STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315375	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS CENTER FOR REHABILITATION AND HEALING	**497 MT PROSPECT AVE , NEWARK, New Jersey, 07104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Survey Date: 8/5/25 Census: 104 Sample: 28 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		10/27/2025
F0804 SS = F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews and review of pertinent facility documents, it was determined that the facility failed to provide food at a safe and appetizing temperature. The deficient practice was identified for 6 of 6 residents (Residents #1, #19, #20, #29, #69 and #78) that participated in the Resident Council Meeting and was evidenced by the following: On 7/31/25 at 10:30 AM, while participating in Resident council meeting 6 of 6 residents verbalized, they receive food that is cold at meals. On [redacted] at 10:15 AM, the surveyor interviewed [redacted] for [redacted] floor. The [redacted] confirmed "occasionally" residents ask for their food to be heated because it arrived cold. The [redacted] further stated cold food gets	F0804	Following the Resident Council meeting on 7/31, the [redacted] met with each of the six residents (Residents #1, #19, #20, #29, #69, and #78) to review their concerns regarding cold meals and confirm their dietary preferences and expectations. The [redacted] attended a resident council meeting. No further concerns were noted by other residents. No further complaints were reported by any of the six residents following these corrective actions. A review of kitchen meal temperature audits and tray line documentation showed no additional residents experiencing food temperature issues. All dietary and nursing staff received re-education on timely meal delivery and maintaining appropriate food temperatures for all residents. Meal temperature checks were incorporated into ongoing kitchen audits to ensure continued compliance for all residents. Re-education was provided to all dietary and nursing staff on proper meal pass procedures, timeliness of meal delivery, and maintaining appropriate food temperatures during transport. The Food Service Director updated the kitchen audit tool to include routine meal temperature monitoring Elevator functionality concerns have been resolved,	10/10/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315375	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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F0804 SS = F	Continued from page 1 heated up on the unit in a microwave. [redacted] stated staff starts passing trays as soon as they are on the floor and acknowledged there are some delays at times getting trays to floor caused by elevators. On 8/5/25 at 10:20AM, the surveyor interviewed CNA #1. CNA#1 verbalized that residents complain of cold food "sometimes" and stated the elevators "slow down the food arrival time" and "sometimes we are busy and food gets passed out slowly". On 8/5/2025 at 10:25 AM, the surveyor interviewed CNA #2. CNA#2 stated that residents get cold food "a lot". CNA#2 verbalized she heats trays up for residents almost every day and stated the elevator causes "big delays" and "we only have one working elevator for a long time now". On 8/5/2025 at 10:40AM, the survey team met with the [redacted] and [redacted] to discuss concerns including food temperature and both acknowledged food temperature and tray delivery delay issues. Both acknowledged residents should receive foods at appropriate temperatures. NJAC 8:39-17.4(a)2, (e)	F0804	Continued from page 1 eliminating prior delays. The Food Service Director or designee will conduct meal temperature audits daily x3, weekly x4, then monthly x3 Monitoring will also include direct observation of timely tray pass during the audit period. All audit results will be submitted to quaterly quality assurance Committee quarterly, and any identified issues will be corrected immediately.	10/10/2025
F0806 SS = F	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that resident's dietary preferences were consistently implemented and followed for 6 of 6 residents (Resident #2, #8, #25, #69, #94, and #116) reviewed for dietary preferences during meal observations. This deficient practice was evidenced as follows: 1. On 7/30/25 at 12:17 PM, the surveyor was observing the lunch meal on [redacted] floor unit. The surveyor observed Resident #69's tray, per the tray	F0806	Resident #69 – Food preferences/allergies were reviewed with resident, and clinical notes were reviewed. Preferences were reviewed for accuracy in ticket system. Resident #25 - Food preferences/allergies were reviewed with resident, and clinical notes were reviewed. Preferences were reviewed for accuracy in ticket system. Resident #116 – Food preferences/allergies were reviewed with resident, and clinical notes were reviewed. Preferences were reviewed for accuracy in ticket system. Resident #94 – Food preferences/allergies were reviewed with resident, and clinical notes were reviewed. Preferences were reviewed for accuracy in ticket system. Resident #2 – Food preferences/allergies were reviewed with resident, and clinical notes were reviewed. Preferences were reviewed for accuracy in ticket system. Resident #8 - Food preferences/allergies were reviewed with resident, and clinical notes were reviewed. Preferences were reviewed for accuracy in ticket system. All residents have the potential to be affected by this finding	10/10/2025

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F0806 SS = F	Continued from page 2 ticket, Resident #69 was supposed to receive coffee, strawberry short cake and NJ Ex Order 26, 4B1, all three items were missing from the tray. 2. On 7/30/25 at 12:23 PM, the surveyor was observing the lunch meal on [redacted] floor unit. The surveyor observed Resident #25's tray, per the tray ticket, Resident #25 was supposed to receive sour cream and NJ Ex Order 26, 4B1, both items were missing from the tray. 3. On 7/30/25 at 12:29 PM, the surveyor was observing the lunch meal on [redacted] floor unit. The surveyor observed Resident #116's tray, per the tray ticket, Resident #116 was supposed to receive coffee and strawberry short cake, both items were missing from the tray. 4. On 7/30/25 at 12:33 PM, the surveyor was observing the lunch meal on [redacted] floor unit. The surveyor observed Resident #94's tray, per the tray ticket, Resident #94 was supposed to receive pot roast, bread and health NJ Ex Order 26, 4B1, all three items were missing from the tray. 5. On 7/30/25 at 12:39 PM, the surveyor was observing the lunch meal on [redacted] floor unit. The surveyor observed Resident #2's tray, per the tray ticket, Resident #2 was supposed to receive coffee and sour cream, both items were missing from the tray. 6. On 7/30/25 at 12:45 PM, the surveyor was observing the lunch meal on [redacted] floor unit. The surveyor observed Resident #8's tray, per the tray ticket, Resident #8 was supposed to receive double portions protein, tea, sour cream, and gravy, all four items were missing from the tray. 1. On 7/30/25 at 12:50 PM, the surveyor reviewed the electronic medical record (E-mar) for Resident #69. A review of Resident #69's Face sheet (FS) (an admission summary) was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26, 4B1 A review of the Quarterly MDS, (an assessment tool used to facilitate care management) dated [redacted], reflected a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident's NJ Ex Order 26, 4B1. A review of the Physician Order (PO) summary revealed a PO dated [redacted], NJ Ex Order 26, 4B1 three times a day for [redacted]	F0806	Continued from page 2 Tray accuracy was monitored to ensure that other residents' preferences were being honored. Residents with special diets, allergies or noted food preferences were reviewed to confirm accuracy. No other issues were identified. Routine tray accuracy audits have been implemented and will continue a ongoing basis. The facility's "Meal Pass" policy was reviewed by the Administrator and determined to remain appropriate with no changes needed. All kitchen staff/nursing received education on the facility's "Meal Pass" policy and the importance of honoring resident preferences. Food Service Director/ Designee will conduct, Tray accuracy audits weekly x 4 weeks and then monthly x3 months Results of all audits will be reported quarterly to the QAA/QAPI committee	10/10/2025

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F0806 SS = F	Continued from page 3 A review of Resident #69's care plan (CP) revealed a nutrition CP with an initiation date of [redacted], the intervention portion of the CP revealed two [redacted] interventions, "Provide, serve diet as ordered" with an initiation date of [redacted] and "Provide and serve supplements as ordered: [redacted] as ordered", with an initiation date o[redacted] 2. On 7/30/25 at 12:55 PM, the surveyor reviewed the E-mar for Resident #25. A review of Resident #25's FS was admitted to the facility with diagnoses that included but were not limited to[redacted] A review of the annual MDS, dated [redacted], reflected a BIMS score o[redacted] indicating Resident #25 had [redacted]. A review of the PO summary dated [redacted] identified an order with an original date o[redacted] "Regular [redacted] A review of Resident #25's CP revealed a [redacted] CP with an initiation date of [redacted], the intervention portion of the CP revealed three [redacted] interventions all with [redacted] initiation dates, "Provide, serve diet as ordered", "Provide fortified foods as indicated", and Provide [redacted] per orders." 3. On 7/30/25 at 1:00 PM, the surveyor reviewed the E-mar for Resident #116. A review of Resident #116's FS was admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the quarterly MDS, dated [redacted], reflected a BIMS score o[redacted] indicating Resident #116 had [redacted]. A review of the PO summary dated [redacted] identified an order with an original date o[redacted], [redacted] [redacted]. A review of Resident #116's CP revealed a [redacted] CP with an initiation date of [redacted], the intervention portion of the CP revealed two [redacted] interventions first with an initiation date o[redacted] "Honor food preferences" and a second with an initiation date o[redacted] "Provide, serve diet as ordered."	F0806		10/10/2025

