STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE , LAKEWOOD, New Jersey, 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint #: 2609208 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). Survey Dates: 03/18/26 to 03/20/26 Survey Census: 187 Sample Size: 40 Supplemental Residents: 7 The facility was found to not be in substantial compliance with 42 CFR 483 subpart B, for Long Term Care facilities based on this Recertification and Complaint visit.	F0000		04/04/2026
F0880 SS = F	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	F0880	The staff member observed removing gloves without performing hand hygiene was immediately re-educated on 3/19/2026 on proper hand hygiene practices per CDC guidelines. Hand hygiene was performed following education, and competency was validated by Infection Preventionist. A facility-wide review was conducted starting 3/20/26 to ensure compliance across all shifts and departments. All staff from all departments were observed by Infection Preventionist for compliance with proper glove removal and hand hygiene practices. This was concluded by 4/10/2026. 100% Compliance was achieved. In future, any staff identified with improper technique will be re-educated and competency validated by Infection Preventionist. Root cause analysis determined the deficient practice was related to a break in adherence to hand hygiene protocol following glove removal, influenced by task-oriented workflow and staff response to	05/01/2026

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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F0880 SS = F	Continued from page 1 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP	F0880	Continued from page 1 observation. Additionally, the workflow design required staff to move away from the point of task completion to remove PPE and perform hand hygiene, creating a gap in immediate hand hygiene and PPE removal sequencing. Interventions include: The workflow in the laundry department was redesigned by the Infection Preventionist in collaboration with the Director of Laundry Services to ensure appropriate PPE removal and immediate hand hygiene at the pint of task completion as follows: Infection Preventionist placed Trash receptacle adjacent to washers to allow immediate glove/PPE disposal Hand sanitizer installed by maintenance director at washer location to ensure hand hygiene occurs immediately after glove removal Infection Preventionist implemented PPE donning/doffing signage, including required hand hygiene steps. Signage provided in Spanish to support staff understanding and compliance Infection Preventionist Reinforced proper sequence: Task → PPE removal → Hand hygiene Facility-wide education and competency validation was conducted starting 3/20/2026 and concluded on 4/10/2026 by the Infection Preventionist with support from Department Managers. Educator conducted in services starting 3/20/2026 to review the key components of F tag F880 and completed on 4/30/2026 The Infection Preventionist or designee will conduct hand hygiene audits with focus on post-glove removal compliance: - 15 audits per week for 4 weeks - 30 audits Monthly thereafter Results will be documented and reported at Quality Assurance Performance Improvement meetings. Staff found non-compliant will receive immediate re-education and follow-up competency validation.	05/01/2026

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F0880 SS = F	Continued from page 2 and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure laundry staff performed hand hygiene immediately after removing personal protective equipment (PPE) worn while handling soiled linen prior to contacting clean laundry equipment and areas. This failure had the potential for contaminated hands to transfer pathogens from soiled linen to clean linen, equipment, and environmental surfaces, placing residents at risk for the development and/or transmission of infections. The facility housed a high-risk population with a census of 187 residents. Findings include: During a tour of the laundry area with the Laundry Manager (LM) on 03/19/26 at 7:38 AM, Laundry Technician (LT) 1 was observed transporting a commercial laundry cart containing soiled washable bed pads and mechanical lift slings, filled above the rim, from the soiled laundry area to the washer. LT1 donned disposable PPE and loaded the items into a front-loading washing machine. After loading approximately two-thirds of the contents, LT1 closed the washer door and started the machine. LT1 then pushed the soiled laundry cart back into the soiled laundry area, removed gloves, gown, and mask, and exited the soiled area. Without performing hand hygiene, LT1 proceeded into the clean laundry area, retrieved a clean laundry cart, and pushed the cart toward a dryer, touching clean equipment and surfaces. During an interview on 03/19/26 at 7:44 AM, the LM stated the proper process after handling soiled laundry included, removing PPE (gloves first, followed by gown and mask) and performing hand hygiene immediately afterward. The LM acknowledged LT1 did not perform hand hygiene after removing PPE. The LM immediately redirected LT1 to wash his/her hands. LT1 initially continued handling the clean laundry cart before stopping and performing hand hygiene after repeated instruction. The LM stated failure to perform hand hygiene after handling soiled laundry created a risk of contamination from dirty to clean areas. During an interview on 03/19/26 at 8:21 AM, the Infection Preventionist (IP) stated the facility follows the Centers for Disease Control (CDC) infection control guidelines, including standard precautions	F0880		05/01/2026

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F0880 SS = F	Continued from page 3 and hand hygiene. The IP stated that failure to perform hand hygiene after handling soiled laundry placed all residents at risk for cross-contamination. Review of an in-service sign-in sheet titled, "PPE – Donning, Doffing, Hand Hygiene and Respiratory Illness," dated 02/20/26, included LT1's name and signature. Review of a "Hand Hygiene Competency Validation," dated 02/20/26 confirmed LT1 demonstrated proper hand hygiene with soap and water, and it was validated by the LM. Review of the facility's policy titled, "Departmental (Environmental Services) - Laundry and Linen," reviewed and updated 10/2025, indicated, ". . . General Guidelines. Standard Precautions. (2) Wash hands after handling soiled linen and before handling clean linen. . . (3) Consider all soiled linen to be potentially infectious and handle with standard precautions. . . . 12. Wash hands before handling clean linen (i.e., when moving from washer to dryer, moving from dryer to sorting table, and through the sorting process). . ." Review of the facility policy titled, "Personal Protective Equipment," reviewed 09/2025, indicated, ". . . staff are trained on proper PPE use, including donning, doffing, and associated infection control practices. . ." NJAC 8:39-19.4	F0880		05/01/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform	F0578	[redacted] reviewed the [redacted] e option and provided education to R95 as signed by the resident on the [redacted] Questionnaire on [redacted]. [redacted] reviewed [redacted] education to R201 and [redacted] provided [redacted] education via a printout to discuss creating an [redacted] and provide an opportunity to do so on [redacted]. A Quality Assurance Performance Improvement project was created on 3/20/2026 for the Social Services Department to review and document Advance Directive Education to resident and/or responsible party within 48 hours of admission within the baseline Care Plan. All residents have the potential to be affected. An Audit was conducted to review NJ Polst status for	04/30/2026

