STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrogate	**400 LOCUST STREET , 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 Standard Survey: 2/9/2026 Census: 59 Sample Size: 18 + 3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		03/10/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods	F0812	F0812: Food Procurement, Store/Prepare/Serve-Sanitary Facility: Harrogate The U. S. FOIA (b) (2) NJ Ex Order 26, 4 completed an audit of the daily surveillance records for all residents from 1/1/26 through 2/20/26 to reconfirm that no infections developed attributable to the stated deficiency. Upon the test strip failing on 2/5/26, the Director of Culinary Service immediately shut down operation of the dish machine and used disposables to service meals. The vendor was also called to repair the dish machine. Vendor came to the location on 2/5/26 and setup the dish machine to operate as a low temperature dish machine with chemical solution temporarily until the scheduled return and repair of the dish machine was repaired by the vendor to operate as a high temperature rinse machine. On 2/9/26 the dish machine was repaired by the vendor to operate as a high temperature rinse dish machine. All residents had the potential to be affected. Based upon the U. S. FOIA (b) (2) review of the wash and rinse temperature logs for the specified period, it was determined that the dishwasher operator inadvertently listed the temperatures acquired from the dish machine gauges in the incorrect columns on the log. The temperatures were reversed by error. On 2/5/26 the U. S. FOIA (b) (2) retrained culinary team members about accurately completing the Dish Machine Temperature Record to ensure that the	03/10/2026

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: 315262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

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F0812 SS = F	Continued from page 1 and maintain sanitation in a safe and consistent manner designed to prevent food borne illness. This deficient practice was evidenced by the following: On 02/05/2026 at 9:47 AM, the surveyor accompanied by the [redacted], observed the following in the kitchen: Upon entry to the kitchen the surveyor confirmed with the [redacted] that the facility utilized a high temperature dish machine that was in operation for the post-breakfast meal service. The surveyor requested to see the dish machine temperature log prior to inspection of the dish machine. A review of the 'DISHMACHINE TEMPERATURE RECORD (HIGH TEMPERATURE MACHINE)", dated FEB (February) 2026, revealed that the Wash temperature for breakfast on 1/5/2026 was recorded as 180 degrees and the Final rinse temperature was recorded as 165 degrees. Federal regulations require a minimum of 150-165 degrees Fahrenheit (F) for a minimum wash temperature and 180 F for a minimum final rinse temperature on a high temperature dish machine. Further review of the log did not reveal that any corrective actions had been taken at any meal period (breakfast, lunch and dinner) for the date range of 1/1/2026 through 1/5/2026 at breakfast. At approximately 9:54 AM, the surveyor and the [redacted] went into the dish machine room to observe the dish washing operation. The surveyor observed the temperature gauges on the dish machine while the machine was in active service. The surveyor observed the following temperatures: Rinse: 130 F, Wash: 118 F. The [redacted] then told the surveyor that the dish machine gauges had broken and that they had been broken for approximately one (1) week. The [redacted] further explained that they utilized a temperature test strip to measure the dish machine temperature and ensured that it met minimum standards for wash and rinse temperature. The surveyor then asked the [redacted] to attach a test strip to the interior of an empty plastic dish rack and run it through the dish machine to test for appropriate wash and rinse temperatures. The [redacted] then proceeded to affix a test strip to the interior wall of the dish rack and then ran the plastic rack through the dish machine for a full wash and rinse cycle. Once the plastic dish rack departed the dish machine the surveyor and [redacted] observed the dish washer temperature test strip. The surveyor observed that the test strip had 3 (three) white squares labeled as the following: 160 F (71C) (Celsius), 170 F (77C), and 180 F (82C). A review of the red lettering on the test strip revealed the following: When indicator turns black, stated	F0812	Continued from page 1 temperatures for the wash and final rinse are recorded in the correct column on the log. On 2/5/26, the Director of Culinary Service updated the facility's policy to specify that the culinary team will run a test strip of the dish machine and dish plate after each meal and records results on the Test Strip Results log. On 2/5/26, team members were educated about this procedure and the requirement to notify the Director of Culinary Service or culinary manager on duty and document such communication on the log if the temperatures do not meet the referenced, minimum readings. In accordance with the policy, the Director of Culinary Service will continue to immediately enact use of disposables for meals until repair is completed and notify the Administrator and Director of Nursing. The culinary manager on duty is responsible for the daily check of logs to ensure appropriate completion. The Director of Culinary Service will also complete thorough weekly inspections of dish machine/dish room operational compliance in accordance with the above policy including proper completion of the logs and any corrective action taken and documented to ensure adherence with §483.60(i)(2). Any findings will be reported to the Administrator and culinary management vendor for appropriate action as necessary. The culinary management vendor has ordered a new dish machine to be installed on or before 4/1/26. The culinary management vendor will complete quarterly audits of the weekly inspections of dish machine operational compliance to ensure no issues exist and continued effectiveness of the above policy. The dish machine vendor will also conduct quarterly inspections to ensure the dish machine is working correctly. The culinary management vendor will report all audit findings to the Administrator and Director of Culinary Service upon completion. All audit findings will also be reported to the QAPI committee quarterly for 3 quarters.	03/10/2026

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F0812 SS = F	Continued from page 2 temperature has been achieved. The test strip had no black squares and the squares remained white upon leaving the dish machine. The white squares indicated that the dish machine did not meet minimum required temperatures to ensure proper ware washing. A black square would indicate that the minimum required temperature had been met. The [U. S. FOIA (b)] told the surveyor that he was shutting the dish machine down and instructed staff not to wash any more dishware. The [U. S. FOIA (b)] stated that he would be contact their service representative and assured the surveyor that they would utilize paper products at the lunch meal and as necessary until the machine was repaired. On 02/05/2026 at 10:14 AM, the surveyor asked the [U. S. FOIA (b)] if staff should ensure that the dish machine was operating properly before starting to wash dishes. The [U. S. FOIA (b)] replied, "Yes, the dishwasher should check that the machine met minimum temperatures before starting to wash dishware." He further explained that if it was not working properly the dishwasher (utility staff) was supposed to notify management immediately. At approximately 10:00 AM on 2/5/2026, the surveyor conducted an interview with the kitchen utility staff (US) who was responsible for ensuring the high temperature dish machine was operating properly prior to dish washing. The surveyor asked the US if he had checked the dish machine temperature gauges prior to initiating dish washing to ensure the machine was operating properly. The US told the surveyor "Yes." The surveyor then asked how he determined that the machine was meeting minimum temperature standards. The US told the surveyor he used (read) the gauges. The surveyor then explained that the gauges were not operating properly and were stuck at the previously mentioned temperatures. The US then informed the surveyor in the presence of the [U. S. FOIA (b)] that the dish machine gauges were broken and that he did not ensure that the machine was meeting minimum temperature standards as they could not be accurately measured. On 2/5/2026 at 2:21 PM, the surveyor met with the facility administration including the [U. S. FOIA (b) (2)]) and discussed the concerns with the high temperature dish machine. The administrative staff informed the surveyor that the dish machine had been set up by service staff to run as a low temperature dish machine with chemical sanitizing until the dish machine could be repaired	F0812		03/10/2026

