care plans. Care plans are to be person centered, are to include residents and families in care plan implementation/reviews. Care plans are to include evidence-based interventions that are individualized to reflect diagnoses, risks and preferences. Care plan checklists are to be utilized by the IDT during care planning to ensure all domains (physical, psychosocial, functional, cognitive, and quality of life needs) are addressed. The DON will monitor a minimum of 10% of new admissions and readmissions weekly for 3 months to ensure pain care plans are initiated and comprehensively updated. The results of these audits will be reported to the QAPI committee for suggestions and recommendations. The QAPI committee meets quarterly and will determine the need for continued monitoring.	10/15/2025

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F0656 SS = D	Continued from page 18 NJ Ex Order 26 that was consistent with professional standards of practice and included measurable objectives and timeframes to meet a resident's medical needs. This deficiency was identified for 1 of 1 resident (Resident #129) reviewed NJ Ex Order 26. This deficient practice was evidenced by the following: On 09/11/2025 at 10:42 AM, the surveyor observed Resident #129 in their bedroom, lying in bed with the head of the bed elevated to approximately 45 degrees. The resident reported having NJ Ex Order 26.4(b)(1) NJ Ex Order 26, 4B1 or NJ Ex Order 26.4(b)(1) NJ Ex Order 26, 4B1 in that area. The resident stated that he/she had received NJ Ex Order 26, 4B1 medication at approximately NJ Ex Order 26, 4B1 and were planning to ask the nurse for additional medication for their NJ Ex Order 26, 4B1 According to the admission record, Resident #129 was admitted to the facility with diagnoses including, but not limited to, NJ Ex Order 26, 4B1 A review of Resident #129's annual Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated NJ Ex Order 26, 4B1, included a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1, indicating NJ Ex Order 26, 4B1. Further review of Section NJ Ex Order 26.4(b)(1) revealed that the resident receives as-needed NJ Ex Order 26, 4B1 and non-medication interventions for NJ Ex Order 26, 4B1. A review of Resident #129's physician orders (PO), dated as of NJ Ex Order 26, 4B1, included the following PO for NJ Ex Order 26, 4B1 every NJ Ex Order 26, 4B1, and PO dated NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 by NJ Ex Order 26, 4B1 every NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1) by NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1. Resident #129 did not have a NJ Ex Order 26, 4B1 for NJ Ex Order 26 to review.	F0656		10/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0656 SS = D	Continued from page 19 During an interview with the surveyor on 09/15/2025 at 12:10 PM, the U. S. FOIA (b) (2) stated that Resident #129 was admitted to the hospital from the facility in NJ Ex Order 26, 4B1 and returned on NJ Ex Order 26, 4B1. She stated that the resident had a NJ Ex Order 26, 4B1 prior to hospitalization, but she was not sure why a NJ Ex Order 26, 4B1 was not in place upon the resident's return. She acknowledged that the resident should have had one in place. The facility was unable to provide a policy regarding the development of a NJ Ex Order 26, NJAC 8:39-11.2(b)	F0656		10/15/2025
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F0657	F657, Care plan timing and revision It was noted that the facility failed to update and revise the U. S. FOI to accurately reflect the care of (Resident #2). Upon notification of the findings from the survey team, the U. S. FOIA (b) (2) immediately reviewed (Resident #2) care plans, changes were promptly made to the care plans interventions to include the use of U. S. FOIA (b) (2), and the discontinuation of U. S. FOIA (b) (2) medication. All residents had the potential to be affected; therefore, the facility conducted a facility-wide audit of all resident care plans. The Care Planning policy and procedure was reviewed and updated. The U. S. FOIA inserviced the IDT members on the updated policy via signed inservice with dates of 9.17.25 – 10.10.25, the inservice included training included the revised care plan policy, the importance of timely updates, and the roles of each U. S. FO team member. The facility implemented a change in the EMR system whereas the unit managers are notified with alerts for upcoming care plan review dates to prevent recurrence of the deficient practice. The DON will conduct weekly audits of 10% of all new or revised care plans for the first 3 months for compliance. The audit findings collected by the DON will be reported to the administrator and QAPI committee. The QAPI committee meets quarterly, the committee will review care plan data to identify any	10/15/2025

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F0657 SS = D	Continued from page 20 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and review of medical records and other pertinent facility documentation it was determined that the facility failed to update and revise a resident's Interdisciplinary Care Plan (ICP) to accurately reflect the care for 1 of 24 residents (Resident #2) and was evidenced by the following: Review of the Face Sheet (admission summary) indicated that Resident #2 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1. Review of the quarterly Minimum Date Set (MDS) an assessment tool that facilitates a resident's care dated NJ Ex Order 26, 4B, indicated that Resident #2 had a score of NJ Ex Order on the Brief Interview for Mental Status (BIMS) which indicated that the resident had NJ Ex Order 26, 4B1. The MDS reflected that the resident required NJ Ex Order 26, 4B1 with NJ Ex Order 26, 4B1. On 9/11/2025 at 10:54 AM, the surveyor observed Resident #2 sitting in the dayroom. The resident was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The surveyor observed that the resident had NJ Ex Order 26, 4B1. The resident was interviewed at the time and was unable to provide the surveyor details about the NJ Ex Order 26, 4B1. The surveyor reviewed the residents electronic medical record which revealed the following information: Review of the Physician's Order (PO) dated NJ Ex Order 26, 4B1, reflected an order to apply NJ Ex Order 26, 4B1 in the AM and remove at night (hs). Review of the Treatment Administration Record (TAR) for NJ Ex Order 26.4(b)(1), reflected that the nurses were signing the TAR that they applied the NJ Ex Order 26, 4B1 in the AM and removed them at hs. Review of the PO dated NJ Ex Order 26, 4B1, reflected that the resident was ordered the NJ Ex Order 26, 4B1 medication NJ Ex Order 26, 4B1 and then subsequently discontinued.	F0657	Continued from page 20 recurring issues and determine the need for continued monitoring.	10/15/2025

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F0657 SS = D	Continued from page 21 Review of the Resident #'2 Comprehensive Interdisciplinary Care Plan (ICP) dated NJ Ex Order 26, 4B1 and reviewed NJ Ex Order 26.4(, reflected that Resident #2 had NJ Ex Order 26, 4B1 output and would be free of NJ Ex Order 26, 4B1 such as NJ Ex Order 26 NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1. The ICP indicated that the resident was still on the medication NJ Ex Order 26, 4B1 and there was no documentation that the resident was to NJ Ex Order 26, 4B1 . On 9/15/2025 at 10:35 AM, Resident #2 was observed lying in bed. The resident was sleeping at this time, and the surveyor was unable to interview. The resident had NJ Ex Order 26, 4B1 on the NJ Ex Order 26.4(b)(1). The surveyor interviewed the primary care U. S. FOIA (b) (2) who stated that NJ Ex Order 26, 4B1 were applied every morning and removed at night for NJ Ex Order 26, 4B On 9/15/2025 at 10:54 AM, the surveyor interviewed the primary care U. S. FOIA (b) (2)) who stated that Resident #2 had NJ Ex Order 26, 4B1 . She reviewed the resident's ICP in the presence of the surveyor and confirmed that the ICP reflected that the resident was on an NJ Ex Order 26, 4B1 medication even though there were no orders for NJ Ex Order 26 medications. The U. S. FOI also stated that the NJ Ex Order 26, 4B1 should be on the ICP as an intervention to reduce the resident's NJ Ex Order 26 She explained that the residents ICP should be resident specific to describe a resident's condition in "real" time. The U.S. FOIA added that the U. S. FOIA (b) (2) was responsible to update residents ICPs. The U. S. FOI reviewed the resident's ICP and stated that the NJ Ex Order 26, 4B1 should be a part of the ICP, and that the resident was not on a NJ Ex Order 26 medication since starting on NJ Ex Order 26, 4 On 9/15/2025 at 11:06 AM, the surveyor interviewed the U. S. FOIA (b) (2) who reviewed Resident #2's ICP and confirmed that the NJ Ex Order 26, 4B1 should be documented on the ICP and that the ICP should have been updated to reflect that. She also confirmed that the NJ Ex Order 26 medication should have been removed from the ICP. On 9/17/2025 at 9:24 AM, the surveyor interviewed the U. S. FOIA (b) (2) who both confirmed that the ICP should have been revised and updated to include the resident's NJ Ex Order 26, 4B1 and discontinuation of the NJ Ex Order 26, 4B1	F0657		10/15/2025