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F0578 SS = D	Continued from page 4 and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure residents were informed of and provided written information, upon admission, regarding their right to formulate [NJ Exec Order 26 redacted] for two residents (Residents (R) 95 and R201) of five reviewed for [NJ Exec Order 26.4b1] out of a total sample of 40 residents. This deficient practice placed residents at risk for more than minimal harm by limiting their ability to make informed decisions and communicate their healthcare preferences, including [NJ Exec Order 26.4b1] treatment, in the event they are [NJ Exec Order 26.4b1]. Findings included: 1. Review of R95's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR) revealed R95 admitted to the facility on [NJ Exec Order 26 redacted]. Review of R95's "Resident Header" did not reflect an [NJ Exec Order 26.4b1]. Review of R95's Quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of [NJ Exec Order 26 redacted] and located under the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated	F0578	Continued from page 4 residents that declined Advanced Directives at time of Admission. Root cause analysis determined the deficient practice was related to the system Social Services has in place. Social Services uses an education printout attached to a questionnaire regarding the creation of an Advance Directive and if the residents already have one in place. The deficient practice found was the timely manner the Advance Directive was being educated and reviewed with the residents and/or family members as well as the documentation aspect supporting it. To combat this issue we plan to create an Advance Directive section in the Baseline Care Plan Assessment to ensure education and discussion of Advance Directives are documented and completed in a timely manner, within 48 hours after Admission. Documentation will include education provided, materials given, and the Resident's decision with creating an Advance Directive. Interventions include: - Implementing a time frame and the need to document after educating the resident and/or family member on the Advance Directive Education as discussed in Quality Assurance Performance Improvement 3/20/2026. - Social Services Department education and competency in-service completed 3/20/2026. A Quality Assurance Performance Improvement plan will be developed to address the deficient practice. The SW will audit the medical record of 5 residents per week for four weeks and 5 records in the following two months to validate that Advance Directive education was provided to the resident/representative in a timely manner and documented appropriately. The results of these audits will be reported to the Quality Assurance Performance Improvement meetings monthly for the next 3 months to ensure the on-gong improvement in this practice.	04/30/2026

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F0578 SS = D	Continued from page 5 NJ Exec Order 26.4b1 A NJ Exec Order 26.4b1 MDS" was completed on R95 previously had a BIMS of out of 15, which indicated NJ Exec Order 26.4b1. Review of R95's "Care Plan," initiated NJ Exec Order 26. indicated, ". . .I have requested that NJ Exec Ord are to be NJ Exec Order 26.4b NJ Exec Order 26.4b1 with an intervention stating, "Please follow my instructions as detailed on my NJ Exec Order 2 . ." Review of the "Misc," tab, located in the EMR, did not reveal a "NJ Exec Order 26.4b1 or other NJ Exec Order 26.4b1 documentation specifying R95's healthcare wishes. There was no evidence to indicate the facility informed R95 of or provided written information regarding NJ Exec Order 26.4b1 upon admission. 2. Review of R201's "Admission Record," located under the "Profile" tab in the EMR, revealed R201 admitted to the facility on NJ Exec Order 26. Review of R201's "Resident Header" did not reflect an NJ Exec Order 26.4b1. Review of R201's "Care Plan," initiated NJ Exec Order 26 indicated, "I have requested that NJ Exec Order 26.4b1 are to be NJ Exec Order 26.4b1 " with an intervention stating, "Please follow my instructions as detailed on my NJ Exec Order 2 . ." Review of the "Misc," tab, located in the EMR, did not reveal a NJ Exec Order 26.4b1 " or other NJ Exec Order 26.4b1 documentation specifying R201's healthcare wishes. During an interview on 03/19/26 at 1:54 PM, R201 stated a preference for NJ Exec Order 26.4 NJ Exec Ord and reported he/she was not provided with information or resources regarding NJ Exec Order 26.4b1 upon admission. During an interview and record review on 03/20/26 at 9:56 AM, Licensed Practical Nurse Unit Manager (LPNUM) 4 stated the admission nurse is responsible for discussing resident preferences regarding life-sustaining treatment during the admission process and documenting those preferences on the POLST form. LPNUM4 stated the POLST must be signed and dated by the resident or representative and the physician to be valid. Review of R95's and	F0578		04/30/2026

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F0578 SS = D	Continued from page 6 R201's medical records with LPNUM4 confirmed the absence of completed [NJ Exec Order] forms or other [NJ Exec Order 26.4b1] documentation for both residents. Review of the facility's policy titled, "Advance Directive Policy and Procedure," last reviewed 09/2025, indicated: ". . .The resident has the right, and the facility will assist the resident to formulate an advance directive at their option. The facility will inform and provide residents with a written description of the facility's policy to implement advance directives. . ." NJAC 8:39-4.1(a)	F0578		04/30/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days	F0582	The Notice of Medicare Non-coverage that was provided at the time of being issued was reviewed. All residents have the potential to be affected. Root cause analysis determined the deficient practice was related to the system Social Services has in place. Social Services issues a Notice of Medicare Non-Coverage as discussed with the ODT team to initiate. When doing so, Social Services provides the Notice of Medicare Non-Coverage within 48-hour notice of the Last Covered Date of services. The issued Beneficiary Notification is discussed in detail, explaining the service/s ending, as well as the appeal process for the resident to decide after knowing all their options. Documentation was lacking as per this resident [NJ Exec Order 26.4b1] with a [NJ Exec Order 26.4b1] BIMS score but has [NJ Exec Order 26.4b1] and can be [NJ Exec Order 26.4b1] Resident's family member was made aware but lacked the documentation to support it. Therefore, for future implementation Social Services will document and review the BIMS scores of each resident when issuing a NOMNC. Interventions include: - Implementing a time frame of 48 hours' notice of the Beneficiary Notification issued. -The need to document after making the family aware and sending out the Beneficiary Notice via certified mail to the family member when required - Social Services Department education and competency in-service completed 3/20/2026	04/30/2026