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F0812 SS = F	Continued from page 3 to run at a high temperature. On 2/9/2026 at 8:45 AM, the [U. S. FOIA (b)] provided the surveyor with copies of the dish machine service provider work orders/invoices. A review of a service order dated 2/5/2026 at 14:30 (4:30 PM) had the following service comments: Bad heating contactor. Replaced. Bad fuse causing machine not to turn on. Will need to get replacement and return. Converted to low temperature until booster problem is fixed. A review of a service order dated 2/5/2026 at 16:39 (6:39 PM) revealed the following service comments: Return visit. Replaced fuse (blew again). ...Tested elements. 1 (One) bad element causing fuse to trip. Will return when I can locate one to replace. Machine is hooked up on sanitizer and is running low temp (temperature). A review of a service order, dated 2/6/2026 at 14:50 (4:50 PM) revealed the following service comment: Bypassed bad element on booster until replacement comes in. Rinse temp is now getting to 185-190. Wash temp was heating slowly. Bad wire on element. Reconnected... On 2/9/2026 at 12:23 PM, the [U. S. FOIA (b)] informed the surveyor that the high temperature dish machine had been repaired and was operating as it should to meet minimum wash and rinse temperatures. The surveyor observed the [U. S. FOIA (b)] enter an empty dish rack into the dish machine. The surveyor observed a wash temperature of 172 F and a final rinse temperature of 186 F. The surveyor reviewed the facility provided "Policy #F019 DISHMACHINE TEMPERATURES" policy, date revised: 1/24, which included: ...Dish machine wash and rinse water should be maintained at temperatures that meet the guidelines established by the Food and Drug Administration. *State or local regulations will apply if stricter. Review of the High Temperature Machine section revealed that the machine, a multi-tank, conveyor, multi-temperature machine required a wash temperature of 150F and a final rinse temperature of 180-194F. The following was observed under PROCEDURES: Supervisor/Food and Nutrition Associate as assigned: High Temperature Dishmachine - record on Dishmachine Temperature Record form: Wash and final rinse temperatures during each period of use. Once a day, run a test strip (160F strip) through the dishmachine to verify the surface temperature of a	F0812		03/10/2026

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F0812 SS = F	Continued from page 4 dish. (The machine readings are the temperatures at the manifold of the machine, and not on the surface of the plate). Attach the used test strip to the Test Strips Result form. The test strip must verify that the surface temperature of the plate reached 160F. ALTERNATIVE: Use an irreversible maximum registering thermometer. Write the sanitizing rinse temperature on the Irreversible Max Temperature form. Director (In the event of inappropriate temperature) Determines if reading is due to malfunctioning temperature gauge or inappropriate temperature. If due to inappropriate water temperature (high temperature machine), or inappropriate concentration of sanitizer solution (low temperature machine, implements disposable service ware or use 3-compartment sink for sanitization. Notifies nursing units of use of disposable serviceware. Contacts sources of repairs. NJAC 18:39-17.2(g)	F0812		03/10/2026
F0868 SS = D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The	F0868	An attestation dated, 2/9/2026, was provided by the Medical Director confirming that he attended the 4/17/2025, QAPI Committee meeting virtually. All residents have the potential to be affected. Revised QAPI Plan explicitly lists the Medical Director as a mandatory attendee of the QAPI Committee meetings. If participating in the meetings via teleconference, the Medical Director will submit an attestation with signature to the Director of Nursing confirming attendance. The attestation will be attached to the applicable QAPI sign-in sheet. On 2/17/26 education was provided to the US FOIA (b)(6) [redacted] on the topic of attestation submission to confirm any virtual attendance of meetings. The Administrator will audit 2026 quarterly (April, July, October) QAPI Committee meeting sign-in sheets for required attendance by the Medical Director. Any attendance sheets with missed signatures will result in immediate corrective action by the Administrator including re-education of the US FOIA (b)(6). Audit results will be reported at the quarterly QAPI Committee meetings. Audits will continue quarterly for the 2026 year and discontinue	03/10/2026

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F0868 SS = D	Continued from page 5 committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that the required members were present during the quarterly Quality Assurance and Performance Improvement (QAPI) Committee Meetings. This deficient practice occurred during 1 of 4 meetings reviewed and was evidenced by the following: On 2/9/26 at 9:15 AM, during an interview with the U. S. FOIA (b) (2) stated that the facility held quarterly Quality Assurance Performance Improvement (QAPI) meetings on the third Tuesday of the month during the months of January, April, July and October. The surveyor then proceeded to review the facility provided Employee Education Attendance Records for the first quarter that was dated 4/17/25, the second quarter that was dated 7/15/25, the third quarter that was dated 10/15/24, and the fourth quarter that was dated 1/2025. At that time, the surveyor asked which staff members were required to attend the quarterly QAPI meetings. The U. S. FOIA stated the required participants were the U. S. FOIA (b) (2), social work, dietary, activities, maintenance, nursing, the U. S. FOIA (b) (2) and vendors such as U. S. FOIA (b) (2) and the lab. The U. S. FOIA further stated, "the Medical Director (MD) sometimes attended the monthly QAPI meetings, but he definitely attended the quarterly meetings." The surveyor then asked the U. S. FOIA (b) (2) to review the quarterly Employee Education Attendance	F0868	Continued from page 5 after the year if 100% compliance is achieved.	03/10/2026

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F0868 SS = D	Continued from page 6 Records signature panels to confirm the attendance of the required attendees. During the review, the surveyor noted that the [U. S. FOIA] did not sign in on the space provided for the quarterly QAPI meeting dated 4/17/25, which was also confirmed by Administrator. The [U. S. FOIA] stated that the [U. S. FOIA] was usually phoned in on a conference call and "via phone" was written on the signature panel of the form, " but I must have missed it". When the surveyor asked if the [U. S. FOIA] attendance via phone should have been documented on the form to confirm attendance the [U. S. FOIA] stated that the sign in sheet should have reflected that the [U. S. FOIA (b) (2)] was present via teleconference. A review of the facility's "QAPI" policy, updated 1/20/2026, included: The community Administrator maintains the role of committee leader for QAPI and will provide an annual report to the Board of Directors. This information will also be shared with the management team, staff, and resident councils. Further review of the policy listed the members of the QAPI Committee which included Administrator/Abuse Coordinator, Medical Director, DON, and Infection Preventionist/Staff Educator… NJAC 8:39-33.1 (b)	F0868		03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061528	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

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S0000	Initial Comments The facility was 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.	S0000		03/10/2026
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 interviews, and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for staffing for 1 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each	S0560	S0560 Mandatory Access to Care Facility: Harrogate Completion Date: 3/10/26 There were no negative outcomes to residents on the day shifts identified as not meeting the NJ staffing requirements on 01/19/26. All residents were assisted with their activities of daily living, meals, and call bell requests, without deviation from the plan of care. In addition, the rehabilitation team rendered bedside ADL assistance to residents receiving therapies. A key root cause for this deficiency, as identified by our team, is the increase in higher paying, non-healthcare related positions of which a number do not require off-shift, weekend or holiday hours and involve less physical work. There was also a decrease in enrollment in CNA certification courses. In addition, despite staffing for the appropriate ratios, staff call outs from work, at times without proper notice, was also a contributing factor. All residents have the potential to be affected by not meeting the staffing requirements of N.J.S.A.30:13-18 on 1/19/26 day shift. The Director of Nursing re-educated the staffing coordinator (Medical Secretary), charge nurses, and supervisors regarding state staffing requirements (N.J.S.A.30:13-18), the protocol for completing the nursing schedule, Director of Nursing /Administrator notification of staffing concerns and managing staff	03/10/2026