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F0657 SS = D	Continued from page 22 The undated facility policy titled, "Interdisciplinary Care Plans" indicated that the care plan shall be designed to meet the resident's medical, nursing and psycho-social needs as identified in the comprehensive assessment. The ICP will be periodically reviewed and revised after each resident's annual assessment, quarterly review and upon significant change in condition. The care plan shall also be updated as warranted by a change in medication or treatments or other changes in condition. NJAC 8:39-11.2(i)	F0657		10/15/2025
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and pertinent facility documentation, it was determined that the facility failed to ensure that the resident's environment was free of possible hazards. This deficiency was identified in 1 of 2 residents (Resident #128) reviewed for accidents. This deficient practice was evidenced by the following: On 09/15/2025 at 11:20 AM, the surveyor reviewed the facility's accident investigation for Resident #128's NJ Ex Order 26, 4B1 that occurred on NJ Ex Order 26.4(b)(1). The identified contributing factor was a NJ Ex Order 26, 4B1) that failed to . Measure to prevent recurrence was notifying the maintenance department. On 09/15/2024 at 11:30 AM, the surveyor reviewed the facility's Housekeeping and Maintenance	F0689	F 689: Free of Accident Hazards/Supervision/Devices 1. (Resident 128) was affected as it was identified that the - NJ Ex Order 26, 4B1 failed to in a incident in Post incident the resident was immediately assessed for and maintenance was notified of the however it was determined the deficient practice occurred as facility could not provide work order for and a facility wide audit post incident. 2. All residents had the potential to be affected by this deficient practice. 3. Following notification of the deficient practice the new DOM immediately implemented a policy for maintenance work order sheets. The work order sheets are to be logged monthly by the DOM and will be used to track all maintenance repairs to prevent recurrence of this deficient practice. 9.17.25 - 10.10.25 the Director of Maintenance inserviced facility Department Heads on the topic- Policy & Procedure for facility work orders and Maintenance Repair Log. 4. The DOM is responsible for maintaining the Maintenance Repair Log. The work order sheets are to be recorded monthly in the Maintenance Repair log by the DOM and they will be presented to the QAPI committee for review or suggestions. The QAPI team meets quarterly, and the DOM will provide a copy of the report to the administrator and the QAPI committee. The QAPI committee will determine the need for continued monitoring.	10/15/2025

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F0689 SS = D	Continued from page 23 Request Forms for the period of NJ Ex Order 26.4(b)(1). Logs showed two work requests for [redacted] submitted by nursing: one on [redacted] and another on NJ Ex Order 26, 4B1. However, there was no maintenance request submitted or completed on [redacted] for Resident #128's [redacted] following the NJ Ex Order 26, 4B1 According to the admission record, the resident was admitted to the facility with diagnoses including, but not limited to, NJ Ex Order 26, 4B1 [redacted] A review of the resident's Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated NJ Ex Order 26, 4B1 included a Brief Interview for Mental Status (BIMS) score of [redacted], indicating NJ Ex Order 26, 4B1 [redacted] The resident's comprehensive care plan, dated [redacted] identified a focus area noting a [redacted] and the need for preventative measures to reduce the NJ Ex Order 26, 4B1. During an interview with the surveyor on 09/15/2025 at 12:10 PM, the U. S. FOIA (b) (2) [redacted] stated that Resident #128's [redacted] were used as safety devices to help prevent [redacted] and assist with NJ Ex Order 26, 4B1. She was unsure why maintenance did not complete a facility-wide audit of [redacted] after Resident #128's NJ Ex Order 26, 4B1, which involved the [redacted], to ensure all were functioning properly, noting that the U. S. FOIA (b) (2) is no longer employed at the facility. A review of a facility policy dated 04/21/2025 titled, "Quality of Life", revealed that, "All staff shall care for our residents in a manner and in an environment that promotes maintenance and enhancement of each resident's quality of life. Environment – safe, comfortable, clean, orderly, home-like, appropriate linens, sound levels, ventilation, lighting, and proper care of personal belongings." NJAC8:39-27.1(a)	F0689		10/15/2025

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F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of electronic medical records (EMR) and other pertinent facility documentation it was determined that the facility failed to document the NJ Ex Order 26, 4B1 and failed to document the administration o[redacted] on the resident's Interdisciplinary Care Plan for 1 of 1 resident (Resident #9) reviewed for NJ Ex Order 26, 4B1 and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." Review of the Face Sheet (admission summary) indicated that Resident #9 was admitted to the facility with diagnoses that included but were not limited t NJ Ex Order 26, 4B1 [redacted]	F0695	F0695: Respiratory/Tracheostomy Care and Suctioning 1. It was observed by surveyor that (Resident #9) had an order for NJ Ex Order 26, 4B1 for a diagnosis of NJ Ex Order 26, 4B1 Facility policy states that any resident with a NJ Ex Order 26, 4B1 order will have a NJ Ex Order 26, 4B1 care plan, as well as order placement on the eMAR for nursing to sign off upon administration. Following notification of the deficient practice (Resident #9's) NJ Ex Order 26, 4B1 care plan was updated by U. S. FOIA (b) (2) to include NJ Ex Ord [redacted] administration for diagnosis reflective of MDS Coding. 2. All residents had the potential to be affected by this deficient practice. A Continuous and PRN oxygen therapy audit was conducted by DON, AIT and Unit Managers on all facility residents to ensure that all oxygen administrations were documented appropriately in the eMAR and their Care Plans reflected individualized usage. 3. All nursing staff were educated by DON immediately following (Resident #9) was observed to NJ Ex Order 26, 4B1 care plan. Education was provided immediately to staff on the PRN and NJ Ex Order 26.4(b)(1) Policy. DON, Unit Managers and nursing staff will ensure care plans reflect appropriate oxygen orders upon admission and when there is any significant change. Monthly audits on residents that are ordered NJ Ex Order 26, 4B1 will continue monthly by DON and Unit Managers to ensure policies are followed and include NJ Ex Order 26 [redacted] are placed on the eMAR and frequency of NJ Ex Order 26, 4B1 is reflective on resident's care plan. 4. Resident oxygen audits will be provided to QA Committee by DON for review and recommendations for 4 months. The QAPI committee meets quarterly and will determine the need for continued monitoring.	10/13/2025