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F0806 SS = F	Continued from page 4 4. On 7/30/25 at 1:05 PM, the surveyor reviewed the E-mar for Resident #94. A review of Resident #94's FS was admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the quarterly MDS, dated [redacted] reflected a BIMS score of [redacted], indicating Resident #94 had [redacted] A review of the PO summary dated [redacted] identified two orders, one with an original date of [redacted], and [redacted] and a second order with an original date of [redacted], two times a day for [redacted]. A review of Resident #94's CP revealed a CP with an initiation date of [redacted], the intervention portion of the CP revealed two interventions both with initiation dates of [redacted] "Provide, serve diet as ordered" and "Provide supplements of [redacted] 5. On 7/30/25 at 1:10 PM, the surveyor reviewed the E-mar for Resident #2. A review of Resident #2's FS was admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the quarterly MDS, dated [redacted] reflected a BIMS score of [redacted], indicating Resident #2 had [redacted]. A review of the PO summary dated [redacted] identified an order, original date of [redacted], and [redacted] A review of Resident #2's CP revealed a CP with an initiation date of [redacted], the intervention portion of the CP revealed a intervention with initiation date of [redacted] "Provide, serve diet as ordered." 6. On 7/30/25 at 1:15 PM, the surveyor reviewed the E-mar for Resident #8. A review of Resident #8's FS was admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the admission MDS, dated [redacted] reflected a BIMS score of [redacted], indicating Resident #8 [redacted]	F0806		10/10/2025

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F0806 SS = F	Continued from page 5 A review of the PO summary dated [NJ Ex Order 2], identified an order, with an original date of [NJ Ex Order 26], [redacted]. A review of Resident #8's CP revealed a [NJ Ex Order 26.4] CP with an initiation date of [NJ Ex Order 26], the intervention portion of the CP revealed two [NJ Ex Order 26.4] interventions both with initiation dates of [redacted], "Provide [NJ Ex Order 26.4(b)(1)] at all meals," and "Provide, serve [NJ Ex O] as ordered." On 7/30/25 at 1:30 PM, the surveyor conducted an interview with the [U. S. FOIA (b) (2)] who stated they have not completed tray accuracy audits, but agreed they need to be done to ensure tray accuracy. On 7/30/25 at 1:40 PM, the surveyor conducted an interview with the [U. S. FOIA (b) (2)] who stated, the kitchen staff needs to have the tray double checked before going up to the units and he needs to perform more tray accuracy audits. On 7/31/25 at 12:36 PM, the surveyor met with the [U. S. FOIA (b)] and [U. S. FOIA (b) (2)]) to review areas of concern found during the survey. The [U. S. FOIA (b)] stated the tray accuracy concerns will immediately be addressed. On 8/4/25 at 11 AM, the [U.S. FOIA] provided the surveyor a facility policy titled, "Meal Pass" with a reviewed dated of 5/2025. Under the description portion of the policy it states, "Meal Services...3. Staff must check the meal ticket upon removing tray from food truck and ensure that items on the meal ticket are present on the tray." On 8/5/25 at 12:27 PM, the survey team met with the [U. S. FOIA (b) (2)] for the exit conference. No further information provided by the facility staff NJAC - 17.4(a)1, (e)	F0806		10/10/2025
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved	F0812	Food that was observed open and without open/use by labels were discarded Food that was observed being used 90 days after "open date" was discarded DA #1 was educated on the policy "Employee Hygiene" Dual oven was cleaned	10/10/2025

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F0812 SS = F	Continued from page 6 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 facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 7/29/25 at 9:37 AM, the surveyor in the presence of the U. S. FOIA (b) (2)) toured the kitchen and observed the following: 1. In the bread storage area, the surveyor observed one loaf of sliced white bread, one loaf of sliced whole wheat bread, one bag of 12 hotdog buns, and one loaf of rye bread all opened and without open/use by labels. The U. S. FOIA stated they use the manufacturers use by dates. 2. On a dry storage shelf the surveyor observed an open bag of penne pasta with an open date of 3/26/25 without a use by label. The U. S. FOIA stated open pasta can be used for 90 days after opening and further acknowledged the pasta was past the 90 days from opening. 3. On the Chef preparatory table, the surveyor observed three opened containers of seasoning: 16 ounce (oz) granulated garlic, 5 oz Italian seasoning, and 16 oz red pepper flakes. All seasonings had been opened and were missing open/use-by labels. The U. S. FOIA stated the seasoning should have been labeled and were discarded.	F0812	Continued from page 6 Standing steamer was cleaned Vent above Ice machine was cleaned Interior fans in walk-refrigerator were cleaned Chef was educated on the proper procedure to take food temperatures All residents have the potential to be affected by this finding Pantry was audited for unlabeled foods, no further findings. Pantry was audited for any foods being used after 90 days of opening, no further findings Kitchen equipment was audited for cleanliness, no further findings. The policy titled "storage of non-perishable goods" was reviewed by the administrator, no changes needed All kitchen staff was educated on above policy The policy titled "kitchen cleaning equipment" was reviewed by the Administrator, no changes needed. All kitchen staff was educated on above policy The policy titled "Employee Hygiene" was reviewed by the administrator, no changes needed All kitchen staff was educated on the above policy, no changed needed Food Service Director/designee will audit pantries weekly x 4 then monthly x3 to ensure all foods are labeled properly. Results of all audits will be reported monthly to the QAA/QAPI committee	10/10/2025

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F0812 SS = F	Continued from page 7 4. The surveyor observed a dietary aide (DA#1) without their hair fully restrained under a hairnet. DA#1 stated they had not realized some of their hair was no longer restrained and put on a new hairnet. 5. The dual ovens were observed with a black colored burnt debris on the bottom area. The U. S. FOIA stated the ovens are cleaned weekly but could not stated why the debris was present. 6. The surveyor observed on the top of the standing steamer a sticky grease like substance was present. The U. S. FOIA stated the steamer is cleaned weekly but could not state why the grease like substance was present. 7. On the ice machine vent the surveyor observed a dust like debris. Per the U. S. FOIA the ice machine vent is cleaned weekly but could not state why the debris was present. 8. In the walk-in refrigerator the surveyor observed a dust like debris on the interior fans and wrapped sliced America cheese without an open/use-by label. The U. S. FOIA stated all items should be labeled and the cheese was On 7/30/25 at 11:15 AM, during the follow up kitchen the surveyor observed the following. 9. As the chef was taking food temperatures of the tray line the surveyor observed, the chef place the food thermometer into a full tray of broccoli past the metal probe where the broccoli was touching the plastic portion, thereby contaminating the broccoli. Per interview the chef stated they had not realized the plastic had touched the broccoli. Per the U. S. FOIA the broccoli would need to be disposed of. During further observation the chef contaminated a full tray of roasted potatoes and a 1/4 tray of mashed potatoes by place the plastic portion of the food thermometer into the food. All food was disposed of by the U. S. FOIA. The U. S. FOIA stated all staff would be re-in-serviced on taking food temperatures. On 7/30/25 the U. S. FOIA (b) (2) provided the surveyor with multiple facility kitchen policies. The facility policy titled "Storage of non-Perishable Goods" with a reviewed date of 5/2025 revealed under the policy interpretation and implementation section, "6. Dry goods (i.e. cereal, grains_ shall be stored for a period not to exceed three months." The "Kitchen Cleaning Equipment" policy with a reviewed date of 5/2025 revealed under the policy	F0812		10/10/2025

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F0812 SS = F	Continued from page 8 interpretation and implementation section, "3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions…Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions." The "Employee Hygiene" policy with a reviewed date of 5/2025 revealed under the policy interpretation and implementation section, "10. Hairnets or caps and beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens." Policy for labeling and dating of food items not provided after surveyor request. On 7/31/25 at 12:36 PM, the surveyor met with the U. S. FOIA (b) (2) to review areas of concern found during the survey. The U. S. FOIA (b) stated all kitchen concerns will immediately be addressed. On 8/5/25 at 12:27 PM, the surveyor team met with the U. S. FOIA (b) (2) for the exit conference. No further information provided by the facility staff NJAC 8:39-17.2(g)	F0812		10/10/2025
F0814 SS = F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the dumpster and surrounding area free of garbage and debris. This deficient practice was observed and evidenced by the following: On 7/29/25 at 9:37 AM, the surveyor in the presence of the U. S. FOIA (b) (2)) toured the kitchen and garbage area; and found the following. There was garbage debris that included food wrappers, food containers, cups, gloves, paper products, and plastic utensil around the dumpster	F0814	Dumpster area was immediately cleaned U. S. FOIA (b) (2) was immediately educated on the policy labeled "Disposal of Refuge" All residents have the potential to be affected by this finding An audit of all disposal and garbage areas was conducted, and no further findings were identified. Administrator reviewed the policy titled "Disposal of Refuge" No changed needed Food Service Director was educated on above policy by Administrator Director of Food Services/designee will monitor dumpster area to ensure the area remains clear from garbage and debris Director of Food Services/Designee will audit dumpster weekly x4 then monthly x3 to ensure the dumpster areas remain clear from garbage and debris	10/10/2025