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F0582 SS = D	Continued from page 7 prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure NJ Exec Order 26.4b1 notification was provided and that the responsible party was notified for one of three residents (Residents (R) 124) reviewed for NJ Exec Order 26.4b1 out of a total sample of 40 residents. This had the potential to affect all residents being discharged from services. Findings include: Review of R124's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed NJ Exec was admitted to the facility on NJ Exec Order 26.4b Review of R124's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26 and located under the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of NJ E out of 15, indicating NJ Exec Orde . Review of R124's 'NJ Exec Order 26.4b1 form revealed the NJ Exec Order 26.4b1 start date was NJ Exec Order 26. and the last day covered was NJ Exec Order 26.4 Further review revealed that R124 signed NJ Exec Order 26.4b1 form on NJ Exec Order 26 . During an interview on 03/20/2026 2:06 PM, the U.S. FOIA (b)(6)) revealed residents	F0582	Continued from page 7 A Quality Assurance Performance Improvement plan to address the deficient practice was developed. An audit will be done to ensure timely delivery of Beneficiary notice and accompanying documentation. The SW will audit 3 Medicare beneficiary notices per week for four weeks. Then three records for the following two months. The results of these audits will be presented at the Quality Performance Improvement meetings monthly for three months to ensure the on-going correction of this practice.	04/30/2026

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F0582 SS = D	Continued from page 8 with a "BIMS" lower than a [NJ E] should not sign their [NJ Exec Order 26.4] forms due to their [NJ Exec Order 26] cognition. She stated the resident's [NJ Exec Order 2] told her to allow the resident to sign the form, but she had no documentation for that interview. During an interview on 03/20/26 at 3:38 PM, the U.S. FOIA (b)(6)) said she expected it was inappropriate for staff to not allow the representative to sign the [NJ Exec Order 26.4] for a resident with a "BIMS" of [NJ Exe] [NJ Exec] agreed it was inappropriate for a resident with a "BIMS" of [NJ Ex] to sign. NJAC 8:39-5.1(a)	F0582		04/30/2026
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §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 physical . . . 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 physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by:	F0604	1. The Facility Educator conducted an immediate comprehensive educational session with the nursing staff member who documented the [NJ Exec Order 2] application for Resident #R125. This session addressed the critical deficiency in clinical documentation and NJ Exec Order 26.4b1. The nurse was instructed on the regulatory requirement that NJ Exec Order 26.4b1 may only be [NJ Exec Order] when a documented medical symptom necessitates their use, and that all NJ Exec Order 26.4b1 must be attempted and documented prior to [NJ Exec Order 2] . The interdisciplinary team (IDT) met to discuss and evaluate NJ Exec Order 26.4b1 measures for Resident #125. The IDT trialed a 3 day [NJ Exec Order 26.4] and discharged Resident #125 from the [NJ Exec Order 26.4b1] on NJ Exec Order 26.4b1, and implemented the following interventions to reduce the NJ Exec Order 26.4b1 [redacted] Resident #125's NJ Exec Order 26.4b1 will be kept in the NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 is NJ Exec Order 26.4b1 per patient request. [NJ Exec Order 26] NJ Exec Order 26.4b1 for safety. NJ Exec Order 26.4b1 of [N] for Resident #125 to ensure resident safety. [NJ Exec Order 26.4b1] to [NJ Exec Order 26] wheelchair with [NJ Exec Order 26] [redacted]	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE , LAKEWOOD, New Jersey, 08701

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F0604 SS = D	Continued from page 9 Based on observation, interview, and record review, the facility failed to ensure a resident was [redacted] for one resident (Resident (R) 125) reviewed for [redacted] out of 40 sampled residents. This failure had the potential to affect all residents' rights at the facility. Findings include: Review of R125's "Admission Record," located under the "Profile" tab in resident's electronic medical record (EMR), revealed the resident admitted to the facility on [redacted] with diagnoses which included [redacted]. Review of R125's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted] and located under the "MDS" tab in the EMR, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated the resident's cognition was [redacted]. Further review revealed the [redacted] was classified as a [redacted]. Review of R125's "Care Plan," dated [redacted] and located under the "Care Plan" tab in the EMR revealed, "I am in a [redacted] Review of R125's "Nurse's Note," dated [redacted] at 11:26 PM and located in the EMR under the "Notes" tab, written by Licensed Practical Nurse (LPN) 2 revealed, "…Resident [redacted] in the hallway by coming out of the room [redacted]. Brought back into room and [redacted] but resident attempted to [redacted] wheelchair. Resident placed in [redacted] for safety…" During an interview on 03/20/26 at 2:43 PM, LPN2 stated [redacted] were considered a [redacted] He/She stated staff should attempt different interventions when a resident is being [redacted] or [redacted]. He/She stated calling R125's [redacted] was usually helpful or offering him/her a [redacted] He/She also said it was not appropriate to [redacted] because they could not be [redacted] LPN2 stated he/she did attempt other interventions prior to [redacted] R125 in the [redacted] and did call a supervisor to get guidance, but he/she did not document that, and he/she couldn't remember whom he/she spoke to. LPN2 was unsure if he/she made the decision to place R125 in the [redacted] on [redacted] or if he/she was told by someone to do so.	F0604	Continued from page 9 The Unit Manager immediately started the 3 day trial to attempt [redacted] was initiated on [redacted] and concluded successfully on [redacted] 2. All residents on the [redacted] unit with the use of any type [redacted] could have been affected by this deficient practice. 3. A. Revised Policies and Procedures. The Director of Nursing has reviewed and revised its policies and procedures regarding the use of restraints on March 20, 2026. The Resident Safety/Physical Restraint Use policy was subsequently revised to ensure full compliance with all applicable regulatory requirements and guidance. B. In-Services. The Facility Educator and/or designee will provide the in-service training on federal regulation F604 related to the appropriate use of restraints provided to all nursing staff members started on March 20, 2026. All staff were educated by March 30, 2026 and will be included in new orientation training. The in-services will be reviewed annually at a minimum with all appropriate staff. The training detailed the facility's new policies, processes and protocols for using restraints, the use of other interventions prior to using restraints, and the need to use the least restrictive device. C. Audit Tool. The Director of Nursing developed an audit tool to ensure compliance with applicable regulatory requirements and the new policy. The DON and/or designee will audit all the residents on restraints weekly for 3 months. 4. The DON and/or Unit Managers will submit the audit report to the Quality Assurance Committee Monthly.	04/30/2026