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

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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. 1. For the 2 weeks of staffing prior to survey from 01/11/2026 to 01/24/2026, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -01/09/26 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. On 02/05/26 at 12:28 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she worked with the Director of Nursing (DON) on staffing. The SC further stated that the DON informed her of the number of CNAs that were needed for each shift, then she staffed accordingly. The SC could not recite the required staff-to-resident ratios when asked. On 2/05/26 at 01:06 PM, the surveyor interviewed the DON who stated that the day shift required 1 (one) direct care staff member for every 8 (eight) residents. The DON stated they had been meeting that requirement. The DON further stated that the facility used Per Diem (employees hired on an as-needed basis) staff and staffing agencies for back-up. A review of the facility's "Staffing, Sufficient and Competent Nursing" policy, revision date April 2025, included, "...The facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. ...6. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident assessments, residents plans of care, and the facility assessment. 7. Factors considered in determining appropriate staffing ratios and skills include an evaluation of the diseases, conditions, physical or cognitive limitations of the resident population, and acuity. 8. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing. ..."	S0560	Continued from page 1 callouts from work. The Director of Nursing or Designee re-educated CNAs regarding procedures and time frames for calling out from work. The Director of Nursing or Designee will continue to meet with the Medical Secretary daily to review community census, any call outs, and staffing needs to meet required ratios. When staffing ratios are not met, the Medical Secretary will continue prioritizing the issuance of requests to all per-diem CNAs to fill a post that a becomes vacant. The Director of Nursing is providing CNAs the option to transfer to day shift and pick up extra shifts for overtime. Monetary-type, individual incentives are offered by the Administrator and Director of Nursing as a last option for filling a CNA opening. The community continues to make every effort to recruit and retain CNAs in this very competitive and challenging market. Job openings have been posted by the Director of Human Resources on multiple job sites to promote CNA recruitment. Referral bonuses are provided to team members upon the successful recruitment of colleagues. The community has signed contracts with staffing agencies and will use agency staff as needed to meet staffing needs/requirements. The Director of Human Resources will provide a weekly report to the Administrator regarding staff retention and recruitment progress and activities in conjunction with Nursing for any open positions that exist. The Infection Preventionist/designee will identify any CNA schools in the area to set up possible recruitment events for new graduates. The Staffing in Emergency policy was updated on 2/25/26 to update the list of staffing agencies. This policy was also revised to say that the facility will utilize the restorative nursing aide as a CNA in the event of a staffing shortage. The Administrator will place a hold on new admissions for an applicable shift when an unanticipated CNA absence occurs and all options have been exhausted without filling the opening.	03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061528	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrogate	**400 LOCUST STREET , LAKEWOOD, New Jersey, 08701**

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S0560		S0560	Continued from page 2 The Director of Nursing/Designee will meet with the Medical Secretary daily and audit staffing schedules to confirm compliance with mandated ratio requirements in advance of worked shifts. The Administrator will audit the weekly report from the Director of Human Resources to ensure that it addresses staff retention and recruitment progress and forementioned activities to fill any open positions. The results of the audits will be presented to the community's QAPI Committee quarterly for review. The audits will be discontinued when compliance to the mandated CNA staffing ratios are achieved for two consecutive quarters.	03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrogate	**400 LOCUST STREET , LAKEWOOD, New Jersey, 08701**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted 03/12/2026 in relation to the 02/09/2026 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: 061528	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/12/2026 in relation to the 02/09/2026 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: 315262	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **02/09/2026**

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K0000 Bldg. 01	INITIAL COMMENTS The NJDOH conducted a Life Safety Code survey on 01/30/2026 and 02/09/2026. 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. Harrogate is a Single-story, Type V Protected building that was built in January 1985. The facility is divided into five smoke zones and has a 150 Kilowatt (Kw) Generator which services approximately 95% of the building according to the U. S. FOIA (b) (2) [redacted], as well as the facilities Electrician, (long-term vendor). The facility has multiple generators which serve IT (Information Technology) rooms as well.	K0000		03/02/2026
K0271 SS = F Bldg. 01	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 01/30/2026 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined the facility failed to maintain a stable, level walking surface at exit discharge for 2 of 5 corridor exterior exits in accordance with NFPA 101: 2012 Edition, Section 7.7, 7.1.6.2, 7.1.6.4, 7.1.10.1 and 19.2.7. This deficient practice had the potential to affect 56 of 68 residents and was evidence by the following:	K0271	No residents were adversely affected by this practice as they did not exit (or require exit) via the specified egress doors. On 1/20/26, immediately upon identification of the findings, the Maintenance team cleared the snow and ice from the discharge walkways from Exit Doors #40 and #42 to the termination points at the start of the public ways. The clearing of the paths resulted in compliance with NFPA 101 Sections 7.7, 7.1.6.2, 7.1.6.4, 7.1.10.1 and 19.2.7 (2012 Edition). All residents (56 of 68) in the specified area had the potential to be affected by this practice. To ensure compliance with NFPA 101 Sections 7.7, 7.1.6.2, 7.1.6.4, 7.1.10.1 and 19.2.7 (2012 Edition), the U. S. FOIA (b) (2) [redacted] will create a formal Maintenance snow/ice event procedure that addresses the prompt removal of snow and ice from the exit discharge walkways at and from all egress doors including Exit Doors #40 and #42 to the applicable public ways. As part of the procedure, the assigned Maintenance staff must document completion of the snow and ice removal from each egress discharge and walkway to the public path. The Maintenance Team were educated regarding this procedure on 2/26/26 by the Plant	03/30/2026

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: 315262	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **02/09/2026**