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F0814 SS = F	Continued from page 9 and surrounding areas. The [redacted] stated that the area should have been cleaned by the maintenance and dietary departments. On 7/30/25 at 1:00 PM, the [redacted] provided the surveyor with a facility policy titled, "Disposal of Refuse" with a reviewed date of [redacted]. Under the interpretation and implementation section of the policy revealed, "4. Outside dumpsters or compactors provided by waste management services will be kept closed and free of surrounding debris." On 7/31/25 at 12:36 PM, the surveyor met with the [redacted]). The [redacted] stated the garbage area concerns would immediately be addressed. On 8/5/25 at 12:27 PM, the surveyor met with the [redacted] for exit conference, no further pertinent information provided. NJAC 8:39-19.7	F0814	Continued from page 9 Results of all audits will be reported quarterly to the QAA/QAPI committee.	10/10/2025
F0692 SS = E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by:	F0692	Resident #64 reviewed by RD; current weights were obtained and entered into the EMR. Current interventions were reviewed and determined if they were effective and appropriate. Updated RD assessment completed and confirmed compliance with physician's weekly weight order. · Physician was notified; interventions/orders confirmed. Resident #8 was discharged on [redacted] Audit of all residents with significant weight changes (> 5% in 30 days, >7.5% in 90 days and > 10% in 180 days) to confirm RD assessment and interventions. Audit of all residents with MD orders for weekly weights completed; any missing weights re-obtained and entered. Backdated or late documentation corrected; RD and nursing staff re-educated on timely documentation.	10/10/2025

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F0692 SS = E	Continued from page 10 Based on observation, interview, record review and review of facility policies it was determined that the facility failed to a.) ensure residents with significant NJ Ex Order 26.4(b)(1) were addressed by the Registered Dietitian (RD#1) in a timely fashion and b.) ensure that a resident was NJ Ex Order 26.4 weekly in accordance with physician's orders and facility policy. This deficient practice was identified for 2 of 2 residents (Resident #8 and #64) reviewed for significant NJ Ex Order 26.4(b)(1) The deficient practice was evidence by the following: 1. On 7/29/25 at 11:18 AM, the surveyor interviewed Resident #64 in their room. Resident #64 stated they are on a NJ Ex Order 26, 4B1 and had NJ Ex Order 26, 4B1 over the past year, but unable to state how much. A review of Resident #64 Face Sheet ((FS) an admission record) revealed that the resident had diagnosis that included but were not limited to NJ Ex Order 26, 4B1 Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26 reflected a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1, indicating Resident #64 had NJ Ex Order 26, 4B1 Review of the weights from the electronic medical record (EMR) revealed: NJ Ex Order 26, 4B1 NJ Ex Order 26.4(b)(1) NJ Ex Order 26, 4B1 NJ Ex Or NJ Ex Order 26, 4B1 NJ Ex Or NJ Ex Order 26, 4B1 NJ Ex Or NJ Ex Order 26, 4B1 NJ Ex Or NJ Ex Order 26, 4B1 NJ Ex Or A review of the RD#1's nutrition progress notes (NPN) for Residents #64 in the electronic medical record revealed the following had two "LATE ENTRY" (Any documentation that is recorded in the	F0692	Continued from page 10 Weight Monitoring Policy updated: Nursing staff must obtain/document weights in the EMR on the scheduled dates per MD orders Unit Manager verifies EMR entries; RD reviews weekly weight variance reports. Any requested reweights must be obtained and re-entered into the EMR. Documentation Policy updated: registered dietician notes must be completed in EMR in a timely manner; no backdating permitted. Communication System implemented: If a re-weigh is needed, the registered dietician will request an MD order is entered and will notify the unit manager and DON via email Nursing and registered dietician staff re-educated on weight monitoring policy, documentation timeliness, and interventions for significant weight changes Registered Dietician will keep a log of weekly weight orders; DON cross-checks against MD orders. DON/designee audits weekly weight logs and EMR compliance reports weekly × 4 DON/designee audits 5 charts monthly × 3 to verify timely weights and RD interventions. Results will be reported quarterly to the QAA/QAPI committee All findings will be reported to the Administrator for any additional corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of correction.	10/10/2025

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F0692 SS = E	Continued from page 11 medical record beyond 24-48 hours of the encounter is classified as a Late Entry.) designation which indicates the notes were not written on the effective date (Date of service): 1. NPN with an effective date of [redacted] but with a created date of [redacted]. Per the RD#1's NPN, dated [redacted], the [redacted] recommended [redacted] twice per day. 2. NPN with an effective date of [redacted], but with a created date of [redacted]. On 7/30/25 at 11:45 AM, the surveyor interviewed [redacted], who stated they are the [redacted] and has been covering the building until the facility is able to hire a part-time [redacted] currently she is in the building 3 times per week. Per the [redacted], residents are [redacted] upon admission, re-admitted, monthly, and weekly [redacted] are completed for residents per [redacted] discretion. [redacted] acknowledged Resident #64's June [redacted] note was backdated from [redacted], and the recommended intervention of [redacted] could not have been entered at that time, but Resident #64 had those [redacted] already in place. On 7/31/25 at 12:36 PM, the surveyor met with the [redacted]) and [redacted] to review areas of concern found during the survey. The [redacted] stated they would look into the RD#1's documentation. On 8/4/25 at 11:35 AM, the [redacted] provided the surveyor with a facility policy titled, "Nutritional Assessment/ Documentation", with a reviewed date of 5/2025. Under the description portion of the policy it revealed, "1. The Dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change on condition that places the resident at risk for impaired nutrition." 2. A review of Resident #8 FS revealed that the resident had diagnosis that included but were not [redacted] Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated	F0692		10/10/2025

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F0692 SS = E	Continued from page 12 A review of the Physician Order Summary (POS) revealed an order dated [NJ Ex Order 26] with a start date of [NJ Ex Order 2] to [NJ Ex Order] resident weekly on Mondays for four weeks. The dates for the four weekly orders were: NJ Ex Order 26, 4B1 . A review of the [NJ Ex Order 2] Review of the weights from the electronic medical record (EMR) revealed the recorded [NJ Ex Order 2] was [NJ Ex Order 26, 4B1] on Thursday [NJ Ex Order 26, 4] On 8/5/25 at 9:15 AM the surveyor interviewed the [NJ Ex O] floor U. S. FOIA (b) (2), who stated that on Monday's the [NJ Ex O] would provide a list of residents who had orders to be [NJ Ex Order 26.4(b)] The [U. S. FO] further stated that the U. S. FOIA (b) (2)) and the nurses on the unit would obtain the [NJ Ex Order 26] and would return the list to the [U. S. F]. The [U. S. F] also stated that the [NJ Ex Order 26] are then recorded by the [U. S. FO] into the medical records. On 8/5/25 at 9:40 AM, the surveyor interviewed the [U. S. FO] who stated Resident #8 had an order for weekly weight to start on [NJ Ex Order 2] for four weeks. The [U. S. F] acknowledged that one [NJ Ex Order 2] was documented for the four-week period. She further stated that she does not document on every [NJ Ex Order 2] and acknowledged that the weekly [NJ Ex Order 26] should be entered in the residents' medical records. The [U. S. F] acknowledged that the weekly [NJ Ex Order 26] should have been obtained and documented weekly as ordered for the entire four-weeks ordered by the physician. The [U. S. FO] confirmed there was no documentation of the [NJ Ex Order 26] stating, "I don't document follow up on every [NJ Ex Order 26.4] the [U. S. FO] further stated that weekly [NJ Ex Order 26] should be entered every week if the weekly [NJ Ex Order 2] data and review documentation should be entered for every week. [U. S. FO] confirmed that the floor nurses and staff do not enter the [NJ Ex Order 26] before she reviews them to prevent inaccurate [NJ Ex Order 26] from being entered in health records and she does not enter them or follow up to see they are entered into the residents' records. On 8/5/25 at 12:27 PM, the survey team met with the U. S. FOIA (b) (2) for the exit conference. No further information provided by the facility staff NJAC 8:39-27(a)	F0692		10/10/2025
F0725 SS = E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services.	F0725	All residents have the potential to be affected by this deficient practice U.S. FOIA (b)(6) has been education on staffing ratios and the importance of staffing at proper ratios	10/10/2025