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F0695 SS = D	Continued from page 25 The quarterly Minimum Data Set (MDS) an assessment tool that facilitates a resident's care dated NJ Ex Order 26, 4B1 indicated that Resident #9 scored ar NJ Ex Orde on the Brief Interview for Mental Status (BIMS) which indicated NJ Ex Order 26, 4B1 The MDS also reflected that Resident #9 required NJ Ex Order 26, 4B1 with all aspect of NJ Ex Order 26, 4B1. On 9/11/2025 at 10:50 AM, during the initial tour, the surveyor observed Resident #9 lying in bed on NJ Ex Order 26, 4B1 by way o NJ Ex Order 26, 4B1 The surveyor was unable to interview the resident at this time because the resident was sleeping. The surveyor did not observe that the resident was NJ Ex Order 26, 4B1 or having NJ Ex Order 26,4 The surveyor reviewed the residents EMR which revealed the following information: A review of the physician's orders (PO) dated NJ Ex Order 26, 4B1 reflected a PO to administer NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1) less thar NJ Ex Orde (percent) on NJ Ex Order 26.4(b) or NJ Ex Order 26, 4B1. A review of the Medication Administration Record (MAR) dated NJ Ex Order 26.4(b) , revealed that there was no documentation that the resident was administered NJ Ex Order 26, 4B1. The surveyor also reviewed the nursing progress notes dated NJ Ex Order 26, 4B1 and there was no documentation that the resident was administered NJ Ex O On 9/15/2025 at 11:25 AM, the surveyor observed Resident #9 in the room lying in bed sleeping and received NJ Ex a NJ Ex Order 26, 4B1. The resident was not able to be interviewed at that time. On 9/15/2025 at 11:42 AM, the surveyor interviewed the U. S. FOIA (b) (2) who explained that she was new to the facility and that her previous nursing experience was from the acute care setting. The U. S. F accompanied the surveyor to the resident's room and confirmed that the resident was being administered NJ Ex Order 26, 4B1. The surveyor reviewed the MAR in the presence of the U. S. Fo and the U. S. Fo admitted that the NJ Ex O was not signed out in the MAR that the resident was receiving NJ Ex O The U. S. Fo stated that she was not familiar with the NJ Ex O regulations and did not know that the nurses were responsible to sign out in the MAR that the resident was administered NJ Ex O She also stated that she worked on NJ Ex Order 26, 4B1 and that the resident was	F0695		10/13/2025

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F0695 SS = D	Continued from page 26 NJ Ex Order 26, 4B1 and required the NJ Ex Order 26, on that day. She admitted that she applied the NJ Ex as ordered by the physician, however, did not sign it out on the MAR when she administered the NJ Ex on NJ Ex Order 26, 4B1 The surveyor reviewed the resident's MAR and progress notes dated NJ Ex Order 26, 4B1 which revealed that there was no documentation that the resident received NJ Ex O Review of the Interdisciplinary Care Plan did not reveal that Resident #9 was being administered NJ Ex O On 9/15/2025 at 11:42 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that if a resident was on NJ Ex all the time that was considered NJ Ex Order 26.4(b)(1) and would require a physician's order. She added that if Resident #9 had a PO for NJ Ex Order 26 that would indicate that the resident would only be administered the NJ Ex O if the resident needed it. The RN explained that Resident #9 was currently being treated for NJ Ex Order 26, 4B1 and needed the NJ Ex at this time. She explained that the resident had a NJ Ex Order 26, 4B for NJ Ex O and the nurses should be signing the NJ Ex out on the MAR if the resident was administered NJ Ex. The U. S. FOIA (b) (2) reviewed the MAR in the presence of the surveyor and confirmed that there were no nurse's signatures documented on the MAR that the resident was being administered NJ Ex. The U. S. FOIA (b) (2 also reviewed the residents ICP and confirmed that there was no documentation on the care plan that the resident was on NJ Ex Order 26, 4B1 On 9/17/2025 at 9:25 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that if a resident was prescribed NJ Ex O that the NJ Ex O should have been care planned and that the nurses were responsible to sign out the NJ Ex on the MAR when administered. On 9/17/2025 at 9:25 AM, the surveyor interviewed the U. S. FOIA (b) (2)) who stated that the NJ Ex Order 26 4B1 should have been care planned for Resident #9 and that the nurses were responsible to sign out the NJ Ex O when it was administered to Resident #9. The facility policy dated 4/21/25 and titled, "Oxygen Administration" indicated that documentation details of emergency, resident condition, oxygen administered, SpO2 testing and the residents' response to therapy. The facility undated policy titled, "Interdisciplinary	F0695		10/13/2025

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F0695 SS = D	Continued from page 27 Care Plans" indicated that the care plan shall be designed to meet the resident's medical, nursing and psycho-social needs as identified in the comprehensive assessment and will include measurable time frames. The care plan shall also be updated as warranted by a change in medications or treatments or other changes in condition. The resident's care plan should address needs or care and be appropriate to the individual. NJAC 8:39-19.4(a)	F0695		10/13/2025
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of the medical record and other facility documentation, it was determined that the facility failed to a.) develop an individualized comprehensive assessment and Care Plan (CP) with resident specific interventions to address [redacted] care, and b.) follow the facility policy for [redacted] care. This deficient practice was identified for Resident #37, 1 of 1 resident reviewed for [redacted] care and was evidenced by the following: Review of the resident Face Sheet (admission summary) indicated that Resident #37 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26, 4B1 [redacted]. Review of the quarterly Minimum Date Set (MDS) an assessment tool that facilitates a resident's care dated [redacted] indicated that Resident #37 had NJ Ex Order 26, 4B1 [redacted]. The MDS also indicated that the resident required [redacted] with activities of [redacted] and did not [redacted]. On 9/11/2025 at 11:15 AM, the surveyor observed Resident #37 sitting quietly in the hallway in front of the nurse's station. The resident was in [redacted], clean and dressed appropriately. The resident was unable to be interviewed due to [redacted]	F0744	F744, Behavioral Health Services – Treatment/Services for Dementia It was noted that the facility failed to develop an individualized comprehensive assessment and care plan with resident specific interventions to address [redacted] care, and follow the facility policy for [redacted] care for (Resident #37). Following the notification of the deficient practice, the interdisciplinary team immediately conducted a comprehensive reassessment to identify and address their specific NJ Ex Order 26, 4B1 needs of (Resident 37). The [redacted] care plan was reviewed, revised, individualized and new interventions were initiated. This reassessment included a review of all medications, including [redacted] drugs, for appropriateness, activity preferences and effectiveness in managing [redacted] symptoms. All residents had the potential to be affected by this deficient practice. At the time of the survey when the deficient practice was noted the IDT immediately conducted comprehensive assessments related to the dementia care planning. All dementia care plans were reviewed and updated to ensure the new interventions were person-centered and respected resident preferences. 9.17.25- 10.10.25, The [redacted] was inserviced by the DON on dementia care policy and procedure, and included training on best practices for dementia care, including identifying behavioral triggers and implementing de-escalation techniques. Dementia care plans will be reviewed by the IDT upon admission, readmission, quarterly, annually and if significant change is warranted.	10/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

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F0744 SS = D	Continued from page 28 On 9/12/2025 at 10:22 AM, the surveyor interviewed the U. S. FOIA (b) (2)) who told the surveyor that Resident #37 required assistance with NJ Ex Order 26, 4B1. The U. S. FOIA also stated that Resident #37 NJ Ex Order 26, 4B1. She explained the resident required assistance with tray set up but was able to feed themselves and did not have NJ Ex Order 26.4(b) that she was aware of. On 9/12/2025 at 10:27 AM, the surveyor interviewed the U. S. FOIA (b) (2)) who stated that Resident #37 required supervision and direction due to the resident's NJ Ex Order 26, 4B1. She stated that the resident had NJ Ex Order 26, 4B1) and NJ Ex Order 26, 4B1 at times NJ Ex Order 26, 4B1. She explained that the resident was NJ Ex Order 26.4(b) with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 She stated that the resident required NJ Ex Order 26, 4B1) at times due to being NJ Ex Order 26, 4B1. She stated that the resident was given a NJ Ex Order 26, 4B1 but not all the time. She stated that the staff would try to bring the resident to activities, but the resident at times would not participate. On 9/12/2025 at 10:34 AM, the surveyor interviewed the U. S. FOIA (b) (2)) who stated that Resident #37 had NJ Ex Order 26, 4B1 and was NJ Ex Order 26, 4B1 in the morning but NJ Ex Order 26, 4B1 in the afternoon and early evening. She stated that the resident NJ Ex Order 26, 4B1 and that they usually had to have a staff member sit with the resident. She stated that the activities department would try to read with the resident, take the resident NJ Ex Order 26, 4B1 sit with the resident, provide snacks or they would let the resident NJ Ex Order 26, 4B1 as a NJ Ex Order 26.4(b) Review of the Interdisciplinary Care Plan (ICP) revealed that there was a ICP dated NJ Ex Order 26, 4B1 with a focus on NJ Ex Order 26, 4B1. There were no resident specific interventions to demonstrate how the facility was managing the resident's NJ Ex Order 26, 4B1 associated with NJ Ex Order 26, 4B1. The interventions included the following: · Use NJ Ex Order 26.4(b)(1). · Maintain a safe environment. · Offer choices of two items. · Evaluate medication regimen.	F0744	Continued from page 28 NJ Ex Order 26, 4B1 care planning process will include that all care plans for residents with dementia are to address specific behavioral health needs, including non-pharmacological interventions. The Director of Nursing and the Director of Social Services will oversee the care plan revisions with IDT involvement. A monthly audit of a minimum of 5 resident charts will be conducted to ensure care plans for residents with dementia are complete and person centered by the Director of Social Services for 3 months. The audits will be conducted using a checklist and the findings will be reported to the facility's QAPI Committee quarterly. The committee will determine the need for continued monitoring.	10/15/2025