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K0271 SS = F Bldg. 01	Continued from page 1 At 9:45 AM, the surveyor observed the exit discharge sidewalk outside of Exit Door #40 and the walkway had been cleared of snow and ice up to approximately 7 (seven) feet from the staff smoking area. The area had a buildup of ice and snow that extended approximately 12 feet to the public way. In an interview at the time the [U. S. FOIA] confirmed the observation. At 10:26 AM, the surveyor observed the exit discharge walkway outside of Exit Door #42 which had ice and snow buildup throughout the walkway which led into an ice and snowbank area, not terminating directly at a public way. The facility's [U. S. FOIA (b) (2)] was notified of the deficient practice during the Life Safety Code exit conference on 02/09/2026 at 1:45 PM. NJAC 8:39-31.2(e)	K0271	Continued from page 1 Operations Director. The Plant Operations Director will audit the egress paths during and after the next two snow and/or ice storms to comply with NFPA 101 Sections 7.7, 7.1.6.2, 7.1.6.4, 7.1.10.1 and 19.2.7 (2012 Edition). The audit results for each snow/ice event will be submitted to the next scheduled QAPI Committee meeting. The audit will be discontinued if 100% compliance is achieved for both snow/ice events. The QAPI Committee will subsequently make recommendations regarding continuation of the audit and its frequency.	03/30/2026
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on documentation review and interview on 01/30/2026 and 2/09/2026, in the presence of the [U. S. FOIA (b) (2)], it was determined that the facility failed to conduct functional testing of the emergency lighting system in accordance with NFPA 101, 2012 Edition, Section 19.2.9.1 and 7.9. This deficient practice had the potential to affect all residents and was evidenced by the following: On 01/30/2026 at 11:50 AM, the surveyor observed an emergency light within the mechanical room. When the [U. S. FOIA] initiated the test button, the lamps did not light. When interviewed at the time, the [U. S. FOIA (b) (2)] confirmed the observation. The [U. S. FOIA] was asked if the facility regularly tested the emergency lights, monthly for 30 seconds and yearly for 1.5 hours. The [U. S. FOIA] was uncertain of the testing but responded he	K0291	No residents were adversely affected by this practice. Immediately following the findings on 1/30/2026, the Plant Operations Director placed an order for a new emergency light located in the mechanical room and scheduled the 90-minute audit of emergency lighting in the health center. Replacement of the emergency lighting in the mechanical room was completed on 2/24/2026 in accordance with NFPA 101 Sections 19.2.9.1 and 7.9 (2012 Edition). The audit record and results of issues corrected will be added to our Life Safety Book. All residents were potentially affected by this practice. On 2/26/26 the Plant Operations Director performed in-house training of the maintenance team regarding the required completion of annual 90-minute, functional testing of emergency lighting (in addition to monthly 30-second testing), and the prompt replacement of any emergency lighting that fails. The Plant Operations Director will also verify that the electronic work order system includes the annual testing (in addition to monthly testing) of the emergency lighting to comply with NFPA 101 Sections 19.2.9.1 and 7.9 (2012 Edition). In the event there is a deficiency reported during a testing, the Plant Operations Director or designated Maintenance staff will immediately act upon resolving this by replacing the battery or the emergency light fixture. The Plant Operations Director will complete annual audits of the Maintenance staff's compliance to the annual functional testing of emergency lighting and	02/26/2026

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K0291 SS = F Bldg. 01	Continued from page 2 would look into the documentation. A documentation review on 02/09/2026 revealed monthly 30 second testing, but no annual 90-minute testing of the emergency lights. During an interview at 11:30 AM, the [redacted] confirmed the document review stating that he was unsure of what testing was completed on the lighting. The [redacted] was not on site for interview on 02/09/2026. The facility's [redacted] was notified of the deficient practice during the Life Safety Code exit conference on 02/09/2026 at 1:45 PM. NJAC 8:39-31.2(e)-31.1(c)	K0291	Continued from page 2 the prompt correction of any deficiencies to comply with to NFPA 101 Sections 19.2.9.1 and 7.9 (2012 Edition). A report of the audit results will be submitted to the QAPI Committee at the next quarterly meeting. Thereafter, the audit will be continued and reported to the QAPI Committee meeting annually as part of ongoing monitoring for life safety.	02/26/2026
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	No residents were adversely affected by this practice. Immediately following the findings on 1/30/26, the Plant Operations Director repaired the deficient door hardware located on the specified, housekeeping closet door to comply with NFPA 101 Sections 19.2.2.2.7, 19.2.2.2.8 and 19.3.5.9 (2012 Edition). All residents (52 of 68) in the applicable care area were potentially affected by this practice. On 2/26/26 the Plant Operations Director performed in-house training to the maintenance team about compliance to NFPA 19.2.2.2.7, 19.2.2.2.8 and 19.3.5.9 (2012 Edition) and promptly repairing any doors to hazardous areas that are operationally deficient. A monthly inspection of the housekeeping closet door will be completed by the designated Maintenance staff for adherence to NFPA 19.2.2.2.7, 19.2.2.2.8 and 19.3.5.9 (2012 Edition). This monthly inspection was added to the facility's electronic work order system to prompt and document completion. In the event a deficiency is identified, the Plant Operations Director will be notified and immediately act upon resolving non-adherence through appropriate repair or replacement. The Plant Operations Director will complete monthly audits of the Maintenance staff's monthly inspections of the housekeeping closet door for adherence to NFPA 101 Sections 19.2.2.2, 2.2.8 and 19.3.5.9 (2012 Edition). A report of the audit results will be submitted to the QAPI Committee meeting quarterly for two quarters. The audit will be discontinued when 100% compliance is achieved for 6 consecutive months. Thereafter, the Plant Operations Director will complete annual audits of	02/26/2026

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K0321 SS = F Bldg. 01	Continued from page 3 (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 on 01/30/2026, in the presence of the U. S. FOIA (b) (2) it was determined that the facility failed to ensure that doors to hazardous areas were self-closing and kept in the closed position, unless held open by a releasing device in accordance with NFPA 101:2012 Edition, Section 19.2.2.2.7, 19.2.2.2.8 and 19.3.5.9. This deficient practice had the potential to affect 52 of 68 residents and was evidenced by the following: On 01/30/2026 at 10:40 AM, the surveyor observed the housekeeping closet directly across from the U. S. FOIA (b) (2) office and noted that the door was being held open by the top of the metal door frame and it was not closed or latched. When the door was opened, a mop sink and bottles of housekeeping chemicals were revealed within. When the door into the closet was opened and released, the door hit the metal frame and was unable to self-close and positively latch. The process was repeated two more times with the same result. During an interview at the time, the U. S. FOIA confirmed the observations. The facility's U. S. FOIA (b) (2) was notified of the deficient practice during the Life Safety Code exit conference on 02/09/2026 at 1:45 PM. NJAC 8:39-31.2(e)	K0321	Continued from page 3 the monthly, hazardous area door inspections including the specified, housekeeping closet door and submit results to the QAPI Committee.	02/26/2026
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	K0324	No residents were adversely affected by this practice. Immediately following the findings on 1/30/26, the U. S. FOIA (b) (2) called Vendor to assess the kitchen yellow and silver box equipment to determine use of the box. Vendor was unable to verify if box was needed so facility reached out to a second vendor scheduled to assess. On 5/1/26 box was repaired and inspected by Vendor. Functionality of box passed inspection. U. S. FOIA (b) (2) initiated monthly tag inspections on active kitchen fire suppression system in accordance with NFPA 101 2012, 18.3.2.5.1	05/01/2026