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F0604 SS = D	Continued from page 10 During an interview on 03/20/2026 at 3:06 PM, Licensed Practical Nurse Unit Manager (LPNUM)3 said it would not be appropriate for staff to place a NJ Exec Order 26.4b resident in a NJ Exec Order 26.4b1 He/She said the NJ Exec Order 26.4b was for safety to prevent NJ Exec and not NJ Exec Order 26.4b1. LPNUUM3 agreed that it would be a NJ Exec Order 26 for staff convivence. He/She said staff should always use the NJ Exec Order 26.4b1 method and attempt other appropriate interventions and document that in the medical record. During an interview on 03/20/26 at 3:38 PM, the U.S. FOIA (b)(6)) said a NJ Exec Order 2 should never be used for resident behaviors, and it was for safety only and to provide care. Review of the facility's undated policy titled, "Use of Restraints," reviewed and updated 11/2025. . . Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. . ." NJAC 8:39-4.1(a) NJAC 8:39-27.1(a)	F0604		04/30/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident.	F0628	Social Services immediately provided Resident R10 with a written bed hold policy and transfer notice and ensured the resident had knowledge of how to appeal the transfer, if desired, and understood the potential to contribute to the possible denial of re-admission and loss of the resident's home following hospitalization for residents transferred to the hospital. Resident R197 transfer/behold notice was not able to be provided at the time of discovery of deficient practice due the fact that the resident is NJ Exec Order 26.4b1 Resident R10 transfer/behold notice was provided immediately sent to the resident's responsible party by the Social Worker. Resident R12 transfer/behold notice was sent late as noted by the surveyor	05/01/2026

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F0628 SS = D	Continued from page 11 (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F0628	Continued from page 11 All residents have the potential to be affected by the deficient practice. The Facility Educator and/or designee re-educated all license nursing staff on federal regulation 628 related to the discharge process and the family notification of transfer or discharge. Education was completed 4/16/2026 Upon Emergency transfer Nursing Department will give the notice to the resident via the emergency transfer form. If the nurse is unable to give the notice to the resident because of the severity of their medical condition at the time of transfer or a low BIMS score the Receptionist/designee will either email or mail the Emergency transfer form to the POA/Family as soon as possible but no later than 24 hours after the emergency transfer. The Unit Secretary and/or designee will audit 5 acute transfer resident weekly for 4 weeks then 10 residents monthly for 3 months. The Unit Secretary and /or designee will submit the audit reports to the Quality Assurance Committee.	05/01/2026

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F0628 SS = D	Continued from page 12 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F0628		05/01/2026

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F0628 SS = D	Continued from page 13 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is	F0628		05/01/2026

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F0628 SS = D	Continued from page 14 not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and document review, the facility failed to ensure three of three residents (Resident (R) 10, R12, and R197) and their resident representatives (RR) reviewed for [redacted] were provided with a written bed hold policy and transfer notice out of a total sample of 40 residents. This failure had the potential to affect the resident and their RR by not having the knowledge of how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following hospitalization for residents transferred to the hospital. Findings include: 1.Review of R10's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), revealed R10 admitted to the facility on [redacted]. Review of R10's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of [redacted] revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated R10 was cognitively intact. Review of R10's "Progress Notes," dated [redacted] and located under the "Progress Notes" tab of the EMR, revealed R10 was transferred to the hospital due to a [redacted] with an [redacted] to the [redacted] and returned to the facility on [redacted] later in the morning. According to documentation the facility called a contact on file and left a message, to return the call to the facility. No return call was noted. Review of R10's "Progress Notes," dated [redacted]	F0628		05/01/2026

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F0628 SS = D	Continued from page 15 and located under the "Progress Notes" tab of the EMR, revealed R10 returned to the Emergency Room (ER) at a NJ Exec Order 26.4b1 service due to NJ Exec Order 26.4b1 and returned on NJ Exec Order 26.4 later that day. According to documentation the facility called a contact on file and left a message, to return call to the facility. The Transfer/Bed hold notice was not provided for these visits. 2.Review of R12's "Admission Record," located under the "Profile" tab in the EMR, revealed R12 admitted on NJ Exec Order 1. Review of R12's annual "MDS," with an ARD of NJ Exec Order 26 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of NJ E out of 15, indicating R12 was cognitively NJ Exec Ord Review of R12's "Progress Notes," dated NJ ExExec Order and located under the "Progress Notes" tab of the EMR, revealed that R12 was transferred to the hospital due to being NJ Exec Order 26.4b1 and returned to the facility on NJ Exec Order 26.4 The Transfer/Bed hold notice was not sent to the NJ Exec Order 26.4b1) until NJ Exec Order 26 per documentation provided by the facility. According to documentation the facility called R12's NJ Exec Order 26.4b1 and made notification. 3.Review of R197's "Admission Record," located under the "Profile" tab in the EMR, revealed the resident admitted to the facility on NJ Exec Order 26. Review of R197's quarterly "MDS," with an ARD of NJ Exec Order 26 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of NJ E out of 15, which indicated R197 was cognitively NJ Exec Ord Review of R197's "Progress Note," dated NJ Exec Order 26 and located under the "Progress Note" tab of the EMR, revealed R197 had a NJ Exec Order 26.4b1. A new order was received to send to R197 to the hospital for evaluation and treatment. Review of the "Notice of NJ Exec Order 26.4b1," form dated NJ Exec Order 26.4b and provided by the facility for R197, revealed that the document was sent to the U.S. FOIA (b)(6) but not the resident. During an interview on 03/20/26 at 11:35 AM, the U.S. FOIA (b)(6) stated R197 was not provided with a copy of the transfer notice, and one was not mailed to NJ Exe emergency contact.During an interview on 03/20/26 at 3:38 PM, the U.S. FOIA (b)(6) said the transfer notice should be provided to	F0628		05/01/2026