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F0744 SS = D	Continued from page 29 Review of the [redacted] medical evaluation dated [redacted], indicated that Resident #37 had diagnoses of [redacted]. The [redacted] lists the [redacted] as [redacted], trying to stand up from the wheelchair and [redacted] looking for his/her daughter. The [redacted] documented that these [redacted] occurred after dinner. There were no resident specific interventions documented on the ICP to address triggers or calming techniques used to manage or address the resident's [redacted] associated with [redacted]. There were no person-centered interventions documented that specifically addressed these [redacted] such as [redacted] On 9/12/2025 at 11:06 AM, the surveyor interviewed the [redacted]) of the recreation department who stated that new residents were assessed within 5 days of admission, quarterly and annually. She stated that these assessments and reviews were important to perform to assure that all residents activity needs, wants and interests were reviewed to assure that the residents were getting their [redacted] needs met. She stated that Resident #37 was encouraged to participate in sensory group activities which was held at 1:30 PM every day. This activity included music, story time and domestic chores such as folding. The [redacted] stated that she was not aware that the resident had [redacted] issues and was not sure if the staff were supposed to let her know. When the surveyor asked the [redacted] if the nurse should have told her that the resident was a [redacted] or had [redacted] in the evening, she stated that she wasn't sure. She stated that she only had access to the progress notes and didn't have access to the ICP. She stated that the [redacted]) was taking care of updating the care plan updating and the [redacted] was out on leave. She stated that if the resident was experiencing [redacted] later in the day, then it would have been important to have a ICP with interventions that were specific for the resident at the time of the day to address the [redacted] On 9/12/2025 at 11:18 AM, the surveyor interviewed the [redacted]) who was employed in the facility for [redacted]. The [redacted] stated that if Resident #37 was experiencing [redacted] such as [redacted] the staff should have been trying [redacted] approaches to manage the [redacted]. The [redacted] reviewed the activities notes and admitted that there was no documentation in the progress notes or on	F0744		10/15/2025

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F0744 SS = D	Continued from page 30 the [NJ Ex Order 26, 4B1] regarding the residents' [NJ Ex Order 26.4(b)] or any specific activities that were being offered to the resident to manage the [NJ Ex Order 26.4(b)(1)]. The surveyor asked the [U. S. FO] regarding [NJ Ex Order 26, 4B1] plans and activities care plans and the [U. S. FO] stated that all resident specific interventions related to [NJ Ex Order 26.4(b)] should have been addressed in the CP. On 9/12/2025 at 12:10 PM, the surveyor interviewed the [U. S. FOIA (b) (2)] who all confirmed that there were no documented interventions on the ICP to address activities or resident specific behavior interventions in the [NJ Ex Order 26.4(b)] care plan. On 9/16/2025 at 10:09 AM, the surveyor interviewed the [U. S. FOIA (b) (2)] who reviewed the ICP in the presence of the surveyor and stated that they "dropped the ball on that one" and there were no documented interventions to address the resident specific behaviors. The facility policy dated 4/21/2025 and titled, "Dementia Care Planning" indicated that the facility would provide person-centered, dignified and safe care for residents living with dementia. All residents with dementia will have a comprehensive care plan developed, implemented and reviewed regularly. Care planning would include a personal history and interest, communication strategies, environmental modifications, triggers and calming techniques, nutritional and hydration support and medication review and management. The policy also indicated that the facility would use non-pharmacological interventions as a first line management of behavior issues. The facility would provide meaningful engagement and activities tailored to cognitive levels and interest. Document all interventions and updates. N.J.A.C 8:39-45.1(a)	F0744		10/15/2025
F0868 SS = D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F0868	Plan of Correction for F868 Date of Survey: 9.11.25 Date of Completion: 10/10/2025 F868: Quality Assessment and Assurance (QAA) Committee All residents had the potential to be affected by the deficient practice.	10/10/2025

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F0868 SS = D	Continued from page 31 (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §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: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the [redacted] or at least one of the individuals if there is more than one [redacted] must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to a.) ensure the U. S. FOIA (b) (2) was present for quarterly Quality Assurance and Performance Improvement (QAPI) meetings, and b.) included as a member of the Quality Assessment and Assurance (QAA) Committee. This deficient practice was identified by the following: On 09/15/2025 at 12:35 PM, the surveyor interviewed the [redacted] who stated that she had worked at the facility for the past NJ Ex Order 26.4(b)(1) in her current role and had never attended a QAPI meeting. She reported that she provided infection control information to the U.S. FOIA (b) (6)), who presented it during the QAPI meetings. On 09/17/2025 at 10:14 AM, the surveyor	F0868	Continued from page 31 No residents were affected by the deficient practice. Upon inspection it was determined that the [redacted] was not present for QA Committee and QAPI committee meetings. To ensure the deficient practice will not occur again the immediate corrections were made. [redacted] was immediately in-serviced on QAPI and QA, to include the roles and responsibilities of the [redacted] Facility QA and QAPI Committee will include the IP, as well as all required members. The facility will document a consistent meeting schedule to ensure the QA and QAPI Committees meets at least quarterly. To ensure the deficient practice is being corrected and will not recur, all the required attendees including the IP will attend and sign attendance sheets for QA and QAPI meetings. The administrator will ensure compliance for the required committee attendees. The attendance sheets will be maintained in the QAPI and QA binders. The attendance sheets will be presented at the QAPI committee meetings for review and recommendations. The QAPI committee meets quarterly and will determine the need for continued monitoring	10/10/2025

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F0868 SS = D	Continued from page 32 interviewed the U. S. FOIA (b) (2) [redacted]) who stated that the U.S. [redacted] did not attend QAPI meetings and was not a member of the QAA committee. The U. S. FOIA (b) (2) [redacted]) presents infection control information during the QAPI meetings. On 09/16/2025 at 12:02 PM, the surveyor reviewed the facility's 2025 quarterly QAPI attendance sheets for meetings that were held on 01/28/2025, 04/25/2025, and 07/29/2025, as well as the list of QAA committee members. The U. S. FOIA (b) (2) [redacted] did not attend any of the QAPI meetings and was not listed as a member of the QAA committee. A review of a facility policy dated 04/01/2025 titled, "Quality Assurance and Performance Improvement (QAPI)", revealed that, "It is the policy of Rose Garden to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life and residents' choice and is based on the scope and complexity of services defined by the Facility Assessment." NJAC 8:39-33.1(a)(b)	F0868		10/10/2025
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record reviews, and a review of pertinent facility documentation, it was determined that the facility failed to consistently implement an Antibiotic Stewardship Program (ASP), a program designed to improve clinical outcomes and reduce harm by promoting the appropriate use of antibiotics and monitoring their use, in collaboration with the facility's consultant pharmacist and medical	F0881	F0881: Antibiotic Stewardship Program It was noted that the facility failed to consistently implement an NJ Ex Order 26, 4B1 Program to improve clinical outcomes and reduce harm by promoting the appropriate use of NJ Ex Order 26.4(b)([redacted] and monitoring their use, in collaboration with the facility's consultant pharmacist and medical director as the roster, provided by the IP did not include (Resident #44) who was receiving NJ Ex [redacted]. Following notification of the deficient practice the resident was added to the NJ Ex Order 26, 4B [redacted], and the facility began inservices on the updated NJ Ex Order 26, 4B1 program and use of NJ Ex Order 26.4 Criteria for compliance and to align with current clinical guidelines. All residents had the potential to be affected by the deficient practice. Facility antibiotic stewardship policy and procedures have been updated by DON and IP to include the current established NJ Ex Order 26.4(b)(Criteria for all residents on antibiotics upon admission or newly prescribed antibiotics and U.S. [redacted] and	10/09/2025