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F0725 SS = E	Continued from page 13 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure sufficient and competent staff were available to provide appropriate[NJ Ex Order 26, 4B1] to dependent residents. This deficient practice occurred for 3 of 4 residents reviewed for sufficient staffing (Resident # 47, #63, and #64) and was evidenced by the following: Refer to F677 Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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	F0725	Continued from page 13 Administrator/Designee will meet and communicate with staffing coordinator to review schedules to ensure facility meets New Jersey staffing requirements Staffing Coordinator has been education on staffing ratios and the importance of staffing at proper ratios The facility has implemented multiple strategies to improve staffing levels, retain current employees, and recruit new team members: Offering sign-on bonuses to new hires for targeted positions. Providing employee referral bonuses for current staff who refer qualified candidates. Posting job openings on multiple online platforms, and local job boards Staffing levels are reviewed daily and weekly by the Administrator and DON Administrator/Designee will audit staffing ratios daily to ensure it meets New Jersey staffing requirements Results of all audits will be reported quarterly to the QAPI committee, and corrective actions will be taken immediately if issues are identified. Responsible party: Administrator	10/10/2025

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F0725 SS = E	Continued from page 14 following ratio(s) were effective on 2/1/21: (1) One Certified Nurse Aide (CNA) to every eight residents for the day shift. (2) One direct staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and (3) One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the two weeks of staffing from 7/13/25 through 7/26/25 prior to the standard survey of 8/5/2025 revealed the facility was deficient in staffing hours as evidenced by the following: For the 2 weeks of staffing prior to the survey from 07/13/2025 to 07/26/2025, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -07/17/25 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/20/25 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. For the week of Complaint staffing from 08/25/2024 to 08/31/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -08/25/24 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. -08/26/24 had 4 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/27/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/30/24 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/31/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 7/31/25 at 8:15 AM, the surveyor completed an	F0725		10/10/2025

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F0725 SS = E	Continued from page 15 incontinence tour on the [redacted] floor Nursing Unit and observed the following: 1. On 7/31/25 at 8:25 AM, the surveyor, accompanied by th [redacted] observed Resident #64 in bed. The [redacted] exposed Resident #64's [redacted], and the surveyor observed that it was [redacted]. The [redacted] confirmed that the [redacted]. A review of the 11-7:00 AM, [redacted]) assignment sheet revealed that the [redacted]-floor nursing unit had a census of 60 Residents with 4 assigned CNAs. The CNA had an assignment of 15 residents on that 11-7 AM shift. 2. On 7/31/25 at 8:30 AM, the surveyor, accompanied by the [redacted] observed Resident #63 in bed. The [redacted] exposed Resident #63's [redacted], which was [redacted]. The [redacted] confirmed that the [redacted]. The [redacted] had an assignment of 15 residents on that 11-7 AM shift. 3. On 7/31/25 at 8:40 AM, the surveyor, accompanied by the [redacted] observed Resident #47 in bed. The [redacted] exposed Resident #47's [redacted], which was [redacted]. The [redacted] confirmed that the [redacted]. The CNA had an assignment of 15 residents on that 11-7 AM shift. On 7/31/25 at 8:50 AM, during an interview with the surveyor, the [redacted] was not sure what the facility policy was on providing [redacted] but confirmed that the 11-7 AM shift should provide [redacted] before the end of the shift between 5 AM-7AM. The [redacted] was not sure what the [redacted] to resident ratio was on the 11-7 AM shift. The [redacted] assigned to the above residents on the 11-7:00 AM shift were unavailable for interviews. On 8/5/25 at 10:25 AM, during an interview with the surveyor, the [redacted] confirmed that on 7/30/25, during the 11:00 PM-7:00 AM shift the census on the [redacted] floor nursing unit was [redacted] and that the CNAs had [redacted] residents on each of their assignments. The [redacted] stated that she was aware of the 1 CNA to 14 resident ratio for the night shift. On 8/5/25 at 10:38 AM, the survey team discussed the above observations and concerns with the [redacted]	F0725		10/10/2025

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F0725 SS = E	Continued from page 16 U. S. FOIA (b) (2) A review of the facility's Activities of Daily Living (ADL) policy, revised July 2024, reflected that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. A review of the facility's Staffing Policy reviewed 5/2025 reflected...To ensure the facility complies with New Jersey state law regarding minimum staffing levels and maintains appropriate direct care staff ratios to ensure quality care and resident safety... NJAC 8:39-5.1 (a), 27.1 (a), 27.2 (h)	F0725		10/10/2025
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 7/30/25 and 7/31/25, the surveyor observed three (3) nurses administer medications to six (6) residents. There were 25 opportunities, and six (6) errors were observed which calculated to a medication administration error rate of 24%. The deficient practice was identified for two (2) of six (6) residents, (Resident #16 and #89), that were administered medications by two (2) of three (3) nurses that were observed. The deficient practices were evidenced by the following: 1). On 7/30/25 at 8:48 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN#1) in the room of Resident #16. The surveyor observed LPN#1 informing Resident #16 that she would be administering the resident's medications. The	F0759	LPN #1 was immediately in-serviced on facility's policy for "Medication Administration" and a Medication Administration Competency was completed on 8/1/2025. RN #1 was immediately in-serviced on facility's policy for "Medication Administration" and a Medication Administration Competency was completed on 8/1/2025. Resident #16 was assessed. No adverse reactions noted. MD evaluated medication regimen and eyedrop orders were reviewed. Resident #89 was assessed. No adverse reactions noted. MD evaluated medication regimen and orders were reconciled NJ Ex Order 26, 4 was discontinued and NJ Ex Order 26, 4B1 . Identification of other Residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected by the identified deficient practice. Measures that will be put in place or Systemic changes to ensure that the deficient practice will not reoccur. The facility policy titled "Medication Administration" was reviewed and determined to be up-to-date and consistent with state and federal requirements.	10/10/2025

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F0759 SS = E	Continued from page 17 surveyor observed the resident who was in their bed and just finished eating breakfast. On 07/30/25 at 8:52 AM, the surveyor observed LPN#1 preparing to administer NJ Ex Order 26, 4B1 to Resident #16 which included [redacted] he surveyor observed LPN #1 entered the resident's room. LPN#1 one told the surveyor that the resident receives NJ Ex Order 26, 4B1 The surveyor observed LPN#1 NJ Ex Order 26, 4B1 (ERROR #1). She then told the surveyor she had to wait NJ Ex Order 26, 4B1 before administering NJ Ex Order 26, 4B1 LPN#1 was then observed to attempt to administer all of Resident #16's NJ Ex Order 26, 4B1 medications, and at that time the surveyor stopped LPN#1 and asked her to leave the room with all of the resident's medications. The surveyor and LPN#1 reviewed the resident's medications and at that time, LPN#1 acknowledge that she put NJ Ex Order 26, 4B1 s into the medication cup instead of NJ Ex Order 26, 4B1 (Error #3) . LPN#1 also acknowledge that she placed a NJ Ex Order 26, 4B1 into the medication cup instead of NJ Ex Order 26, 4B1 (Error #4). The surveyor then observed LPN#1 disposing medication into a drug disposal system (drug buster) and then reprepared all the medications for administration. LPN #1 was then observed going back to Resident #16's room and administering the resident's medication. LPN #1 was then observed NJ Ex Order 26, 4B1 (error #2). After medication administration, the surveyor in the presence of LPN#1 reviewed Resident #16's Electronic Medication Administration Record (e-MAR) which revealed that Resident #16 had a physician's order for NJ Ex Order 26, 4B1 with a direction to NJ Ex Order 26, 4B1 and a physician's order to NJ Ex Order 26, 4B1 NJ Ex Orde with a direction to NJ Ex Order 26, 4B1	F0759	Continued from page 17 Staff Nurses were educated about the facility guidelines on Medication Administration Plans to monitor its performance to make sure that the solutions are lasting. Including who will be responsible for overseeing compliance with the plans. The Director of Nursing / designee will conduct weekly Medication Administration Competency on 5 nurses x 4 weeks then monthly Medication Administration Competency on 5 nurses x 3 monthly to ensure that staff are in compliance with the facility policy titled "Medication Administration". Any deficient practices will be corrected immediately. Audit of competencies will be presented to the quarterly quality assurance meeting. All findings will be reported to the Director of Nursing/ designee for possible additional corrective or disciplinary actions. The Administrator / designee will be responsible for ensuring compliance with the plan of correction.	10/10/2025