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F0628 SS = D	Continued from page 16 the resident or representative within 24 hours of discharge. NJAC 8:39-4.1(a)	F0628		05/01/2026
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly	F0640	The completed discharge assessments were immediately submitted to CMS. The MDS Coordinators have reviewed the current resident population to identify any individuals covered under NJ Exec Order 26.4b1 [redacted] who may be affected by the potential for delayed or missed MDS submissions. As of March 24, 2026, two residents with NJ Exec Order 26.4 [redacted] coverage were identified in the facility, and both are current and up to date with all required MDS submissions. The MDS Coordinator will review all discharges for residents with Medicare Advantage and Medicare HMO payer sources during the weekly UR meeting to verify that all required discharge MDS assessments have been completed and successfully submitted to CMS/iQIES. The Lead MDS Coordinator will audit this process monthly for three months and quarterly thereafter to ensure ongoing compliance. The MDS Coordinator will run and review the MDS 3.0 Missing Assessment Report in iQIES at least monthly to verify that all required discharge assessments, including those for residents with Medicare Advantage and Medicare HMO payer sources, have been completed and accepted by CMS. Any residents appearing on the report will be investigated to determine the cause (e.g., demographic error, transmission issue, or missed assessment), and corrections will be completed and resubmitted immediately. The Lead MDS Coordinator will review the report and related follow-up monthly for three months and quarterly thereafter to ensure ongoing effectiveness of this monitoring process. The MDS coordinator will submit the audit reports to the Quality Assurance Performance Improvement Committee.	05/04/2026

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F0640 SS = D	Continued from page 17 assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure that a discharge "Minimum Data Set (MDS)" assessment was submitted timely for two residents (Resident (R) 31 and R13) reviewed for "MDS" assessments out of a total sample of 40 residents. The failure to submit the discharge "MDS" did not allow for the closure of the residents' "MDS" cycle. Findings include: 1. Review of R31's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R31 admitted to the facility on [NJ Exec Order 26]. Further review revealed R33 was discharged to the hospital on [NJ Exec Order 26.4] Review of R31's discharge "MDS," with an assessment reference date (ARD) of [NJ Exec Order 26] and located under the "MDS" tab of the EMR, revealed the assessment was completed but not submitted. 2. Review of R13's "Admission Record," located under the "Profile" tab of the EMR, revealed R13 admitted to the facility on [NJ Exec Order 26.4] Further review revealed that R13 was discharged to the hospital on [NJ Exec Order 26]. Review of R13's discharge "MDS," with an assessment reference date of [NJ Exec Order 26.4] and located under the "MDS" tab of the EMR, revealed the assessment was completed but not submitted. During an interview on 03/20/26 at 2:41 PM, the [U.S. FOIA (b)(6)] stated both assessments were missed due to the coding to submit to the Centers for Centers for Medicare and Medicaid Services	F0640		05/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE , LAKEWOOD, New Jersey, 08701**

(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
F0640 SS = D	Continued from page 18 (CMS) not being updated. He/She stated they should have been submitted after they were completed in [NJ Exec Order 26.4b1]. During an interview on 03/20/26 at 3:38 PM, the [U.S. FOIA (b)(6)] said He/She expected "MDS" assessments to be submitted timely after they were completed. Review of the facility policy titled, "Comprehensive Assessments," revised 10/2025 revealed, ". . . Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. . ." NJAC 8:39-11.2	F0640		05/04/2026
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. §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	F0641	The MDS assessment for Resident R163 with an ARD of [NJ Exec Order] was promptly modified to include the [NJ Ex] that occurred during the look-back period, and the corrected MDS was re-submitted. All residents who experienced falls during the applicable look-back periods for their most recent MDS assessments were identified as potentially affected, and their MDS assessments were reviewed to ensure that all falls were accurately coded. Education was provided to the MDS Coordinators on 3/20/2026 on the correct look-back period and coding requirements for falls. Effective immediately, the Lead MDS Coordinator will verify the accuracy and completeness of all fall coding on MDS assessments prior to submission. The Lead MDS Coordinator will review all completed MDS assessments once weekly for the next four weeks, then monthly for three months, and quarterly thereafter to verify accurate fall coding and identify any missed events. The MDS coordinator will submit the audit reports to the Quality Assurance Performance Improvement Committee. This audit schedule will be used to monitor the ongoing effectiveness of the corrective actions.	05/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE , LAKEWOOD, New Jersey, 08701

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F0641 SS = D	Continued from page 19 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 interviews, record review, facility policy, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the "Minimum Data Set (MDS)" was coded accurately for two residents (Resident (R)25 and R163) reviewed for "MDS" accuracy out of a total sample of 40 residents. This failure placed residents at risk of unmet care needs. Findings include: 1. Review of R25's "Admission Record," located under the "Profile" tab in the EMR, revealed the resident was admitted to the facility on [redacted] with diagnoses that included NJ Exec Order 26.4b1 [redacted] Review of R25's "Nursing [redacted] Note," dated [redacted] and located under the "Notes" tab in the EMR revealed, "Admission [redacted] assessment with [Name of [redacted] company] done this morning. NJ Exec Order 26.4b1 [redacted]." Review of R25's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted] and located under the "MDS" tab in the EMR, revealed R25 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, indicating the resident was cognitively [redacted] Section "I for Active Diagnosis" did not include the diagnoses of NJ Exec Order 26.4b1 [redacted]. Section "[redacted] for [redacted] did not assess the resident has having a [redacted] During an interview on 03/20/26 at 2:50 PM, the U.S. FOIA (b)(6) [redacted] reviewed the admission "MDS" for R25's diagnoses with NJ Exec Order 26.4b1 [redacted] stated it should have been listed on the list for Active Diagnosis, and it must have been an oversight. The [redacted] confirmed R25's documentation should have included the NJ Exec Order 26.4b1 2. Review of R163's "Admission Record," located under the "Profile" tab in the EMR, revealed the	F0641		05/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