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F0881 SS = D	Continued from page 33 director. This deficiency was identified in 1 of 1 resident (Resident #44) reviewed for [redacted] use. The deficient practice was evidenced by the following: On 09/15/2025 at 1:00 PM, the surveyor reviewed the facility's monthly [redacted] roster for [redacted] which is used to monitor all residents receiving [redacted]. The roster, provided by the [redacted], did not include Resident #44, who had received [redacted] during [redacted]. According to the admission record, Resident#44 was admitted to the facility with diagnoses including, but not limited to, [redacted] A review of Resident's #44 Admission Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated [redacted], included a Brief Interview for Mental Status (BIMS) score of [redacted] indicating [redacted]. Further review of Section [redacted] revealed that the resident had received [redacted] Resident's #44 comprehensive care plan, dated [redacted], included a care area indicating that the resident was receiving [redacted] for an [redacted]. A review of Resident #44's Physician Orders (PO), dated [redacted], included an order for [redacted] to be [redacted] every [redacted] hours for a total of [redacted] doses. During an interview with the surveyor on 09/15/2025 at 12:35 PM, the [redacted] stated that, as part of her daily infection control tasks, she keeps detailed records for each resident receiving [redacted] including the type of [redacted] lab results, start and end dates, and the prescribed	F0881	Continued from page 33 nursing staff were in serviced by DON. To prevent recurrence inservicing on the updated policy and procedure was conducted by the DON 9.17.25- 10.2.25. [redacted] criteria and symptomatic line listing sheet will be documented during the initial phase of residents' illness and be provided to DON and IP by nursing staff every Friday. Documentation of indication, start date, and stop/review date will be documented in the medical record by nursing staff at the start of antibiotic therapy. A facility audit of residents on antibiotics within the last 30 days was conducted to ensure proper documentation and indication, progress notes were implemented reflecting effectiveness and response to treatment and that if antibiotic was discontinued, resident was reassessed and monitored. DON and IP will conduct weekly audits for antibiotic stewardship compliance. IP will be responsible for providing results of the audits to the QAPI committee. The QAPI committee meets quarterly and will determine need for continued monitoring. In addition, the facility implemented an Antibiotic Stewardship Committee that will meet quarterly for quality assurance.	10/09/2025

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F0881 SS = D	Continued from page 34 NJ Ex Order 26.4(b) She stated that she was not sure what specific criteria the facility uses to diagnose infections and would need to follow up to determine that information. She further stated that she is not familiar with established clinical criteria used to identify infections in long-term care facilities. During an interview with the surveyor on 09/16/2025 at 11:20 AM, the U.S. FOIA (b) (6) stated that she was unsure of the clinical criteria the facility used to identify infections. She also indicated that if Resident #44 had received NJ Ex Order 26.4B1 the resident should have been included on the NJ Ex Order 26, 4 monthly NJ Ex Order 26, 4B roster. During an interview with the surveyor on 09/16/2025 at 11:32 AM, the facility's U.S. FOIA (b) (6) stated that the facility uses the Situation, Background, Assessment, Recommendation (SBAR) form as the primary tool for tracking and managing NJ Ex Order 26.4(usage. During an interview with the surveyor on 09/16/2025 at 12:58 PM the facility's U. S. FOIA (b) (2) stated that the facility uses the Situation, Background, Assessment, Recommendation (SBAR) form as the primary tool for tracking and managing NJ Ex Order 26.4(usage. A review of the facility's policy dated 03/28/2025, titled, "Antibiotic Stewardship Policy", revealed that, "It is the policy of the facility to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The facility is committed to improving antibiotic prescribing practices and reducing inappropriate antibiotic use. A monthly infection control report will be completed, including both a quantitative and qualitative rationale for why the antibiotic was needed, the outcome of its effectiveness in treating the infection, and any associated adverse side effects." N.J.A.C. 8:39-19.4(a)	F0881		10/09/2025
F0882 SS = D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s)	F0882	F0882: Infection Preventionist Qualifications Role It was noted that the facility failed to ensure the Infection Preventionist actively performed responsibilities in accordance with the facility designated role implementing programs and	10/15/2025

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F0882 SS = D	Continued from page 35 as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure the U. S. FOIA (b) (2) actively performed responsibilities in accordance with the facility designated role implementing programs and activities to prevent and control infections. The deficient practice was evidenced by the following: During an interview with the surveyor on 09/15/2025 at 12:35 PM, the [redacted] stated that she was not sure what specific criteria the facility used for diagnosing infections and would need to follow up to determine that information. She further stated that she is not familiar with established clinical criteria used to identify infections in long-term care facilities. The [redacted] also reported that she is not involved in the facility's water management or treatment plan, explaining that those responsibilities are handled by the maintenance department. Additionally, she stated that she does not conduct regular surveillance in the kitchen or laundry areas and only enters those areas if she needs something. During an interview with the surveyor on 09/16/2025 at 11:20 AM. the NJ Ex Order 26, 4B1 [redacted] stated that she was unsure what clinical criteria the facility used to identify infections. She further stated that the [redacted] does not conduct surveillance in the kitchen or laundry areas. Instead,	F0882	Continued from page 35 activities to prevent and control infections. Following notification of the deficient practice on 9.17.25 the facility DON initiated inservicing on [redacted] criteria for the [redacted] Stewardship Program, in addition the [redacted] provided education to nursing staff on their role in infection identification, tracking and reporting to IP. IP was notified that the SBAR criteria being utilized for the past two and half years has been changed to McGreer's criteria. All residents had the potential to be affected by this deficient practice; therefore, a facility audit was conducted by the DON, and no residents were identified as [redacted] but all residents were monitored for infection-related concerns during the period of [redacted] To prevent recurrence, 9.18.25 -10.5.25 inservicing was conducted by the DON titled [redacted] criteria - the Antibiotic Stewardship Program. This included the updated policy and procedure for the Antibiotic Stewardship Program. Immediately following the survey, the Administrator and DON met with the IP for review qualifications requirements and her role in the IP program, signed inservice was conducted. The Infection Preventionist was reenrolled in an approved CMS/CDC Infection Preventionist training program for additional training. The IP is currently collaborating with Director of Dietary and Director of Housekeeping to maintain surveillance rounding to identify potential breaks in infection prevention protocols and will document findings. Administrator, and DON will ensure the designated IP is fully qualified, trained and carrying out their responsibilities. Facility wide surveillance audits conducted by the IP will be recorded and presented to the QAPI committee for compliance and quality assurance for 6 months. In addition, the facility implemented an Antibiotic Stewardship Committee that will meet quarterly for quality assurance. The QAPI Committee meets quarterly and will determine the need for continued monitoring.	10/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GARDEN NURSING AND REHABILITATION CENTER	1579 OLD FREEHOLD ROAD , TOMS RIVER, New Jersey, 08753