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K0324 SS = F Bldg. 01	Continued from page 4 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 * 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 on observations and interviews on 01/30/2026 and 02/09/2026 in the presence of the U. S. FOIA (b) (2) it was determined that the facility failed to ensure that a monthly Owners Inspection was conducted on the two kitchen suppression systems in accordance with NFPA 17 A:2010 Edition, Section 7.2. This deficient practice had the potential to affect all residents and was evidenced by the following: On 01/30/2026 at 12:00 PM, the surveyor observed a large metal box directly opposite of the main kitchen hood system with a yellow, "PULL IN CASE OF FIRE" station attached to it. When interviewed at the time, the U. S. FOIA was asked what the yellow pull station activated. The U. S. FOIA stated he was not sure but thought it was for the hood suppression system. When interviewed at that time, two cooks were asked by the surveyor what they would do if there was a fire under the range hood. Cook 1 looked at the yellow station and stated that he would pull that in order to activate the suppression system. During an interview with the U. S. FOIA the surveyor asked what he would do in the event of a fire under the range hood, and the U. S. FOIA stated that he would pull the yellow pull station first then use the Class C extinguisher if necessary. The U. S. FOIA was then asked	K0324	Continued from page 4 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 and NFPA 17 A:2010 Edition, Section 7.2.; NJAC 8:39-31.2(e)-31.1(c) All residents have the potential to be affected by this practice. The U. S. FOIA (b) (2) performed in-house, kitchen fire suppression system training of the U. S. FOIA (b) (2) on 1/30/26. Training addressed the proper utilization of the system and requirements for monthly inspections of updated, tag documentation by the vendor. The Plant Operations Director will verify that a Preventative Maintenance work order in the electronic work order system is in place to ensure that required quarterly kitchen fire suppression system inspections with testing are completed by the vendor and maintenance is addressing the monthly tag inspections. If there is a deficiency identified based upon these monthly/quarterly inspections, the Plant Operations Director will immediately implement corrective action(s) to comply with NFPA 101 2012, 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 and NFPA 17 A:2010 Edition, Section 7.2, NJAC 8:39-31.2(e)-31.1(c). The audit record and results of issues corrected will also be added to our Life Safety Book. The Plant Operations Director will audit completion of the quarterly, kitchen fire suppression system inspections along with proper tagging documentation for the next four quarters. A report of the audit results will be submitted to the QAPI Committee meetings quarterly. The audit will be discontinued when 100% compliance is achieved for four consecutive quarters. Thereafter, the Plant Operations Director will continue the above audit quarterly and submit results to the QAPI Committee annually.	05/01/2026

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K0324 SS = F Bldg. 01	Continued from page 5 if staff were in-serviced on the operation of the Suppression system. The [U. S. FOIA] stated he was uncertain. The surveyor requested any in-services that had been completed with staff on the operation of the suppression system. At 12:10 PM, the surveyor observed an inspection tag attached to the suppression chemical tank. There were no initials indicating the system had been inspected. An observation made by the surveyor revealed a second suppression system emergency pull by the kitchen entry door. The pull station had an inspection tag provided by the fire inspection vendor indicating it had been inspected. The inspection tag had not been initialed by the facility in order to indicate the system had received a monthly owner's inspection. In an interview at the time, the [U. S. FOIA] was asked what the suppression system pull station by the door operated, the [U. S. FOIA] stated he did not know. In an interview at the time, the [U. S. FOIA (b)] was asked if he knew what the yellow pull station operated or what the pull station by the door operated, the [U. S. FOIA (b)] stated that he did not know. A documentation review performed on 02/09/2026, revealed inspections for a 2-cylinder suppression system that was last inspected on 1/21/2026 and a separate 1-cylinder suppression system that was last inspected on 11/13/2025. No in-services for the operation of the suppression system were found within the documentation. In an interview during the Life Safety exit conference, the [U. S. FOIA (b)] was asked what the facility had learned about the two systems, the [U. S. FOIA (b)] stated that he still did not know but thought the yellow pull station worked a system by the dishwasher. The [U. S. FOIA (b)] was not aware that there were two systems noted within the inspection documentation. The [U. S. FOIA] was not present on the day of exit. On 02/09/2026 at 1:45 PM, the facility's [U. S. FOIA (b) (2)] was notified of the deficient practice during the Life Safety Code exit conference NJAC 8:39-31.2(e)-31.1(c) NFPA 13	K0324		05/01/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observations, documentation review, and interviews on 01/30/2026 and 02/09/2026, in the presence of the U. S. FOIA (b) (2) it was determined that the facility failed to ensure the testing and maintenance of the battery powered smoke detectors located in the resident rooms in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations made throughout the Life Safety Tour on 01/30/2026 from 9:20 AM to 12:15 PM, revealed different brands of smoke detectors within all resident rooms. In an interview at 9:20 AM, the U. S. FOIA was asked if the smoke detectors were hard wired to the alarm panel or battery powered. The U. S. FOIA responded that they were battery powered. When the U. S. FOIA was asked how often the smoke detectors were tested, he responded that he was uncertain. The U. S. FOIA was asked to provide the manufacturers documentation for each type of smoke detector with testing requirements as well as battery replacement requirements. The requested documentation was not provided prior to exit. On 02/09/2026 at 1:45 PM, the facility's U. S. FOIA (b) (2) was notified of the deficient practice during the Life Safety Code exit conference NJAC 8:39-31.2(e)-31.1(c) NFPA 70, 72	K0345	No residents were adversely affected by this practice. Immediately following the findings on 1/30/26, the Plant Operations Director scheduled an audit of the battery-operated smoke detectors that addresses testing and battery replacement. The audit of the battery-operated smoke detectors was completed on 3/2/26 in accordance with NFPA 70 and 72 (2012 Edition) and NFPA 101 Sections 9.6.1.3 and 9.6.1.5. The audit record and results of issues corrected will be added to our Life Safety Book. All residents have the potential to be affected by this practice. On 2/26/26, the Plant Operations Director performed in-house training of the maintenance team on testing all battery-operated smoke detectors and replacing the batteries in accordance with the manufacturer's instructions. By 3/6/26 the Plant Operations Director will add to the electronic work order system the monthly completion of testing along with necessary battery replacement of all battery-operated smoke detectors. In the event there is a deficiency identified during the required testing, the Plant Operations Director will immediately act upon resolving this by replacing the battery and/or the battery-operated smoke detector. The Plant Operations Director will audit and log the testing of the battery-operated smoke detectors monthly for three consecutive months and then every quarter in accordance with NFPA 70 and 72 (2012 Edition) and NFPA 101 Sections 9.6.1.3 and 9.6.1.5. A report of the audit results will be kept in the life safety book and submitted to the QAPI Committee meetings for the next two quarters and then annually.	03/31/2026

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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 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 observations and interviews on 01/30/2026, in the presence of the U. S. FOIA (b) (2) [redacted] it was determined that the facility failed to ensure that sprinkler system installation was in accordance with NFPA 101:2012 Edition, Section 19.3.5.1 and NFPA 13. This deficient practice had the potential to affect all residents and was evidenced by the following: At 10:39 AM, the surveyor observed two different sprinkler heads within the same smoke compartment. Resident room [redacted] contained a fusible link sprinkler head within the bathroom and a standard sprinkler head installed in the shower. At 10:55 AM, the surveyor observed what appeared to be a standard action sprinkler head in the Activities Office and three fusible link sprinkler heads installed in the activity room directly outside of the Activity Office. At 12:00 PM, the surveyor observed the staff breakroom with 3 of 4 sprinkler heads being fusible	K0351	No residents were adversely affected by this practice. Immediately following the findings on 1/30/26, the Plant Operations Director notified the vendor about the finding and scheduled the audit of fire sprinkler heads located in the same compartment. The audit of the fire sprinkler heads was scheduled for 3/6/26 and to be completed by 3/9/26 in accordance with NFPA 13 Standard for Installation of Sprinkler Systems (2012 Edition), and NFPA 101 Section 19.3.5.1 (2012 Edition). The audit record and results of issues corrected will be added to our Life Safety Book. All residents have the potential to be affected by this practice. The Plant Operations Director will coordinate with the contractor and Administration to develop a replacement plan for affected sprinklers to ensure heads are of the appropriate type. In the event there is a deficiency reported by the vendor, the Plant Operations Director will immediately act upon resolving this through the vendor services. Preventative Maintenance work order will be created in electronic system to ensure regular inspection/testing/maintenance of sprinkler heads. On 2/26/26 the Plant Operations Director provided education for all maintenance staff. The Plant Operations Director will direct the vendor to audit, annually, the facility's compliance with fire alarm testing including same style fire sprinkler heads in the same compartment in accordance NFPA 13 Standard for Installation of Sprinkler Systems (2012 Edition), and NFPA 101 Section 19.3.5.1 (2012 Edition). A report on the audit results will be submitted to the QAPI Committee annually and may be discontinued when 100% compliance is achieved for two consecutive years.	03/13/2026