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F0759 SS = E	Continued from page 18 At that time, LPN#1 acknowledge that she should have NJ Ex Order 26, 4B1 for both the NJ Ex Order 26, 4B1 . A review of the Admission Record (an admission summary) reflected that Resident #16 was admitted to the facility with diagnoses that included but not limited to: NJ Ex Order 26, 4B1 A review of the quarterly Minimum Data Set, an assessment tool used to facilitate the of care, dated NJ Ex Order 26, 4, reflected that the resident's cognitive skills for daily decision-making score was NJ Ex Order 26, 4, which indicated that the resident's NJ Ex Order 26, 4B1 . A review of the NJ Ex Order 26, 4B Physician's Orders (PO) revealed a Physician's Order dated NJ Ex Order 26, 4, for NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 and a PO dated NJ Ex Order 26, 4B for NJ Ex Order 26, 4B1 , a PO dated NJ Ex Order 26, for NJ Ex Order 26 , giv NJ Ex Order 26, 4B1 , and a PO dated NJ Ex Order 26, , for NJ Ex Order 26, 4B1 , give NJ Ex Order 26, 4B1 A review of the NJ Ex Order 26, 4B EMAR revealed a PO dated NJ Ex Order 26, 4B for NJ Ex Order 26, 4B1), NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 and PO dated NJ Ex Order 26, 4B for NJ Ex Order 26, 4B1 , NJ Ex Order 26, 4B1 a PO dated NJ Ex Order 26, for NJ Ex Order 26, 4B1 , give NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 fo NJ Ex Order 26, 4B1 giv NJ Ex Order 26, 4B1 2). On 07/31/25 at 8:30 AM, the surveyor while observing medication administration pass, observed a Registered Nurse (RN#1) entered Resident #89 who was eating breakfast, that she was going to take the resident's vitals and administer their medications.	F0759		10/10/2025

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F0759 SS = E	Continued from page 19 On 07/31/25 at 8:32 AM, the surveyor observed RN#1 preparing to NJ Ex Order 26, 4B1 to Resident #89 which included NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1). The surveyor observed RN#1 preparing the resident's medications for administration. She told the surveyor that the resident is administered their medications crushed and in NJ Ex Order 26, 4B1. The surveyor observed RN#1 crush each medication including NJ Ex Order 26, 4B1 and place each medication in a separate medication cup with NJ Ex Order 26, 4B1. The surveyor then observed RN#1 enter Resident #89's room and administered the resident their medications, which included NJ Ex Order 26, 4B1 Error #5) and NJ Ex Order 26, 4B1 (Error #6). The surveyor reviewed Resident #89's medical records. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; NJ Ex Order 26, 4B1 A review of the Annual Minimum Data Set, an assessment tool used to facilitate the management of care dated NJ Ex Order 26, 4B reflected that the resident's cognitive skills for daily decision-making score was NJ Ex Order 26, 4B1 which indicated that the resident' had NJ Ex Order 26, 4B1 . A review of the July 2025 Order Summary Report (physician's order sheet) (OSR) revealed a physician's order (PO) dated NJ Ex Order 26, 4, for NJ Ex Order 26, 4 and an PO dated NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1) give NJ E A review of the NJ Ex Order 26, 4B electronic medication administration record (eMAR) revealed a PO dated NJ Ex Order 26, 4B1, for NJ Ex Order 26, 4B1) NJ Ex Order 26, 4B1 and an PO dated NJ Ex Order 26, 4B for NJ Ex Order 26, 4B1	F0759		10/10/2025

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F0759 SS = E	Continued from page 20 NJ Ex Order 26, 4B1) give NJ Ex Order 26, 4B1 with both medications having a plotted time of 9 AM. A review of the Manufacturer's Specifications for both NJ Ex Order 26, 4B1 revealed the following: NJ Ex Order 26, 4 should be NJ Ex Order 26, 4B1. Th NJ Ex Order 26 NJ Ex Order 26, 4B1 should NJ Ex Order 26, 4B1 NJ Ex Order On 07/31/25 at 09:00 AM, the surveyor in the presence of the RN#1 reviewed Resident#89's physician's orders and there were no instructions on the e-MAR instructing the nurse not to crush NJ Ex Order 26, 4B1. The surveyor in the presence of RN#1 reviewed Resident #89's NJ Ex Order 26, 4 medication card which contained no auxiliary label NJ Ex Order 26, 4B1. At that time, the surveyor interviewed RN#1 who stated that she was not aware that both NJ Ex Order 26, NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1 couldn't be crush that she would not crush those two medications. On 7/31/25 at 1:15 PM, the surveyor presented the above concerns to the U. S. FOIA (b) (2) and the Minimum Data Set (U. S. FOIA (b) (2) who was covering for the U. S. FOIA (b) (2). No further information was provided. On 8/5/25 at 8:50 AM, the surveyor interviewed the CP via a telephone interview who acknowledge that both NJ Ex Order 26, 4B1 should be taken whole and should not be NJ Ex Order 26, 4B1. She stated that NJ Ex Order 26, 4 both medications won't affect the activity or the distribution of the medication or harm the resident. The CP stated that the recommendation not to crush both NJ Ex Order 26, and NJ Ex Order 26, 4B1 was due to NJ Ex Order 26, 4B1 She felt it was not necessary to make this recommendation when it won't affect the way the medication works or harm a resident. A review of the facility's policy for "Medication Administration" that was dated 6/2025 and was provided by the U.S. FOIA (b) revealed the following:	F0759		10/10/2025

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F0759 SS = E	Continued from page 21 "3. Reads medication order on electronic Medication Administration Record (e-MAR)." "4. Removes medication from resident's drawer in the medication cart. Checks name of resident Checks name of drug Checks strength/dose of drug Frequency given." "5. Checks medication order again. Compares e-MAR to blister pack to ensure it reads the same." NJAC 8:39-11.2(b), 29.2(a)(d)	F0759		10/10/2025
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	LPN #1, CNA#1 and [redacted] floor U. S. FOIA (b) (2) were in-serviced on Proper Hand Hygiene, Infection Prevention and Control and a Hand Hygiene competency was completed The Big Electric Fan and small Electric Fan in the laundry room were cleaned by the Housekeeper Director The clean clothes in the laundry rooms were put in the clean laundry cart with a cover and clean towels were put in the covered clean linen cart Rehabilitation supplies and equipment and pipes were cleaned A daily accountability log sheet/book was placed in the laundry room and signed by the housekeeping, laundry and maintenance staff daily Maintenance Director replaced the soap dispenser and replenished the paper towel in the shower room The clogged sink in the shower room was repaired immediately by the Maintenance staff The porter/housekeeping staff immediately picked up the two big plastic bag of garbage on the floor in the shower room and disposed of them in the dumpster. The garbage bin lids were immediately closed by the Maintenance Director All staff were given in-service training regarding proper Garbage Disposal and keeping the garbage disposal bins always closed	10/10/2025

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F0880 SS = E	Continued from page 22 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and other facility documentation, it was determined that the facility failed to a.) maintain a sanitary clean environment; b.) minimize the potential spread of infection to residents during medication administration for 1of 3 nurses observed during medication pass on 1 of 2 nursing units and c.) follow the Centers for Disease Control recommendations and guidelines for Hand	F0880	Continued from page 22 All residents have the potential to be affected by this deficient practice. The U. S. FOIA (b) (2) reviewed the Policy and Procedure of Handwashing/Hand Hygiene, Laundry and Linen Policy, Handling of Linen Policy and Cleaning a Resident's room policy. No changes needed In addition, all staff were in-serviced on Proper Hand Hygiene and Infection Prevention and Control Housekeeping Staff were in-serviced on Handling of Laundry/Linens, Cleaning the Resident's Room and Proper Garbage Disposal Findings will be reported to the Quality Assurance and performance Committee (QAPI) to ascertain the effectiveness of the corrective actions and preventive measures. The Infection Prevention committee will do weekly rounds weekly x4 then monthly x 3. All findings will be reported to the Administrator for any corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of correction.	10/10/2025

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F0880 SS = E	Continued from page 23 Hygiene for 3 of 3 staff members. This deficient practice was evidenced by the following. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated [redacted], Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to a clean body site on the same patient ... After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. On 07/30/25 at 8:52 AM, during medication administration observation the surveyor observed a Licensed Practical Nurse (LPN#1) preparing Resident #16's medications which include [redacted]. After preparing all the medications, the nurse told the surveyor that she will be applying a pair of gloves to administer the resident's [redacted] The surveyor observed LPN#1 cleaning her hands with a hand sanitizer and then putting on her a pair of gloves. The surveyor then observed the LPN #1 while wearing the pair of gloves touching the lid of a trash bin that was attached to the medication cart. LPN#1 was then observed entering Resident #16's room and placing the resident's medications on the overbed table. The surveyor observed LPN#1 without performing hand hygiene and changing her gloves, touched the resident's bed and headrest. The surveyor observed LPN#1 with the same pair of gloves [redacted] to Resident #16's [redacted] and then [redacted] with a tissue. At that time, the surveyor interviewed LPN#1 who acknowledge that after touching the trash bin and the resident's bed she should have removed her gloves, performed hand hygiene and then reapplied gloves before [redacted] and then [redacted]	F0880		10/10/2025