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F0882 SS = D	Continued from page 36 she does weekly rounds throughout the facility every Monday with the Maintenance Director. A review of the facility's policy dated 03/28/2025, titled, "Infection Control Rounds", revealed that, "the objective of infection control round is to evaluate compliance with infection control policies and procedures throughout the facility, and data collected during rounds shall be utilized for educating staff and improving resident care and facility practices." NJAC 8:39-19.1(b)	F0882		10/15/2025
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F0883	Plan of Correction for F883 Date of Survey: 9.11.25 Date of Completion: 10/10/2025 F883: Influenza and Pneumococcal Immunizations 1. 1 resident was affected, the Infection Preventionist immediately reviewed the records of the affected resident to confirm NJ Ex Order 26.4(b)(1). The identified resident was no longer in the facility to offer NJ Ex Order 26.4(b)(1). 2. All residents had the potential to be affected by the deficient practice. The Director of Nursing and IP conducted an audit of all current residents' medical records to verify that all residents were offered or received the influenza and pneumococcal immunizations according to federal and state regulations. Any resident identified as not having been offered the vaccination, a licensed nurse immediately contacted the resident/or their representative to offer the immunization. 3. The facility's admission procedure has been revised to include a mandatory step for obtaining or offering influenza and pneumococcal immunizations upon admission. This process ensures that residents receive information and are offered vaccinations promptly. All nursing including U.S. and U.S. FOIA (b) (6) were in-serviced on the updated immunization policy, including proper documentation of offers, consents, and declinations.	10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

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F0883 SS = D	Continued from page 37 that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the [redacted] was offered to all residents upon admission to the facility to prevent incidence of [redacted] for 1 of 5 residents (Resident # 87) reviewed for [redacted] administration. This deficient practice was evidenced by the following During the initial tour of the facility on 09/11/2025 at 10:21 AM, Resident #87 was observed seated in a wheelchair in their bedroom. A review of Resident #87's Admission Record revealed that the resident was admitted to the facility with diagnosis which included, but were not limited to, [redacted] A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had	F0883	Continued from page 37 A new tracking system was implemented to monitor each resident's immunization status. 4. For the next three months, the IP will conduct a monthly audit of all new admissions to ensure the required immunization consent/declination process is followed and properly documented. The results of the monthly audits will be reviewed by the facility's QAPI Committee on a quarterly basis to identify any further issues and determine the need for continued monitoring. The QAPI committee will determine the need for continued monitoring.	10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

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F0883 SS = D	Continued from page 38 a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's [redacted]. Further review of the MDS identified under Section [redacted] that the [redacted] was offered but [redacted]. A review of Resident #87's Immunization Consent form, dated [redacted], identified under [redacted] (checked) "I do want [resident name] to be given the [redacted]". When the surveyor requested a printed copy of [redacted] form, it was observed that a handwritten year was entered into the line that stated: "[Blank] has received the [redacted] previously on [redacted] which was not identified in the electronic medical record. A review of Resident #87's Nursing [redacted] Record form, created on [redacted] and completed on [redacted], identified under [redacted]: "Is the resident's [redacted] up to date?" and "Yes" is checked. On 9/16/2025 at 9:18 AM, during an interview with the surveyor, the [redacted] advised that she was responsible for overseeing the [redacted] consents. When asked for documentation of Resident #87 [redacted] the [redacted] responded that the resident was admitted for [redacted] and that the [redacted] is only admitted to long term care residents. On 9/12/2025 at 9:54 AM, during an interview with the surveyor the [redacted] confirmed that all residents, both [redacted] and [redacted] should be offered the [redacted] and that it was one of the questions asked during admission. On 9/12/2025 at 11:26 AM, during an interview with the surveyor the [redacted], in the presence of the [redacted] confirmed that all residents, both [redacted] and [redacted] should be offered the [redacted]. A review of the undated facility provided document "Prevention and Control of Nosocomial Pneumonia Pneumococcal Vaccine" revealed the following: The facility shall offer the pneumococcal vaccine to every resident upon admission who has not had the vaccine unless medically contraindicated or refused by the resident […] Consent or refusal for the initial and second shall be signed by the resident or family member after receiving documented education on the risks and benefits of the vaccination.	F0883		10/10/2025

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F0883 SS = D	Continued from page 39 NJAC 8:39-19.4 (h) (i)	F0883		10/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061511	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		11/16/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 2-day shifts reviewed, as evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents	S0560	Plan of correction for S560 Date of Survey: 9.11.25 Date of Completion: 10.14.25 S560, Mandatory Access to Care During survey it was identified that the facility did not maintain the minimum direct care staff-to resident ratios as mandated by the state of NJ for 2-day shifts. All residents had the potential to be affected by the deficient practice. The DON, administrator and staffing coordinator met to review mandatory staff-to resident ratios, adjusting staffing assignments for all shifts to ensure sufficient nursing personnel are on duty to meet the residents' needs. The staffing assignments will be completed by the staffing coordinator and signed off by the DON. The facility will Implement an aggressive recruitment plan, which includes increased utilization of staffing agencies, hiring bonuses, employee referral programs, and market-based wage adjustments. Revise the staff scheduling process by implementing	10/14/2025

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

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S0560	Continued from page 1 for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of staffing prior to survey from 08/24/2025 to 09/06/2025, the facility was deficient in CNA staffing for residents on 5 of 14-day shifts, was deficient in CNAs to total staff on 2 of 14-day shift. -08/24/25 had 8 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/31/25 had 10 CNAs for 117 residents on the day shift, required at least 15 CNAs. -08/31/25 had 7 CNAs to 18 total staff on the evening shift, required at least 9 CNAs. -09/01/25 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -09/01/25 had 7 CNAs to 18 total staff on the evening shift, required at least 9 CNAs. -09/03/25 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -09/06/25 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. 2. For the 2 weeks of AAS-12 staffing prior to survey there were no deficient practices identified for staffing as submitted. During an interview on 09/17/2025 at 10:14 AM, the Assistant Licensed Nursing Home Administrator (ALNHA) stated that the facility is meeting staffing requirements. The ALNHA acknowledged that maintaining adequate staffing can be challenging, noting that some days are better than others. Staffing levels are determined based on the daily census and the acuity of resident needs. Staffing evaluations are conducted every shift and reassessed daily to ensure that coverage remains	S0560	Continued from page 1 oversight via the DON over the staffing coordinator to ensure the facility maintaining mandatory staffing ratios. Reinforce the policy for staff callouts, including a protocol for notifying unit managers and the DON to secure replacement staff or re-prioritize resident care tasks to ensure safety Conduct an in-service for all nursing staff (RNs, LPNs, and CNAs) on the importance of adhering to the call-out policy and the standards for sufficient staffing. 4. The DON will perform daily audits of the staffing schedule to confirm adequate coverage for all shifts based on census and resident acuity. Issues identified will be addressed immediately. The QAPI committee will review staffing data, including audit results and recruitment progress, monthly for at least six months. The QAPI team meets quarterly, the committee will determine the need for continued monitoring.	10/14/2025

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S0560	Continued from page 2 appropriate as resident conditions or census levels change. The ALNHA also confirmed that any increase in census or acuity is considered, and staffing is adjusted accordingly when indicated. A review of a facility policy dated 04/21/2025 titled "Resident Care Staffing", revealed that, "The staffing will include current resident census to reflect the number of residents in the facility at the start of each shift."	S0560		10/14/2025

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/18/2025 in relation to the 9/18/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		02/06/2026

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061511	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/18/2025 in relation to the 9/18/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		02/06/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ROSE GARDE... B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