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F0641 SS = D	Continued from page 20 resident initially admitted to the facility on [NJ Exec Order 26] with diagnoses that included [NJ Exec Order 26.4b1] [redacted] Review of R162's quarterly "MDS" with and ARD of [NJ Exec Order 26] and located under the "MDS" tab of the EMR, revealed the resident's "BIMS" score was [NJ E] out of 15 which indicated the resident's cognition was [NJ Exec Ord] Section "J for Health Conditions" failed to reveal that the residen[NJ Exec Order 26.4b1] during the assessment period. Review of R162's "[NJ Exec Order 26.4b] Assessment," completed on [NJ Exec Order 26.] and located under the "Assessments" tab in the EMR identified the resident was at [NJ Exec Order] for [NJ Exec Ord] Review R162's "[NJ Exec Order 26] Assessment," completed on [NJ Exec Order 26.] and located under the "Assessments" tab in the EMR identified the resident was at NJ Exec Order 26.4b1. Review R162's "Nurses Notes," dated [NJ Exec Order 26] located under the "Notes" tab in the EMR indicated the resident [NJ Exe] [NJ Exec] the wheelchai[NJ Exec Order 26.4b1] [redacted] . [NJ Exec Order 26.4b1] were [NJ Exec Order 26.4b] [redacted] During an interview on 03/19/26 at 4:10 PM, Licensed Practical Nurse Unit Manager (LPNUM)1 revealed the resident NJ Exec Order 26.4b1 [NJ Exec Order] [NJ Exec Order 2] [redacted] The resident has[NJ Exec Order 26.4b1] [redacted] since that time. During an interview on 03/20/26 at 2:50 PM, the [U.S. FOIA (b)] nurse revealed the resident's quarterly "MDS" dated [NJ Exec Order] did not reflect the [NJ Ex] the resident [NJ Exec Order 26.4b] on [NJ Exec Ord]. The [U.S. FOIA (b)] agreed that since the [NJ Exe][NJ Exec Order 26.4b1] occurred during the assessment period it should have been reflected on that quarterly "MDS". A review of the facility policy tilted, "Comprehensive Assessments," with a revision date of 10/2025 revealed, ". . .Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. . ." Review of the October 2024 "RAI," manual, page 1-5 revealed, ". . .An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. . . It is important to note here that information obtained	F0641		05/04/2026

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LEISURE CHATEAU REHABILITATION	**962 RIVER AVE , LAKEWOOD, New Jersey, 08701**

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F0641 SS = D	Continued from page 21 should cover the same observation period as specified by the MDS (minimum data set) items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) by the IDT (interdisciplinary team) completing the assessment. . ." NJAC 8:39-33.2(d)	F0641		05/04/2026
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure residents did not have [NJ Exec Order 2] when they were not assessed to have them for one of four residents (Resident (R) 28) reviewed fo[NJ Exec Order 26.4] out of a total of 40 sampled residents. The lack of appropriate assessment could lead to potential [NJ Exec Order 2] or [NJ Exec] Findings include: Review of R28's "Admission Record," located under	F0700	1) Maintenance department immediately removed [NJ Exec Order 26.4b1] from Residents #R28 [NJ Exec] confirmed via work order documentation. 2) All residents have a potential to be affected by this deficient practice. 3) The Facility Educator and/or designee educated involved nursing staff on 30/20/2026 on federal regulation F700 related to side rails use constitute physical restraints when they restrict voluntary movement, cannot be easily released by resident, or create entrapment. Training emphasized person-centered assessment for medical symptoms (e.g., severe postural instability), ≥2 alternatives (low bed, mats), informed consent, and bed compatibility prior to any rail use. A room-by-room audit of all beds was completed on 3/23/2026 by team of DON, ADON, UM, Maintenance on unit to locate and remove any siderails that are not being used for independence with bed mobility to prevent reoccurrence. 4) After completion of room-to-room audit, a random weekly audit of 5 residents for 4 weeks of beds and side rail use, then 10 residents monthly for 3 months will be conducted by Unit Manager and/or designee to ensure compliance. The Director of Nursing will submit the audit reports to the Quality Assurance Performance Improvement Committee	05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

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LEISURE CHATEAU REHABILITATION	962 RIVER AVE , LAKEWOOD, New Jersey, 08701

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F0700 SS = D	Continued from page 22 the "Profile" tab of the electronic medical record (EMR), revealed R28 admitted to the facility on [redacted] with diagnosis of NJ Exec Order 26.4b1 Review of R28's annual "Minimum Data Set (MDS)," with an assessment reference date (ARD) of [redacted] and located under the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, indicating [redacted] Review of R28's "Care Plan," dated [redacted] and located under the "Care Plan" tab of the EMR, revealed R28 was care planned for NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1. Review of R28's "Physician Orders," located under the "Orders" tab in the EMR, dated [redacted] revealed no current order for [redacted]. Review of R28's "Quarterly/Annual/Significant Change Nursing Evaluation Packet," dated [redacted] and located under the "Assessments" tab in the EMR, revealed [redacted] were not necessary at this time. During observations on 03/18/26, 03/19/26 and 03/20/26, a [redacted] was observed on the [redacted] of R28's NJ Exec Order 26.4b1. During an interview on 03/20/26 at 10:38 AM, the Licensed Practical Nurse Unit Manager (LPNUM)3 said he/she was aware R28's [redacted] assessment indicated he/she was NJ Exec Order 26.4b1 [redacted]. He/She said the residents changed units and R28 was placed in a [redacted] that already had [redacted] on it but that it should be removed. During an interview on 03/20/26 at 3:38 PM, the U.S. FOIA (b)(6) stated a resident should not have [redacted] unless they are assessed to require them. Review of the facility policy titled, "Bed Safety and Bed Rails," Reviewed and Updated 11/2025 revealed, ". . . Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. . ." NJAC 8:39-27.1(a)	F0700		05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE , LAKEWOOD, New Jersey, 08701**

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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		04/06/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each	S0560	1. The Staffing Coordinator immediately notified the staffing agency to provide additional Certified Nursing Assistant (CNA) to supplement the staffing need. The Administrator immediately in-serviced the Staffing Coordinator on 4/6/2026 in reference to the state guideline S 560. The Staffing Coordinator immediately called all the aides scheduled for the next shift to come in early. The Administrator offered an overtime bonus for aides who will stay for the shift or work extra. 2. All the residents may be affected by the short staff as required by NJ DOH. 3. The Administrator in-serviced the Staffing Coordinator on 4/6/2026 in reference to the state guideline S560. Director of Human Resources will continue to post the vacancies in all 3 shifts. The Staffing Coordinator and/or designee will post and/or offer an OT pay to in-house staff. The Administrator and / or Staffing Coordinator will increase the hourly pay rate by $3 or more as	05/01/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