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F0880 SS = E	Continued from page 24 the resident's NJ Ex Order 26, 4B1 2. On 7/30/25 at 9:41 AM, during medication administration observation, the surveyor observed LPN#1 cleaning her hands with a hand sanitizer and then putting on a pair of gloves. The surveyor observed LPN#1 NJ Ex Order 26, 4B1 with a disinfectant wipe. After allowing them to dry, the surveyor observed LPN#1 without removing her gloves and performing hand hygiene take Resident #54's vitals. At that time, the surveyor interview LPN#1 who acknowledge that after cleaning the NJ Ex Order 26, 4B1 she should have removed her gloves and perform hand hygiene. She further stated that after performing hand hygiene she should have reapply her gloves and then took Resident #54's vitals. On 07/31/25 at 1:00 PM, the surveyor presented the above concerns to th U. S. FOIA (b) (2) and the Minimum Data Set U. S. FOIA (b) (2) who was the U. S. FOIA (b) (2) for this survey. A review of the facility's policy titled "Handwashing/Hand Hygiene" with a review date of 5/2025 and was provided by the U.S. FOIA revealed the following: "6. In most situations, the preferred method of hand hygiene is an alcohol-based rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: Before and after direct contact with residents Before donning sterile gloves Before performing any non-invasive procedures Before preparing or handling medications Before handling clean or soiled dressing, gauze pads, etc Before moving a contaminated body site to a clean body site during resident care	F0880		10/10/2025

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F0880 SS = E	Continued from page 25 After contact with a resident's intact skin After handling used dressing, contaminated equipment, etc After contact with objects (e.g medical equipment) in the immediate vicinity of the resident After removing gloves 2. On 7/30/25 at 8:54 AM, Surveyor #1 (S#1) toured the laundry area in the presence of the [redacted] Both S#1 and the [redacted] observed the following: -Next to the dirty area of the laundry room was the washer area and the [redacted] stated that it was considered a clean area. Upon entry, there were three folding tables, the 1st two tables with folded clean residents' clothes and towels uncovered, at the end of the 3rd table was the big electric fan blowing air towards uncovered clothes and towels. The electric fan observed with heavy accumulation of blackish substances, which the [redacted] stated they were heavy accumulation of dust. Below the table was a small electric fan blowing air with accumulations of dust. -At the back of the big electric fan were metal racks with folded clean towels, linens, and blankets, and they were all uncovered. The other back side were rehabilitation (rehab) supplies and equipment (wheelchair, walkers, positioning equipment) heavily covered with dust (grayish substances). Above were pipes with heavy accumulation of grayish substances and the [redacted] stated should have been cleaned. At that same time, the [redacted] was unable to state when the last time was it was cleaned and there was no accountability log. He stated it was the responsibility of the maintenance people to clean the area. He also stated that the clean supplies should have been covered. The laundry area at that time was left unattended.	F0880		10/10/2025

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F0880 SS = E	Continued from page 26 On 7/30/25 at 9:14 AM, both S#1 and the U. S. FOIA toured the NJ Ex C floor unit shower room. Both S#1 and the U. S. FOIA observed the door was left open, the U. S. FOIA (b) (2) entered the room, and performed handwashing in the sink. The U. S. FOIA, while washing her hands stated that there were no soap and paper towels, and the water accumulated in the sink. The U. S. FOIA stated that the sink was clogged and should have been fixed. He further stated that he would ask U. S. FOIA (b) (2) to put soap and paper towels. At that same time, both S#1 and the U. S. FOIA observed the left side of the shower room, there were two big plastic bags of garbage on the floor next to the three compartment bins, and the lids were left open. The U. S. FOIA stated that the bags of garbage should have been disposed properly in one of the three compartment bins and the lids should have been closed. On 7/30/25 at 10:09 AM, S#1 in the presence of the U. S. FOIA (b) (2)) interviewed the U. S. FOIA (b) (2) . The U. S. FOIA (b) informed S#1 that she was responsible for infection control, ensuring hand hygiene, infection control protocols were followed, education of staff, immunizations of residents and staff, and antibiotic stewardship. She stated that part of her responsibility also was to do daily rounds in the unit, including shower rooms, and residents' room, and monthly rounds for the laundry area. She further stated that she ensure that all areas were clean and with enough supplies. At that same time, S#1 notified the U. S. FOIA (b and the U. S. FOIA (b) (2) of the above findings and concerns with laundry area, shower room on the NJ Ex C floor, and hand hygiene of the U. S. FOIA. The U. S. FOIA (b stated that the garbage should not be on the floor, it should be inside the three compartment bins, and lids should be down to cover the bins. She further stated that there should be soap and paper towels for the staff to be able to perform appropriate hand hygiene. A review of the facility's "Laundry and Linen Policy" with a reviewed date of 5/2025, that was provided by the MDSC/RN, revealed, under purpose…this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen…	F0880		10/10/2025

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F0880 SS = E	Continued from page 27 A review of the facility's "Handling of Linens Policy" with a reviewed date of 5/2025, that was provided by the MDSC/RN, revealed, under purpose…the facility will ensure that all linens are handled, stored, processed and transported so as to prevent the spread of infection… A review of the facility's "Cleaning a Resident's Room Policy" with a reviewed date of 5/2025, that was provided by the MDSC/RN, revealed, under Important things to remember…2. Never:..d. Place soiled items (example garbage) directly on the floor. On 7/31/25 at 1:30 PM, the survey team met with the U. S. FOIA (b) (2) , and S#2 notified them of the above findings and concerns. 3. On 7/31/25 at 8:25 AM, during the NJ Ex Order 26, 4B1 tour on the NJ Ex O floor nursing unit, the surveyor observed the U. S. FOIA (b) (2)) enter Resident 64's room and perform hand hygiene. The U. S. FOIA (b) (2) applied soap and immediately placed his hands under the stream of running water without first lathering and applying friction. The U. S. FOIA (b) (2) used the same paper towel he dried his hands with to turn off the faucet. The U. S. FOIA (b) (2) put on gloves and exposed Resident #63's NJ Ex Order 26, 4B1 The U. S. FOIA (b) (2) removed his gloves, applied soap, and immediately placed his hands under the stream of running water without first lathering or applying friction. The U. S. FOIA (b) (2) dried his hands and used the same paper towel to turn off the faucet. On 7/31/25 at 8:30 AM, the U. S. FOIA (b) (2) entered Resident #63's room and performed hand hygiene. The U. S. FOIA (b) (2) applied soap and immediately placed his hands under the stream of running water without lathering and applying friction. The U. S. FOIA (b) (2) dried his hands and used the same paper towel to turn off the faucet. The U. S. FOIA (b) (2) put on gloves and exposed Resident #63's NJ Ex Order 26, 4B1 The U. S. FOIA (b) (2) removed his gloves, applied soap, and immediately placed his hands under the stream of running water without first lathering or applying friction. The U. S. FOIA (b) (2) dried his hands and turned off the faucet with the same paper towel. On 7/31/25 at 8:32 AM, the Certified Nursing Assistant (CNA #1) assigned to Resident #63's care entered the room and performed hand hygiene. The	F0880		10/10/2025

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F0880 SS = E	Continued from page 28 surveyor observed the [redacted] applied soap and lathered her hands for 6 seconds outside the stream of running water, then placed her hands under water. On 7/31/25 at 8:40 AM, the [redacted] entered Resident #47's room. The [redacted] applied soap and immediately placed his hands under the stream of running water without lathering or applying friction. The [redacted] dried his hands and with the same paper towel turned off the faucet. The [redacted] put on gloves and exposed Resident #47's [redacted] The [redacted] removed his gloves, applied soap, and immediately placed his hands under the stream of running water without first lathering and applying friction. The [redacted] dried his hands and turned off the faucet with the same paper towel. On 7/31/25 at 8:45 AM, during an interview with the surveyor, the [redacted] stated he thought that as long as he washed his hands for 20 seconds, it didn't matter whether it was outside or under the stream of water. On 7/31/25 at 8:55 AM, during an interview with the surveyor, CNA #1 stated that she was educated by the U. S. FOIA (b) (2)) to wash and lather her hands outside the stream of water for 20 seconds. CNA #1 could not speak to why she only lathered for 6 seconds outside the stream of water. On 7/31/25 at 8:58 AM, during an interview with the surveyor, the [redacted] stated she was the facility's educator and that she instructed all staff on how to perform hand hygiene properly, which included applying soap and lathering their hands outside the stream of water for a minimum of 20 seconds. On 8/4/25 at 10:00 AM, the surveyor discussed the above observations and concerns with the [redacted]) and [redacted], who confirmed that hand hygiene included lathering and applying friction for at least 20 seconds out of the stream of water. NJAC 8:39-19.4(a)(1),(m)	F0880		10/10/2025