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K0000 Bldg. 02	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 9/11/2025 and 9/12/2025 and Rose Garden Nursing and Rehabilitation was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Rose Garden Nursing and Rehabilitation Center is a 2-story building that was built in 2005. It is composed of Type II Protected Construction. The facility is divided into 4- smoke zones. The facility has one 450 KW (Kilowatt) Natural Gas Emergency Generator which currently serves approximately three quarters of the facility according to the U. S. FOIA (b) (2). The census was 117 out of 128 beds at the time of survey.	K0000		01/06/2026
K0521 SS = F Bldg. 02	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 interview on 9/11/2025 in the presence of U. S. FOIA (b) (2) [redacted]), it was determined that the facility failed to maintain the Packaged Terminal Air Conditioner (PTAC) units in a safe and optimal condition. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0521	Plan of Correction for K521 Date of Survey: 9.17.25 Date of notification of deficient practice: 11.2.25 Upon annual inspection it was noted that the facility failed to maintain the Packaged Terminal Air Conditioner (PTAC) units in safe and optimal condition. This deficient practice had the potential to affect all residents. All noted units from annual survey have been prioritized for cleaning and the noted units were cleaned by 11.15.2025. The facility was notified of the deficient practice on 11.2.2025, immediately following the notification of the deficient practice, the maintenance team	11/20/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ROSE GARDE... B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

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ROSE GARDEN NURSING AND REHABILITATION CENTER	1579 OLD FREEHOLD ROAD , TOMS RIVER, New Jersey, 08753

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K0521 SS = F Bldg. 02	Continued from page 1 An observation at 10:10 AM in room 208 revealed the PTAC units filter was fully clogged with dust and debris. Further observations during the Life Safety Tour from approximately 9:50 AM to 1:00 PM revealed all 33 resident room PTAC units located on the second floor were clogged with dust and debris. In an interview, the [redacted] stated that the filters were on a quarterly cleaning schedule but was uncertain if it had been performed by the former [redacted] The [redacted] stated he had not cleaned the filters as he had just begun the position in August. No cleaning schedules were provided. The [redacted] and the [redacted] were asked if they agreed all filters viewed were clogged, each confirmed the observations. The facility' [redacted] were notified of the deficient practice during the Life Safety Code exit conference on 9/12/2025 at 12:30 PM. N.J.A.C 8:39-31.2 (e)	K0521	Continued from page 1 members were inserviced on 11.3.2025 by the administrator on the updated procedure for maintaining and cleaning facility PTAC units whereas the facility will adhere to the manufacturer's recommendations for optimal performance. The washable filters are to be cleaned no later than 60 days. PTAC unit log was created for quality assurance and to ensure the deficient practice does not recur. The electric units used will follow the same schedule. The Director of Maintenance will be responsible for maintaining the cleaning schedule. The Director of Maintenance will present the PTAC cleaning logs to the QAPI committee for a minimum of 6 months. The QAPI committee meets quarterly they will review for compliance, make any recommendations, and will determine the need for continued monitoring.	11/20/2025
K0531 SS = F Bldg. 02	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	K0531	Facility Response Request for a TLW for K531: Rose Garden Nursing and Rehabilitation is requesting that a waiver be granted until 1.31.2026 for annual elevator inspection, due to the shortage of NJ inspectors. Rose Garden has confirmation from the DCA that annual inspection will be conducted on 12.22.25, in addition the facility elevator vendor confirmed they will also be present. Prior to annual survey the DOM and facility vendor had reached out to the state to coordinate the facilities annual inspection, however the vendor was told Rose Garden was already scheduled for the month of December and due to the NJ requirement, a state inspector be present they were not able to make any schedule changes or even give a date in December as to when the inspection would occur. On 12.2.25 the facility Assistant Administrator contacted the DCA leaving a message related to the ongoing scheduling issues and recent life safety	12/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ROSE GARDE... B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GARDEN NURSING AND REHABILITATION CENTER	1579 OLD FREEHOLD ROAD , TOMS RIVER, New Jersey, 08753

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K0531 SS = F Bldg. 02	Continued from page 2 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 9/11/2025 and 9/12/2025 in the presence on the U. S. FOIA (b) (2) [redacted] it was determined that the facility failed to ensure that elevators were inspected, tested and maintained in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A 17.1/CSA B 44, Safety Code for Elevators and Escalators and NFPA 101:2012 Edition, Sections 19.5.3, 9.4, 9.4.2, and 9.4.6. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review during the Life Safety Tour on 9/11/2025 at 12:09 PM, revealed that the last Annual inspection of 2 of 2 elevators took place on 12/5/2022. In an interview with the U. S. FOIA (b) (2), it was confirmed that an annual certificate of compliance for 2023, 2024 or 2025 could not be produced for the elevators that serve the Healthcare unit. The facility's U. S. FOIA (b) (2) [redacted] were notified of the deficient practice during the Life Safety Code exit conference on 9/12/2025 at 12:30 PM. N.J.A.C 8:39-31.2 (e) ASME A 17.1/CSA B 44	K0531	Continued from page 2 results. On 12.3.2025, the call was returned and the email for supervisor assigned to Ocean County region and the supervisor was provided. The supervisor was contacted and was able to assist the facility in coordinating a date for a state inspector to meet with facility vendor. On 12.3.2025, the facility was notified of the 12.22.25 inspection date via phone and email (see attachment). Rose Garden continues to have a preventative maintenance plan with the facility elevator vendor that includes the annual state inspection in addition to 2 independent inspections by the vendor per year for quality assurance. The facility elevators were inspected on 1.22.2025 and 3.27.2025 by the vendor (inspection reports/results are attached). The facility DOM will remain in contact with elevator vendor for any potential changes in scheduled date with the DCA and will be responsible to schedule the 2026 annual inspection. 12.22.2025, the elevators are scheduled to have the required annual inspection. The DOM will be responsible for following up with the DCA and elevator vendor. The 12.22.2025 report will be maintained by the DOM for quality assurance. The DOM will provide a copy of the results of the annual elevator inspection to the Administrator and the QAPI committee. The QAPI committee meets quarterly and will determine the need for continued monitoring. Plan of Correction: During annual inspection it was it was noted that the facility failed to ensure that elevators were inspected, tested and maintained in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A 17.1/CSA B 44, Safety Code for Elevators and Escalators and NFPA 101:2012 Edition, Sections 19.5.3, 9.4, 9.4.2, and 9.4.6. This deficient practice had the potential to affect all	12/01/2025

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K0531 SS = F Bldg. 02		K0531	Continued from page 3 residents. The facility has a preventive maintenance contract with a licensed elevator service provider that remains active and includes scheduled inspections and maintenance in accordance with New Jersey code requirements. The facility continues to have 2 preventative maintenance inspections annually which were conducted on 1.22.25 and 3.27.25. The licensed elevator service provider was contacted prior to survey with the earliest projected elevator inspection of 12.22. 2025 as the delay of inspections remains statewide due to shortages with NJ inspectors who must conduct the inspection with the individual facility vendors and NJ does not permit for long term care facilities to hire independent auditors. The DCA was contacted and confirmed that an NJ inspector will be avail for 12.22.2025 annual inspection along with the facilities elevator provider. The DOM will continue to maintain communication with licensed elevator service provider for scheduled elevator inspections and document dates of completion for quality assurance. The inspection results will be provided by the DOM to the administrator and QAPI committee, the QAPI committee meets quarterly and will determine the need for continued monitoring. Facility has requested a waiver.	12/01/2025
K0741 SS = F Bldg. 02	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.	K0741	Plan of Correction for K741 Date of Survey: 9.11.25 Date of notification of deficient practice: 11.2.25 During annual survey it was noted that the facility failed to ensure that metal containers were readily available to all areas where smoking was permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. This deficient practice had the potential to affect all residents. Following the notation from life safety during survey in September, the facility immediately purchased commercial steel outdoor, standing cigarette containers with inner barrels made of high-quality galvanized steel, fireproof, rustproof, rainproof, that are corrosion resistant suitable for all kinds of	11/15/2025