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S0560	Continued from page 1 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. For the 2 weeks of staffing prior to survey from 03/01/2026 to 03/14/2026, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -03/14/26 had 21 CNAs for 177 residents on the day shift, required at least 22 CNAs.	S0560	Continued from page 1 necessary for open shifts to increase the chance of pickup during a call out coverage and on weekends. The staffing agency will block a schedule for the open position to cover for the vacancies. 1 out of 3 Restorative CNA will be reassigned to direct patient care when challenged with staffing ratio to meet the state guidelines 4. The Staffing Coordinator and/or designee will audit the staffing weekly for 4 weeks then monthly for 3 months. The Staffing Coordinator and DON will submit the audit report to the Quality Assurance Performance Improvement Committee.	05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 05/08/2026 in relation to the 03/20/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 05/08/2026 in relation to the 03/20/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities	S0000		

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: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/18/26 and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Leisure Chateau Rehabilitation is a two-story building with a partial basement constructed in 1982. It is composed of Type II (000) construction and is divided into twelve smoke compartments. The facility has a complete automatic sprinkler system (wet). The 500 KW (kilowatt) diesel generator powers 100% of the building per the U.S. FOIA (b)(6). The number of occupied beds was 187 out of 243.	K0000		04/06/2026
K0100 SS = F Bldg. 01	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure vehicles were not parked in the fire lanes and that gazebos were not placed in fire lanes around building in accordance with NFPA 1 Fire Code (2010 Edition) Section 18.2.4.1.1., 18.2.4.1.3 and 18.2.3.2.2.1. This deficient practice had the potential to affect all 23 residents who resided on the first floor of building 12 at the facility and was evidenced by the following:	K0100	The Director of Maintenance immediately relocated the "NO PARKING – FIRE ZONE" signage to ensure greater visibility for visitors and employees. Gazebos were removed from the designated fire zone lane. All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) was in-serviced by the Administrator on the importance of maintaining a clear fire zone lane at all times. Staff educator implemented an in service to all employees on the importance of maintaining a clear fire zone lane at all times. The Director of Maintenance or designee will monitor the fire zone area weekly for four (4) weeks, then monthly for six (6) months to ensure the fire zone remains clear at all times. The findings will be reported to the QAPI committee on a quarterly basis X2.	04/30/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE , LAKEWOOD, New Jersey, 08701

(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
K0100 SS = F Bldg. 01	Continued from page 1 Observations on 03/18/26 at 12:50 PM of the facilities fire lanes near building 12 revealed three cars a Red {Name Redacted}, Gray {Name Redacted}, and Blue (Name Redacted} were parked in the fire lane and three 12-foot by 12-foot brown wooden screened gazebos were placed in the fire lanes. The fire lane was clearly marked with signs reading “No Parking Fire Lane”. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the vehicles were parked in the fire lane, gazebos were in the fire lane and that the fire lane did not extend to the rear of the building. NJAC 8:39-31.1(c), 31.2(e)	K0100		04/30/2026
K0321 SS = F Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K0321	The facility immediately ordered automatic closing and latching hardware, in accordance with NFPA 101 Life Safety Code, to be installed on the storage room door. All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) was in-serviced by the Administrator on the requirement that all storage rooms larger than 50 square feet must have doors that automatically close and latch in accordance with NFPA 101. If any issues are identified, they will be reported and corrected promptly The Director of Maintenance or designee will audit all storage rooms monthly for six (6) months to ensure compliance and will report findings to the QAPI Committee quarterly for three (3) quarters	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

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K0321 SS = F Bldg. 01	Continued from page 2 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure doors in storage rooms larger than 50 square feet automatic closed and latched in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.2.1.3. This deficient practice had the potential to affect all 58 residents who resided in the [NJ Exec Order 26.4] Wing of the facility and was evidenced by the following: An observation on 03/18/26 at 2:42 PM of the storage room in the [NJ Exec Order 26.4] Wing near room [NJ Exec] revealed that the room was larger than 50 square feet with beds, chairs and tables and two-fire doors that did not automatically close when opened. During an interview at the time of the observation, the[U.S. FOIA (b)(6)] confirmed the double doors did not automatically close. The doors remained ajar after allowed to close. NJAC 8:39-31.2(e)	K0321		04/30/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K0324	The Dietary Director immediately removed, cleaned, and reinstalled the grease filters of the kitchen hood system in accordance with NFPA 96: Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. All residents have the potential to be affected by this practice. The[U.S. FOIA (b)(6)] was in-serviced by the Administrator on the importance of maintaining clean grease filters in accordance with NFPA 96. Dietary Director added a monthly routine cleaning to the grease filters in addition to the biannual professional cleaning.	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01 - MAIN BUILD...** B. WING	**03/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE , LAKEWOOD, New Jersey, 08701**

(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
K0324 SS = F Bldg. 01	Continued from page 3 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based observation and interview, it was determined that the facility failed to ensure the kitchen's hood system was cleaned in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition) section 11.6.2. This deficient practice had the potential to affect all 187 residents and was evidenced by the following: An observation on 03/18/26 at 2:50 PM of the kitchen hood system in the main kitchen revealed heavy grease buildup on the grease filters. The kitchen hood filters had not been cleaned recently. No documentation was available about the kitchen hood filter cleaning. During an interview at time of observation, the U.S. FOIA (b)(6) confirmed the hood system had heavy grease buildup and had not been cleaned. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K0324	Continued from page 3 The Dietary Director or designee will ensure grease filters are cleaned monthly and that a professional commercial cleaning is conducted semi-annually. Dietary Director or designee will audit the grease filter cleaning monthly for six (6) months to ensure compliance and will report findings to the QAPI Committee quarterly for two (2) quarters.	04/30/2026
K0351 SS = F Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K0351	The facility immediately contacted a licensed fire protection vendor to install sprinkler coverage in the boiler room, specifically addressing obstruction created by HVAC ductwork, in accordance with NFPA 13: Standard for the Installation of Sprinkler Systems. A new sprinkler head was installed specifically addressing obstruction created by HVAC ductwork in accordance with NFPA 13: Standard for the Installation of Sprinkler Systems. All residents have the potential to be affected by this practice.	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE , LAKEWOOD, New Jersey, 08701