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K0351 SS = F Bldg. 01	Continued from page 8 link style and 1 of 4 being what appeared to be a standard action sprinkler head. When interviewed after each finding, the U. S. FOIA (b) (2) confirmed the observations. The facility was unable to identify the temperature release of the two different sprinkler heads within the same smoke compartment. On 02/09/2026 at 1:45 PM, the facility's U. S. FOIA (b) (2) was notified of the deficient practice during the Life Safety Code exit conference NJAC 8:39-31.2(e)-31.1(c) NFPA 13	K0351		03/13/2026
K0363 SS = F Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K0363	No residents were adversely affected by this practice. Immediately following the findings on 1/30/26, the Plant Operations Director ordered parts to correct the specified door gap of a quarter/half inch to prevent the passage of smoke from one compartment into the next in accordance with NFPA 101 Sections 19.3.6, 19.3.6.3, 19.6.3.1, and 19.6.5 (2012 Edition). The parts are scheduled to be replaced by 3/6/26 which will establish compliance NFPA 101sections 19.3.6, 19.3.6.3, 19.6.3.1, and 19.6.5 (2012 Edition). All residents have the potential to be affected by this practice. On 2/26/26 the Plant Operations Director performed in-house training of the maintenance team to inspect fire doors monthly for compliance to NFPA 101sections 19.3.6, 19.3.6.3, 19.6.3.1, and 19.6.5 (2012 Edition). A Preventative Maintenance work order will be created in the electronic system accordingly to ensure regular inspection/testing/maintenance of fire doors. Upon completion of the inspections, any doors of non-compliance will be reported to the Plant Operations Director who will ensure that necessary corrective actions are implemented. The Plant Operations Director will complete and log fire door testing audits quarterly to monitor compliance with NFPA 101sections 19.3.6, 19.3.6.3, 19.6.3.1, and 19.6.5 (2012 Edition). A report of the audit results will be kept in the life safety book and submitted to the QAPI Committee quarterly for one year. When 100% compliance is achieved for four consecutive quarters, the audit will then be completed and submitted to the QAPI Committee annually.	03/06/2026

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K0363 SS = F Bldg. 01	Continued from page 9 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and interviews on 01/30/2026 at 11:20 AM, in the presence of the U. S. FOIA (b) (2) [redacted] it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Section 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect all residents and was evidenced by the following: At 11:20 AM, the surveyor observed a set of fire doors separating the hallway from the Skilled Nursing side into the Independent Living side. When closed, the doors revealed a gap from the bottom to the top of the meeting edges that measured approximately a quarter of an inch to a half inch which would allow for the passage of smoke from one smoke compartment into the next. During an interview at the time, the U. S. FOIA (b) and the U. S. FOIA [redacted] confirmed the observation. On 02/09/2026 at 1:45 PM, the facility's U. S. FOIA (b) (2) [redacted] was notified of the deficient practice during the Life Safety Code exit conference NJAC 8:39-31.2(e)-31.1(c)	K0363		03/06/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K0761	No residents were adversely affected by this practice. Immediately following the findings on 1/30/26, the Plant Operations Director contacted a door vendor to replace the clean utility room door on Blue Hallway and the soiled utility room door. Doors replaced on 4/6/2026 to establish compliance with NFPA 101 Sections 7.2.1.5 (2012 Edition) and NFPA 80 Sections 5.2.1 and 5.2.4.2 (1-11) (2010 Edition). All residents have the potential to be affected by this practice. On 2/26/26 the Plant Operations Director performed in-house training of the maintenance team to inspect fire rated doors quarterly and create a Preventative Maintenance work order in the electronic system accordingly to ensure regular	04/06/2026

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K0761 SS = F Bldg. 01	Continued from page 10 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 01/30/2026, in the presence of the U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to ensure that fire door assemblies were inspected, tested and maintained (ITM) annually in accordance with NFPA 101:2012 Edition, Sections 7.2.1.15 and the minimum requirements of NFPA 80:2010 Edition, Section 5.2.1 and 5.2.4.2 (1) - (11). This deficient practice had the potential to affect all residents and was evidenced by the following: 1). At 10:10 AM, the surveyor observed the clean utility room located on Blue Hall by the main lobby. The door to the clean utility room had approximately 28 screws going into the face of the door in order to hold it onto its frame. At 10:14 AM, the surveyor observed the soiled utility room door had screws throughout the edges of it holding the face to the frame. Both doors were labeled with a fire rating of 3/4 hour. During an interview at the time, the U. S. FOIA confirmed the observations. NJAC 8:39-31.2(e) NFPA 80	K0761	Continued from page 10 inspections/testing/maintenance of smoke/fire doors for compliance with NFPA 101 Sections 7.2.1.5 (2012 Edition) and NFPA 80 Sections 5.2.1 and 5.2.4.2 (1-11) (2010 Edition). On a quarterly basis, the Plant Operations Director will audit and log inspections of the fire rated doors in accordance with NFPA 101 Sections 7.2.1.5 (2012 Edition) and NFPA 80 Sections 5.2.1 and 5.2.4.2 (1-11) (2010 Edition). A report of the audit results will be kept in the life safety book and submitted to the QAPI Committee quarterly for 4 quarters. When 100% compliance is achieved for 4 consecutive quarters, the audits and results will be respectively completed and reported to the QAPI Committee annually.	04/06/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K0918	No residents were adversely affected by this finding. Immediately following the surveyor's finding of no documentation of a monthly 30-minute load test for the 150KW generator capable of supplying power within 10 seconds, annual fuel test, and a 3-year 4-hour load bank test, the Plant Operations Director notified the facility's generator service vendor about this finding and scheduled the load testing for 3/5/26. Fuel testing was conducted on 2/6/26 and results received on 2/20/26 showed no fuel deficiencies. On 2/6/26 the 30-minute load test was completed and demonstrated a satisfactory result. While performing the 3-year 4-hour load bank test the Vendor noted that the unit overheated at 80%. Part ordered to repair radiator so that generator can operate at 100%. Vendor noted that the generator is fully operational until the 80% threshold. Part	04/22/2026