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K0741 SS = F Bldg. 02	Continued from page 4 (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: Based on observation and interview on 9/11/2025 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to ensure that metal containers with self-closing cover devices were readily available to all areas where smoking was permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:30 AM within the smoking courtyard revealed that facility provided ashtrays to the staff smoking area but failed to ensure that metal containers with self-closing cover devices were readily available. In an interview at 11:35 AM, U. S. FOIA (b) (2) confirmed the observation. The facility's U. S. FOIA (b) (2) [redacted] were informed of the deficient practice during the Life Safety Code exit on 9/12/2025 at 12:30 PM. N.J.A.C 8:39-31.2 (e)	K0741	Continued from page 4 weather. The metal top and metal opening is for cigarettes, and cigars only. The container has metal barrels for safe disposal. The containers have been installed in the designated outdoor smoking area. The previous containers were removed from the designated smoking areas. Following notification of deficient practice on 11.2.25, the maintenance team was educated/inserviced on the type of smoking containers that can be utilized in the designated smoking areas by the administrator on 11.3.2025. The DOM created a Monthly log to check smoking containers in the designated smoking area for quality assurance for a minimum of three months. The log will be provided to the QAPI team. The QAPI committee meets quarterly they will review for compliance, make any recommendations, and will determine the need for continued monitoring.	11/15/2025
K0761 SS = F Bldg. 02	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient	K0761	Plan of Correction for K761 Date of Survey: 9.17.25 Date of notification of deficient practice: 11.2.25 During annual inspection it was noted that the facility failed to ensure that fire door assemblies were inspected, tested, and maintained (ITM) annually in accordance with NFPA 101:2012 Edition,	12/12/2025

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K0761 SS = F Bldg. 02	Continued from page 5 rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on documentation review and interview on 9/11/2025 and 9/12/2025 in the presence of the U. S. FOIA (b) (2) , it was determined that the facility failed to ensure that fire door assemblies were inspected, tested, and maintained (ITM) annually in accordance with NFPA 101:2012 Edition, Sections 7.2.1.15 and the minimum requirements of NFPA 80:2010 Edition, Section 5.2.1 and 5.2.4.2 (1) - (11). This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 9/12/2025 revealed that annual fire door assemblies' inspections and functional testing performed by individuals who can demonstrate knowledge and understanding of the operating components and the minimum requirements of NFPA 80 were not conducted. In an interview with the U. S. FOIA (b) (2) the findings were confirmed. The facility' U. S. FOIA (b) (2) were informed of the deficient practice during the Life Safety Code exit conference on 9/12/2025 at 12:30 PM. N.J.A.C. 8:39-31.2(e) NFPA 80	K0761	Continued from page 5 Sections 7.2.1.15 and the minimum requirements of NFPA 80:2010 Edition, Section 5.2.1 and 5.2.4.2 (1) - (11). This deficient practice had the potential to affect all residents. Following notification of the deficient practice on 11.2.2025 the following interventions were implemented, the facility policy titled- Annual Inspection of Fire Door Assembly was updated and all door assemblies were coded/identified. 11.3.2025, the maintenance team was educated by the administrator related to the requirements for fire door assemblies, including frames and hardware, should be inspected and tested, and that all deficiencies must be corrected without delay. To prevent recurrence, the facility has scheduled inspection via specialist/vendor for door safety and security for compliance on 11.19.2025. The vendor conducted the inspection and will be scheduled annually thereafter. The Fire Door Assembly Log was created, and all fire door assemblies have been inspected, coded/labeled by the director of maintenance and vendor. The vendor inspections and the annual fire door assemblies log will be presented by the maintenance director to the QAPI committee for quality assurance. The maintenance director will be responsible for maintaining the log annually thereafter for compliance. The QAPI committee meets quarterly and will determine the need for continued monitoring.	12/12/2025
K0914 SS = F Bldg. 02	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing	K0914	Plan of Correction for k914 Date of Survey: 9.11.25 Date of notification of deficient practice: 11.2.25	11/26/2025

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K0914 SS = F Bldg. 02	Continued from page 6 Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on documentation review and interview on 9/11/2025 and 9/12/2025 in the presence of the U. S. FOIA (b) (2) it was determined that the facility failed to ensure non-hospital grade outlets in patient care rooms were tested annually in accordance with NFPA 99:2012 Edition, Section 6.3.3, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect all residents and was identified by the following: In an interview during the Life Safety tour on 9/11/2025, the U. S. FOIA (b) (2) were asked if they performed a non-hospital grade receptacle functionality test annually, neither U. S. FOIA (b) (2) were aware of the test requirement. A documentation review on 9/12/2025 revealed there was no documentation indicating the functionality test had been performed. In an interview, the U. S. FOIA (b) (2) confirmed the findings. The U. S. FOIA (b) (2) were informed of the deficient practice during the Life Safety Code exit conference on 9/12/2025 at 12:30	K0914	Continued from page 6 During annual survey it was determined that the facility failed to ensure non-hospital grade outlets in patient care rooms were tested annually in accordance with NFPA 99:2012 Edition, Section 6.3.3, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect all residents. Following the noted concern during annual survey in September, the following interventions were implemented so the deficient practice would not recur. The facility immediately purchased a receptacle tension tester for quality assurance. When the facility was notified of the deficient practice on 11.2.2025, the maintenance team was inserviced by the administrator on 11.3.2025 on the updated facility policy titled- Annual inspection of non-hospital grade outlets in Patient Care Rooms. A log was created by the DOM to document the testing and results of all non-hospital grade outlets for compliance, and all outlets will be inspected and logged by 11.21.25. The maintenance director is responsible for maintaining the log and ensuring annual inspections are conducted by maintenance team members. The log will be provided to the QAPI team for quality assurance and compliance. The QAPI committee will make recommendations if needed and determine the need for continued monitoring.	11/26/2025

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K0914 SS = F Bldg. 02	Continued from page 7 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K0914		11/26/2025
K0921 SS = F Bldg. 02	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 9/11/2025 and 9/12/2025 in the presence of the U. S. FOIA (b) (2) [redacted] it was determined that the facility failed to ensure that patient care related electrical equipment (PCREE) was inspected, tested, and maintained (ITM) in accordance with NFPA 99:2012 Edition, Chapter 10. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview on 9/11/2025 at 10:25 AM, the U. S. FOIA [redacted] was asked if the facility performed an annual PCREE	K0921	Plan of Correction for K921 Date of Survey: 9.17.25 Notification of Deficient Practice: 11.2.25 It was determined that the facility failed to ensure that patient care related electrical equipment (PCREE) was inspected, tested, and maintained (ITM) in accordance with NFPA 99:2012 Edition, Chapter 10. This deficient practice had the potential to affect all residents Following notification of the deficient practice on 11.2.2025 the following interventions were implemented to ensure the deficient practice did not recur, on 11.3.2025, maintenance staff were educated and inserviced by the administrator on the Policy and Procedure for (PCREE) inspections through a comprehensive equipment management program. The program includes scheduling regular inspection, documenting maintenance activities, ensuring compliance with regulations, and training staff on proper equipment usage and reporting procedures. The facility is to ensure all equipment used for patient care is safe, functional, and complain with regulatory requirements. Vendor was hired and conducted (PCREE) inspections on 11.18.25. The DOM will log (PCREE) inspections for quality assurance, any Issues identified will be addressed immediately. The (PCREE) inspection log will be submitted to the QAPI team quarterly for a minimum of 6 months. In addition the vendor was scheduled for 2026 inspections for quality assurance. The QAPI team meets quarterly, the committee will determine the need for continued monitoring.	11/23/2025

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K0921 SS = F Bldg. 02	Continued from page 8 testing. The [U.S. FOIA] stated he was unaware of the requirement. A documentation review on 9/12/2025 confirmed that an annual PCREE testing had not been performed by the facility. In an interview, the [U.S. FOIA (b) (6)] confirmed the document review. The [U. S. FOIA (b) (2)] were notified of the deficient practice during the Life Safety code exit conference on 9/12/2025 at 12:30 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K0921		11/23/2025

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 9/11/2025 and 9/12/2025. The facility was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		01/06/2026

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

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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
K0000 Bldg. 02	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 1/7/2026 in relation to the 9/17/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. The facility had a time-limited waiver for K531 that expired on 1/31/2026.	K0000		02/11/2026

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