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K0351 SS = F Bldg. 01	Continued from page 4 measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure fixed obstructions four feet wide had a sprinkler installed underneath the obstruction in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (2010 Edition) Section 8.6.5.3.3. This deficient practice had the potential to affect all 187 residents and was evidenced by the following: During an observation on 03/18/26 at 1:37 PM in the boiler room, it was revealed a fixed obstruction of a 4-foot by 4-foot HVAC ductwork did not have the required sprinkler under the obstruction. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed a sprinkler list was not present under the fixed obstruction. NJAC 8:39-31.1(c). 31.2(e) NFPA 13	K0351	Continued from page 4 The U.S. FOIA (b)(6) was in-serviced by the Administrator on the requirement that fixed obstructions exceeding four (4) feet in width must have sprinkler protection installed beneath them in accordance with NFPA 13. Monthly Life safety rounds have been updated to include an audit of fixed obstructions exceeding four (4) feet in width have sprinkler protection installed beneath them in accordance with NFPA 13. The Director of Maintenance or designee will audit all areas with fixed obstructions exceeding four (4) feet monthly for six (6) months and report findings to the QAPI Committee. Any deficiencies identified will be corrected immediately.	04/30/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K0353	The facility immediately contacted a licensed sprinkler contractor to perform a hydrostatic test of the Fire Department Connection (FDC) at 200 PSI in accordance with NFPA 25: Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) was in-serviced by the Administrator on the requirement that the FDC must undergo hydrostatic testing every five (5) years at 200 PSI in accordance with NFPA 25. Maintenance	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE , LAKEWOOD, New Jersey, 08701

(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
K0353 SS = F Bldg. 01	Continued from page 5 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure the fire department connection (FDC) was hydrostatic tested to 200 pounds per square inch (PSI) in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) Section 6.3.2.1. This deficient practice had the potential to affect all 187 residents who resided at the facility and was evidenced by the following: During record review on 03/18/26 of the {vendor name redacted} sprinkler report on December 01, 2025, revealed the sprinkler contractor only hydrostatic tested the FDC at 150 PSI and not the required 200 PSI. There was no additional information. During an interview on 03/18/26 at 3:45 PM the U.S. FOIA (b)(6) confirmed that the hydrostatic test was conducted at 150 PSI and not the required 200 PSI. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K0353	Continued from page 5 policy was updated to have the hydrostatic testing every five (5) years at 200 PSI in accordance with NFPA 25 instead of 150PSI. The Director of Maintenance or designee will ensure the required five (5)-year hydrostatic testing of the FDC is completed by a licensed sprinkler contractor. The Director of Maintenance or designee will audit monthly for three (3) months to ensure compliance with NFPA standards and report findings to the QAPI Committee	04/30/2026
K0355 SS = F Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10	K0355	The Director of Maintenance immediately removed the non-compliant fire extinguisher and replaced it with a new, compliant unit in the boiler room. All residents have the potential to be affected by this practice. The U.S. FOIA (b)(6) was in-serviced by the Administrator on the requirement that dry chemical fire extinguishers must be serviced every six (6)	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE , LAKEWOOD, New Jersey, 08701

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K0355 SS = F Bldg. 01	Continued from page 6 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that dry chemical fire extinguishers were serviced every six years in accordance with NFPA 10 Standard for Portable Fire extinguishers (2010 Edition) 7.3.1.2.1. This deficient practice had the potential to affect all 187 residents and was evidenced by the following: An observation on 03/18/26 at 1:32 PM of the boiler room revealed a five-pound dry chemical fire extinguisher with a service collar and a durable, weather-resistant metallic label on the back of the fire extinguisher was hydrotested in 2019. The fire extinguisher was not serviced as scheduled in 2025. During an interview at the time of observation, the U.S. FOIA (b)(6) confirmed that the fire extinguisher was not serviced according to NFPA 10 (2010 edition) section 7.3.1.2.1. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K0355	Continued from page 6 years in accordance with NFPA 10: Standard for Portable Fire Extinguishers. The facility implemented a review process during routine maintenance inspections to verify that the fire extinguishers are in compliance with service. The Director of Maintenance or designee will audit all fire extinguishers monthly for three (3) months to ensure compliance with NFPA standards and report findings to the QAPI Committee. Any deficiencies will be corrected immediately.	04/30/2026
K0211 SS = E Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure three of six fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect all 53 residents who resided on the second floor of the NJ Exec Order 26.4b Wing at the facility and was evidenced by the following: Observations on 03/18/26 between 12:00 PM to	K0211	The facility immediately ordered fire exit hardware, in accordance with NFPA 101 Life Safety Code, to be installed on three (3) fire-rated stairwell exit doors. All residents have the potential to be affected by this practice. The Director of Maintenance audited all fire-rated door assemblies throughout the facility to ensure they are equipped with compliant fire exit hardware in accordance with NFPA 101. The U.S. FOIA (b)(6) was in-serviced by the Administrator regarding the requirement to ensure fire doors are equipped with compliant fire exit hardware in accordance with NFPA 101. If any issues are identified, they will be reported and corrected promptly. The Director of Maintenance or designee will audit all fire-rated door assemblies monthly for six (6) months to ensure continued compliance and will report findings to the Quality Assurance Performance Improvement (QAPI) Committee quarterly for three (3) quarters.	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE , LAKEWOOD, New Jersey, 08701

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K0211 SS = E Bldg. 01	Continued from page 7 3:30 PM of all the facility's stairways' fire rated door assemblies revealed three stairway fire doors on the [NJ Exec Order] floor in the [NJ Exec Order 26.4b] Wing were equipped with panic hardware and not approved fire exit hardware. During an interview at the time of observations, the U.S. FOIA (b)(6) confirmed the stairway exit doors were not equipped with fire exit hardware. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K0211		04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 03/18/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		04/04/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/08/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE , LAKEWOOD, New Jersey, 08701**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 05/08/2026 in relation to the 03/20/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 05/08/2026 in relation to the 03/20/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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

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