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F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and a review of pertinent facility documents, it was determined that the facility failed to treat each resident with respect and dignity in a manner that promotes their quality of life. The deficient practice and violation of privacy were identified for 3 of 28 residents (Resident #70,	F0550	The identified Maintenance worker who entered the room of resident #70 and resident #71 without knocking on the door and introducing himself before entering the room was given Inservice to treat each resident with Respect and Dignity in a manner that promotes their Quality-of-Life The two identified transporters were also given Inservice. Additionally, [redacted] and 2 other transport service providers were contacted by the Administrator to inform them of the deficient practice. All other residents have the potential to be affected by this deficient practice. The Administrator and Director of nursing reviewed the Policy and Procedures regarding Resident Dignity. No changes needed All staff were given Inservice on Resident Dignity The Nursing Administration will interview 5 random residents weekly x4, then monthly x 1 Findings will be presented to the Quality Assurance Performance Improvement (QAPI) committee. All finding will be reported to the Administrator for any additional corrective and disciplinary actions.	10/10/2025

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F0550 SS = D	Continued from page 30 #71 and Resident #123) reviewed for residents' rights and was evidenced by the following: On 7/30/25 at 11:30 AM, the surveyor was interviewing Resident #70. At that time, the surveyor observed a U. S. FOIA (b) (2) enter the room without knocking or announcing themselves. The maintenance worker opened a step ladder and inspected the privacy curtain and then exited the room. On 7/30/25 at 11:40 AM, the surveyor observed the same U. S. FOIA (b) (2) enter the room of Resident #71, without knocking, waiting for permission or introducing themselves before entering the room. At that time, the surveyor interviewed the U. S. FOIA (b) (2) who stated that they should have knocked, announced themselves and attempted to get permission before entering the room. On 7/30/25 at 11:45 AM, the surveyor interviewed the NJ EX floo U. S. FOIA (b) (2) who stated that all staff should knock, announce themselves, and state the purpose for entry into any resident's room. On 7/30/25 at 12:13 PM, the surveyor observed two transpor U. S. FOIA (b) (2) pushing a stretcher, enter Resident #123's room. Neither person was observed to knock, announce themselves, or state their purpose upon entering the room. At that time, the surveyor interviewed the ambulance personnel, who stated that they did not knock or announce themselves before entering the room, and both acknowledged that they should have. On 7/30/25 at 12:25 PM, the surveyor interviewed the NJ EX floo U. S. FOIA who stated that outside contractors should respect the policies of the facilities, knock and announce themselves before entering a resident's room. On 7/30/25 at 12:37 PM, the surveyor interviewed the U. S. FOIA (b) (2)), who stated that all staff are expected to knock before entering a resident's room and then wait to receive permission from the resident before entering. On 7/30/25 at 1:45 PM, the surveyor interviewed the U. S. FOIA (b) (2)), who stated that all employees and contractors must knock and announce themselves before entering a resident's room. No further information was	F0550		10/10/2025

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F0550 SS = D	Continued from page 31 provided. NJAC 8:39-27.1 (a)	F0550		10/10/2025
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F0584	Immediately upon identification, residents with soiled or insufficient linens were provided clean bed linens, towels, and washcloths. A facility-wide sweep of resident rooms, shower rooms, and clean linen storage areas was conducted. Broken privacy curtains, missing hooks, damaged blinds, and other maintenance issues were logged in the online work order system and corrected. Soiled or damaged privacy curtains were replaced. Tube feeding pumps, poles, and oxygen concentrators that were no longer in use were removed from resident rooms, and all equipment in use was cleaned and disinfected. All residents were considered at risk; therefore, the facility conducted a building-wide inspection of linens, equipment, vents, and resident rooms. Emergency linen stock was ordered immediately to ensure adequate supply. All vents and high surfaces in resident care areas were inspected and cleaned. A facility-wide environmental round was conducted by the Maintenance Director to identify and address any additional risks. Linen par levels were re-calculated based on census and daily usage needs; emergency stock is now maintained. The Housekeeping Director re-educated staff on the “Cleaning a Resident’s Room” and “Linen” policies, including daily vent cleaning, curtain inspection, and proper reporting of shortages or repairs. A clear assignment of responsibility was reinforced: Housekeeping is responsible for cleaning medical equipment such as feeding pumps, poles, and concentrators, unless disposable or sterile. The online work order system was reviewed with staff, and staff were re-educated on timely entry of maintenance needs (e.g., curtains, broken blinds, clogged sinks).	10/15/2025

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F0584 SS = D	Continued from page 32 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 maintain the residents' living environment in a clean, sanitary, and homelike manner for a.) 1 of 2 Nursing Units reviewed for environment; b.) ensure clean linens were provided daily for 6 of 6 residents who attended the resident group meeting (Resident #1, 19, 20, 29, 69 and 78); c.) ensure equipment was kept in a clean, sanitary manner for 2 of 2 residents, (Resident #113 and #70) and e). ensure privacy curtains were clean and in working order for 2 of 2 Residents (Resident #47 and #13)). This deficient practice was evidenced by the following: 1. On 7/30/25 at 9:14 AM, Surveyor #1 (S#1) and the U. S. FOIA (b) (2) toured the NJ Ex C floor unit and observed the following: The clean linen room was observed with the door closed, upon entry there was a metal rack uncovered with clean folded towels. On top was a vent with heavy accumulation of grayish substance and the ceiling tile with dried brownish discoloration. The U. S. FOIA stated that the heavy accumulation of grayish substance was dust and the last time it was cleaned was beginning of March this year. He further stated that there was no specific timeframe when to clean the vent but when it was dirty it should have been reported to the Maintenance department and to be cleaned. On that same date and time, the U. S. FOIA informed S#1 that it was not cleaned because they were doing some projects. He also stated that the ceiling tile where the vent had a dried brownish discoloration was from the condensation from the vent. The shower room door was left open, upon entry there were 6 and ½ missing tiles and broken tiles on the floor. The U. S. FOIA stated he was aware of concerns with missing and broken tiles in the NJ Ex C floor unit shower room a month ago and had not had a chance to fix it. The shower curtain with missing hooks, the exhaust on the ceiling, and vent with accumulation of blackish substances. The U. S. FOIA stated they were accumulations of dust. At that same time, the U. S. FOIA (b) (2)) entered the shower room and performed handwashing in the sink. Both S#1 and the U. S. FOIA observed water accumulation in the sink, and the U. S. FOIA stated that the sink was clogged and should be	F0584	Continued from page 32 Facility-wide linen and housekeeping compliance were added to staff education during orientation and annual in-services. The Director of Housekeeping/Designee will complete weekly linen supply audits and random daily spot-checks of 3 resident rooms for 4 weeks, then monthly for 3 months. The Maintenance Director/Designee will complete weekly environmental rounds for 4 weeks, then monthly for 3 months, including vents, curtains, and equipment cleanliness. Results of audits will be submitted to the QAPI Committee for review and action at quarterly meetings. Any identified deficiencies will be corrected immediately, and staff re-educated as needed.	10/15/2025

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F0584 SS = D	Continued from page 33 fixed. The two shower cubicles vents were heavily covered with dust and the [redacted] stated that they should have been cleaned daily. The [redacted] was unable to state the last time it was cleaned, there was no accountability log. The [redacted] stated that the housekeepers knew it should be cleaned daily. On 7/30/25 at 9:25 AM, both S#1 and the [redacted] floor [redacted] went to Resident Room #416 (RR#416) and observed privacy curtains with missing hooks. The resident's closet in the 1st bed observed the 1st drawer with chipped wood and the light was busted. The [redacted] stated it should have been fixed. The toilet room vent with heavy accumulation of grayish substances, which the [redacted] claimed it was dust, and should have been cleaned. At that same time, both S#1 and [redacted] observed the shade blind was broken and the windowsill with accumulation of blackish substances, which the [redacted] claimed should have been cleaned. The air-conditioning (aircon) system was blowing air, inside was observed individual packets of handwipes, dust accumulations, and dried brownish items. The [redacted] stated that those brownish items were dried leaves. On 7/30/25 at 9:35 AM, both S#1 and the LPN/UM went to RR#431, observed privacy curtains with missing hooks, the floor with brownish discoloration, and dust. Both S#1 and [redacted] also observed the aircon with dried brownish discoloration on top and accumulation of dust. The [redacted] stated that the floor and aircon should have been cleaned. On that same date and time, outside RR#431, in the hallway, both S#1 and the [redacted] observed the vent with heavy accumulation of dust, and [redacted] stated it should have been cleaned. On 7/30/25 at 9:39 AM, S#1 interviewed the [redacted]) assigned in the [redacted] floor unit in the presence of the [redacted]. The [redacted] informed S#1 that it was her responsibility to maintain the cleanliness of the unit, that included mopping the floor, cleaning the tables, resident's toilet rooms, and shower room daily. At that same time, the [redacted] informed S#1 that she did not have a chance to check the shower room "yet" today. She further stated that she was aware of the privacy curtains in resident rooms with missing hooks but did not report it to anyone. On 7/30/25 at 10:09 AM, S#1 in the presence of the	F0584		10/15/2025