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K0918 SS = F Bldg. 01	Continued from page 11 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on documentation review and interviews on 02/09/2026, in the presence of the U. S. FOIA (b) (2) [redacted] it was determined that the facility failed to ensure that the emergency backup generator was Inspected, Tested and Maintained in accordance with NFPA 110:2012 Edition, Section 8.3.8. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review from 8:30 AM to 1:00 PM revealed: No documentation of a monthly, 30-minute load test showing the 150 Kw (kilowatt) generator was capable of supplying service within 10 seconds. No documentation of an annual fuel test. No documentation of a 3-year 4-hour load bank test. During an interview with the U. S. FOIA (b) (2), they confirmed the documentation reviews and stated that the generator service company was "scheduled to come out" to perform all work. The U. S. FO stated that the generator service company performed the monthly load bank testing remotely and that they had the records. When asked if the	K0918	Continued from page 11 installed on 4/21/26 and 3-year 4-hour load bank test performed and passed on 4/22/26. All residents have the potential to be affected by this practice. The U. S. FOIA (b) (2) arranged for testing of the monthly 30-minute load test for the 150KW generator capable of supplying power within 10 seconds, annual fuel test, and a 3 year 4-hour load bank test in accordance with 2012 NFPA 110 section 8.3.8. The Plant Operations Director will train all Plant Operations team members on 3/5/26 regarding completion of the monthly 30-minute testing of the 150KW generator along with requirements for documentation. A Preventative Maintenance work order will be created in the electronic system to ensure regular inspection/testing/maintenance of generators in accordance with 2012 NFPA 110 section 8.3.8. Any deficiencies will be reported to the Plant Operations Director who will address them as a priority. The Plant Operations Director will annually audit the generator testing documentation for compliance of checks for completion of the proper documentation of testing the 150KW generator. For the next six months, the Plant Operations Director will audit completion of each monthly 30-minute load test of the 150KW generator to ensure it is capable of supplying power within 10 seconds,. The Plant Operations Director will also audit the vendor's completion of the annual fuel and 3 year 4-hour load bank tests for adherence to 2012 NFPA 110 section 8.3.8. The Plant Operations Director will report the audit results of the monthly testing to the QAPI Committee at its quarterly meetings. When 100% compliance is achieved for six months, the audit will be continued and reported to the QAPI Committee on a semi-annual basis. The Plant Operations Director will report audit results of the vendor's annual fuel and 3-year, 4-hour load testing to the QAPI Committee annually and at 3 years, respectively. Thereafter, these audits will be continued as part of the preventive maintenance program and reported to the QAPI Committee according to the same schedule.	04/22/2026

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K0918 SS = F Bldg. 01	Continued from page 12 facility personnel could produce the records, the [redacted] stated he could call them. No new documentation was provided by the time of the Life Safety exit conference. On 02/09/2026 at 1:45 PM, the facility's [redacted] was notified of the deficient practice during the Life Safety Code exit conference NJAC 8:39-31.2(e) NFPA 99, NFPA 110, NFPA 111, NFPA 70	K0918		04/22/2026
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K0222	No residents were adversely affected by this practice as they did not require exit through the specified egress doors. Immediately following the findings on 1/30/2026, the Plant Operations Director scheduled the vendor to assess and replace parts on emergency exit #40 to ensure correct operation on 2/26/26. Replacement was completed on 3/15/26 resulting in the compliance of NFPA 101sections 19.2.2.2.5.2 and 19.2.2.2.6 (2012 Edition). All residents of the specified wing (28 of 68) had the potential to be affected by this practice. On 2/26/26 the [redacted] trained the maintenance team to test the magnetic locking system on the egress door monthly and document results on the egress inspection log. A work order to prompt for and ensure monthly completion of the door testing will also be entered in the electronic work order system. The Plant Operations Director will audit monthly completion of the magnetic locking system egress door testing on a quarterly basis to ensure compliance with NFPA 101sections 19.2.2.2.5.2 and 19.2.2.2.6 (2012 Edition). A report of the audit results will be maintained in the life safety book and submitted to the QAPI Committee quarterly. The audit will be discontinued if 100% compliance is achieved for four consecutive quarters. Thereafter, the audit will be conducted and reported to the QAPI Committee annually by the Plant Operations Director.	03/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315262	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **02/09/2026**

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Harrogate	**400 LOCUST STREET , 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
K0222 SS = E Bldg. 01	Continued from page 13 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 01/30/2026, in the presence of the U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstruction or impediment to full instant use in the case of fire or other emergencies in accordance with NFPA 101:2012 Edition, Section 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice had the potential to affect 28 of 68 residents and was evidenced by the following: At 9:33 AM, the surveyor observed at emergency exit #40 that the exit door had a sign posted on it which indicated, "Emergency Exit Only Push Until Alarm Sounds Door can be opened in 15 seconds". When the [redacted] pressed on the door for 15 seconds, it failed to go into alarm or to open. The [redacted] then attempted to press on the door for 15 seconds two more times with the same result. The door failed to go into alarm, and it failed to open.	K0222		03/15/2026

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K0222 SS = E Bldg. 01	Continued from page 14 When the [U. S. FOIA] tested the keypad next to the door, the egress lock released and the door was able to be opened. During an interview at the time, the [U. S. FOIA] confirmed the observations. The facility's [US FOIA (b)(6)] was notified of the deficient practice during the Life Safety Code exit conference on 02/09/2026 at 1:45 PM. NJAC 8:39-31.2(e)	K0222		03/15/2026
K0353 SS = E 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 _____ 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 documentation review, observations and interviews on 01/30/2026 and 02/09/2026, in the presence of the [U. S. FOIA (b) (2)] it was determined that the facility failed to ensure that fire sprinkler systems were Inspected, Tested and Maintained (ITM)	K0353	No residents were adversely affected by this practice. Immediately following the findings on 1/30/26, the [U. S. FOIA (b) (2)] performed an audit of the fire sprinkler bodies covered with paint. Sprinkler deficiencies found on 1/30/26 in resident rooms #[NJ B] and #[NJ B] will be corrected by 3/30/26 (if replacement is necessary) in accordance with NFPA 25 Sections 5.1.1.2, 14.2.1, 5.2.4, and 5.3.2. (2011 Edition). Documentation will be added to our Life Safety Book. Separately, immediately following the findings 1/30/26, the fire sprinkler vendor was scheduled to conduct testing in accordance with NFPA 25 Sections 5.1.3, Table 5.1.1.2, 14.2.1, 5.2.4, and 5.3.2. (2011 Edition) , i.e., of the 4.60 capacity, 1 cylinder and the 7.60 capacity, 2-cylinder kitchen suppression system systems and the three year air-leak test of the dry sprinkler system starting and finishing on 3/6/26 and 3/9/26, respectively. Separately, immediately following the findings on1/30/26, in accordance with NFPA 25 Sections 5.1.3, Table 5.1.1.2, 14.2.1, 5.2.4, and 5.3.2. (2011 Edition), the Plant Operations Director immediately performed an audit of the ceiling tile of the main kitchen and immediately installed/replaced ceiling tiles in the three sections specified in the dishwasher room on 2/1/26. Separately, immediately following the findings on 1/30/26 in accordance with NFPA 25 Sections 5.1.3, Table 5.1.1.2, 14.2.1, 5.2.4, and 5.3.2. (2011 Edition) the Plant Operations Director immediately performed work to seal penetrations through a barrier above the dishwasher and above barrier doors dividing Independent Living and Skilled Nursing. All residents have the potential to be affected by this	03/30/2026

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K0353 SS = E Bldg. 01	Continued from page 15 in accordance with NFPA 25:2011 Edition, Section 5.1.3, Table 5.1.1.2, 14.2.1, 5.2.4 and 5.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: 1). At 10:34 AM, the surveyor observed a sidewall, fusible link sprinkler in resident room [NJE] with paint covering the deflector and body of the sprinkler. At 10:38 AM, the surveyor observed a fusible link sprinkler head in resident room [NJE] with paint on its body. At 11:36 AM, the surveyor observed a sidewall, fusible link sprinkler in resident room [N] with paint on its body. During interviews after each observation, the [U. S. FOIA] confirmed the observation. 2). A documentation review performed on 02/09/2026, revealed 1 of 2 semi-annual reports for the kitchen suppression system identified as the 7.60 capacity, 2 cylinder, dated 01/21/2026. A second suppression system identified as the 4.60 capacity, 1 cylinder, had semi-annual inspection reports dated 11/13/2025 and 02/03/2025. These reports were nine months apart. 3). There was no documented evidence for the 3-year air leak test of the dry sprinkler system. In an interview with the [U. S. FOIA (b) (2)], they confirmed the findings of the documentation review. The [U.S.RO] stated that he had spoken to the sprinkler company and been told that "the previous [U. S. FOIA (b) (2)] had not permitted the company to perform the air-leak testing". 4). An observation on 01/30/2026 at 12:02 PM, of the main kitchen, dishwasher room revealed: The room was missing: One section of approximately 4x4 ceiling tile. One section of approximately 1x2 ceiling tile. One section of approximately 36-inch x5 foot ceiling tile. The surveyor observed the ceiling above the dishwasher had a vent running through it. There was unprotected spacing around the vent which would allow the passage of smoke and flame. Tape was	K0353	Continued from page 15 practice. On 2/26/26 the [U. S. FOIA (b) (2)] performed in-house training of the maintenance team relating to barrier wall penetrations, and fire sprinkler integrity to comply with NFPA 25 Sections 5.1.3, Table 5.1.1.2, 14.2.1, 5.2.4, and 5.3.2. (2011 Edition). The [U. S. FOIA (b) (2)] educated the [U. S. FOIA (b) (2)] about completing quarterly and every three year checks, respectively, to ensure that the fire suppression system inspections and air leak testing of the specified areas are completed timely by the vendor. A Preventative Maintenance work order was also added to the electronic system for the vendor's quarterly fire suppression inspections and three-year air leak testing as well as Maintenance monthly inspections for the barrier wall penetrations and fire sprinkler integrity. In the event there is a deficiency identified through the monthly/quarterly inspections, the Plant Operations Director will immediately act upon resolving this by repairing gaps around barrier wall penetrations and addressing any compromised fire sprinkler bodies to comply with NFPA 25 Sections 5.1.3, Table 5.1.1.2, 14.2.1, 5.2.4, and 5.3.2. (2011 Edition). For the next two months, the Plant Operations Director will audit compliance of the specified areas to NFPA 25 Sections 5.1.3, Table 5.1.1.2, 14.2.1, 5.2.4, and 5.3.2. (2011 Edition) through separately logged, monthly inspections of barrier wall penetrations and fire sprinkler body integrity. The Administrator will audit completion of the vendor's quarterly fire suppression system inspections and air leak testing quarterly for the first year and at three years, respectively. A report of the above audit results will be kept in the life safety book. The results of the first audit will be submitted to the QAPI Committee's third quarter meeting. When 100% is achieved for two consecutive months, the Plant Operations Director will continue the audits quarterly and results will be submitted to the QAPI Committee semi-annually. The results of the second audits will be submitted to the QAPI Committee meetings quarterly and in three years, respectively. When 100% compliance of fire suppression system inspections is achieved for four consecutive quarters, the audit will be discontinued. The Plant Operations Director will continue to monitor compliance quarterly through the preventive maintenance program and report findings to the	03/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 02/09/2026

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K0353 SS = E Bldg. 01	Continued from page 16 seen hanging from the area and watermarks surrounded the area. In an interview at the time the [redacted] and the [redacted] confirmed the observations. 5). On 01/30/2026 at 11:19 AM, the surveyor observed the set of barrier doors dividing Independent Living from Skilled Nursing. When the ceiling tile was moved aside, two PVC electrical conduits were seen passing from the Skilled Nursing side into an open area of the wall. This area was unprotected and would allow for the passage of smoke and flame. During an interview at the time, the [redacted] and the [redacted] confirmed the observation. On 02/09/2026 at 1:45 PM, the facility's [redacted] was notified of the deficient practice during the Life Safety Code exit conference NJAC 8:39-31.2(e)-31.1(c) NFPA 25 NFPA 13	K0353	Continued from page 16 QAPI Committee annually. The audit of the three-year air leak test will also be discontinued when 100% compliance is achieved on the next due date. As part of the preventive maintenance program, the Plant Operations Director will continue to monitor this testing and report compliance to the QAPI Committee every three years.	03/30/2026
K0523 SS = E Bldg. 01	HVAC - Suspended Unit Heaters CFR(s): NFPA 101 Suspended Unit Heaters Suspended unit heaters are permitted provided the following are met: * Not located in means of egress or in patient rooms. * Located high enough to be out of reach of people in the area. * Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1) This STANDARD is NOT MET as evidenced by: Based on observation and interviews on 01/30/2026, in the presence of the [redacted] it was determined that the facility failed to prohibit the use of electric suspended unit heaters that are not	K0523	No residents were adversely affected by this practice. Immediately following the findings on 1/30/26, the Plant Operations Director coordinated with a vendor to assess the safe removal of the unit heater to establish compliance with NFPA 101 2012, 18.5.2.3(1), 19.5.2.3(1). The heater was removed on 2/26/26. All residents have the potential to be affected by this practice. On 2/26/26 the Plant Operations Director trained Maintenance staff on adherence to NFPA 101 2012, 18.5.2.3(1), 19.5.2.3(1) for wall mounted heater installations. A procedure was also developed that requires staff to consult with and obtain approval from the Plant Operations Director prior to the addition of a wall mounted heater. Education about this procedure was included in the staff training and also addresses proper heater installation in accordance with NFPA 101 2012, 18.5.2.3(1), 19.5.2.3(1). The Plant Operations Director will audit the space of the previous wall heater monthly to ensure no unit heaters are reinstalled and compliance is maintained with NFPA 101 2012 Sections 18.5.2.3(1), 19.5.2.3(1). A report of the audit results will be kept in the life	02/26/2026

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Harrogate	400 LOCUST STREET , LAKEWOOD, New Jersey, 08701

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K0523 SS = E Bldg. 01	Continued from page 17 located high enough to be out of reach of people in the area in accordance with NFPA 101: 2012 edition, Section 19.5.2.3(1). This deficient practice had the potential to affect all residents using the Rehab gym area and was evidenced by the following: At 11:00 AM, the surveyor observed an electric wall heater suspended at the rear wall of the Rehab Gym. The bottom of the heater unit was less than six-foot from the ground and was not high enough to be out of reach of people in the area. The heater was located close to gym equipment and at the time of observation there was a patient walking by it while participating in exercise. In an interview with the [redacted] she stated, "they did use the heater, especially on these colder days we have been having as the gym does get cold." During an interview at that time, the [redacted] confirmed the observation and that the heater was used when needed. On 02/09/2026 at 1:45 PM, the facility's [redacted] was notified of the deficient practice during the Life Safety Code exit conference. NJAC 8:39-31.2(e)	K0523	Continued from page 17 safety book and submitted to the QAPI Committee quarterly. When 100% compliance is achieved for six months, the audit will be discontinued. The QAPI Committee will make recommendations for periodic monitoring as necessary.	02/26/2026

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/30/2026 and 02/09/2026. The facility was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		03/02/2026

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: 315262	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 5/6/2026 in relation to the 2/9/2026 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.

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