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F0584 SS = D	Continued from page 34 U. S. FOIA (b) (2) interviewed the U. S. FOIA (b) (2) U. S. FOIA (b). The informed S#1 that part of her responsibility also was to do daily rounds in the unit, including shower rooms, resident rooms, and monthly rounds for the laundry area. She further stated that she ensured that all areas were clean and with enough supplies. At that same time, S#1 notified the U. S. FOIA (b) (2) who was covering for the U. S. FOIA (b) (2) in the presence of the U. S. FOIA (b) the above findings and concerns. The U. S. FOIA (b) had no answer as to why the above concerns were not identified during her routine rounds. A review of the facility's "Cleaning a Resident's Room Policy" with a reviewed date of 5/2025, that was provided by the MDSC/RN, revealed, under policy: to ensure that all residents' rooms are cleaned on a regular basis. Under procedure, daily cleaning, 1. Using a clean cloth treated with an appropriate disinfectant or dusting utensil: a. dush/high dust all appropriate surfaces including, but not limited to: i. vents,…windowsills…c. clean floors…e. inspect privacy curtains. Replace curtains that are soiled or damaged… On 7/31/25 at 1:30 PM, the survey team met with the U. S. FOIA (b) (2) and Surveyor #2 notified them of the above findings and concerns. 2. On 7/30/25 at 9:00 AM, during a tour of the NJ Ex () floor Nursing unit, two alert and oriented unsampled residents (who wished to remain anonymous) stated that they were not provided clean towels or wash cloths daily and that the U. S. FOIA (b) (2) often used their top sheets to dry them after bathing. They both stated that they received clean gowns daily. On 7/31/25 at 9:05 AM, during an interview with the surveyor, the CNA (CNA #1), who was assigned to the NJ Ex floor nursing unit, stated that 5 out of 7 days, she was unable to provide fresh clean towels or wash clothes to her residents. CNA #1 stated that she had brought it to the attention of the U. S. FOIA (b) (2) and the U. S. FOIA (b) on the NJ Ex () floor. On 7/31/25 at 9:10 AM, during an interview with the surveyor, CNA #2 stated that there were not enough towels or washcloths for the residents, and that when towels were unavailable, she used the top sheets to dry the residents after their showers and	F0584		10/15/2025

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F0584 SS = D	Continued from page 35 bed baths. On 7/31/25 at 9:12 AM, during an interview with the surveyor, CNA #3 stated that she did not have enough towels or washcloths for the residents on her assignment and sometimes needed to use their top sheets to dry them. On 7/31/25 at 9:15 AM, during an interview with the surveyor, CNA #4 stated she often was unable to provide fresh, clean linens to the residents on her assignment. She stated that she had notified [U. S. FOIA] with no resolution. On 7/31/25 at 9:30 AM, during an interview with the surveyor, the CNA (CNA #5) stated that when she notified the [U. S. FOIA (b) (2)] staff that she needed more linens, the response was that there were no clean towels or washcloths available. CNA #5 further stated that the facility was always running out of paper towels. On 7/31/25 at 10:30 AM, during the resident council meeting, 6 out of 6 alert and oriented residents (#1, #19, #20, #29, #69, #78) chosen by the facility to attend the meeting stated that they did not receive clean towels and or washcloths daily. They further stated that the top sheets were not changed often. On 7/31/25 at 11:00 AM, during an interview with the surveyor, the [U. S. FOIA (b) (2)] stated that he did not keep a record of PAR levels or the number of linens ordered and had no idea of how much linen the facility had. The [U. S. FOIA] stated that every resident should be provided with 3 towels per shift. He further confirmed that the [U. S. FOIA (b)] often told him that they were short and needed more, but he stated that the [U. S. FOIA (b)] hoarded the linens and more were not always available. The [U. S. FOIA] showed the surveyor the emergency linen supply closet. [U. S. FOIA] confirmed that there should be enough emergency supplies for 3 days...Facility Census was 106. The surveyor and [U. S. FOIA] observed that there were no fitted sheets and no top sheets. There were three boxes of towels, each containing 60 towels. The facility had a total of 180 towels for 106 residents. Additionally, there was one box with 10 dozen (120) washclothes. The surveyor observed 3 boxes of disposable wipes, which the [U. S. FOIA] stated that the facility no longer used. The [U. S. FOIA] acknowledged that he did not have 3 days' supplies of emergency linens. On 7/31/25 at 11:15 AM, during an interview with	F0584		10/15/2025

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F0584 SS = D	Continued from page 36 the surveyor, the U. S. FOIA (b) (2) stated that the CNAs would notify him a few times a week that they were short and needed more linens, but they were not always available. They would be in the washer and dryer. He further stated that he would be unable to provide additional linens. The surveyor asked the porter if he had notified the U. S. FOIA that there were not enough linens. The U. S. FOIA (b) replied that the U. S. FOIA was aware. On 7/31/25 at 12:35 PM, the survey team discussed the above observations and concerns with the U. S. FOIA (b) (2)) and U. S. FOIA (b) (2) U. S. FOIA (b) (2) . The U. S. FOIA (b) stated that he would get back to me regarding facility policy on linens provided to the residents and PAR levels. On 8/4/25 at 2:30 PM, during an interview with the surveyor, Resident #1 stated that she only received one towel for the entire week. 3. On 7/31/25 at 8:45 AM, the surveyor and the U. S. FOIA (b) (2) entered room NJ Ex Or and observed that the privacy curtain for Resident #47 was heavily soiled with NJ Ex Order 26.4(b)(1) across the bottom section of the curtain. The U. S. FOIA (b) (2) confirmed that the curtain should have been replaced as the residents should be provided a clean environment. On 7/31/25 at 8:52 AM, during an interview with the surveyor, the U. S. FOIA (b) (2) stated that when she saw a soiled curtain, she would report it to the U. S. FOIA (b) (2)), but had not realized the curtain was soiled. On 8/4/25 at 10:00 AM, the survey team met with the U. S. FOIA (b) (2) coordinator to discuss the above observations and concerns. A review of the facility's Linen policy reviewed 5/2025 reflected...The purpose of this policy is to ensure that all residents in the facility receive adequate, clean, and well-maintained linens. Establishing proper linen par levels will help maintain a consistent and efficient supply of linen for daily use while minimizing waste and shortages...Policy...The facility will maintain an appropriate par level of linens to ensure that each resident has access to sufficient and appropriate clean linens (e.g., bed sheets, towels, pillowcases, incontinence products) at all times. Linen par levels will be established based on resident census, facility	F0584		10/15/2025

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F0584 SS = D	Continued from page 37 needs, and infection control protocols... Linen Par Level: The ideal quantity of linen items needed to meet daily demand and allow for turnover without running short...This includes the standard linens provided for each resident, as well as an additional inventory to account for laundry processing time, emergencies, or high usage. Par Level Calculation: The quantity of linen required for daily usage, factoring in the number of residents, laundry processing time, and anticipated fluctuations (e.g., seasonal changes, special needs)... A review of the facility's Terminal Cleaning policy reviewed 5/2025 reflected...It is the policy to ensure that all resident rooms, treatment areas, and common areas are thoroughly and effectively cleaned and disinfected... Medical Equipment Cleaning: Clean and disinfect all non-disposable resident care equipment such as...PEG tube feeding stands... 4. On 7/30/25 at 9:30 AM, during medication administration the surveyor observed a Certified Nursing Assistant (CNA#1) in the process of starting morning care for Resident #13. The surveyor observed CNA #1 attempting to close the privacy curtain which could only close halfway. The surveyor observed the curtain not attached to multiple rings which connects the privacy curtain to the rail . The surveyor interviewed CNA #1 after she completed morning care. CNA#1 told the surveyor that she's been working at the facility for around one month and the curtain has been that way since she started. On 7/30/25 at 9:45 AM, the surveyor interviewed the resident's nurse, Licensed Practical Nurse (LPN#1). LPN#1 stated that the resident's curtain has been broken for a long time and the facility were aware that the curtain was broken. She was unable to tell the surveyor why the privacy curtain was not fixed. On 7/31/25 at 1:15 PM, the surveyor presented the	F0584		10/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315375	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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F0584 SS = D	Continued from page 38 above concern to the U. S. FOIA (b) (2) who was the U. S. FOIA (b) (2) 5. On 7/30/25 at 9:00 AM, during a tour of the NJ Ex O floor nursing unit, two unsampled residents (who wished to remain anonymous) stated that they didn't receive clean towels or wash cloths daily. The residents further stated that the U. S. FOIA (b) (2) often used their top sheets to dry them after bathing. On 7//31/25 at 10:30 AM, the surveyor conducted the Resident group meeting with 6 residents. All 6 of 6 residents stated that they were not provided with clean towels or washcloths daily and further stated that their sheets were not changed very often. On 8/4/25 at 2:30 PM, during an interview with the surveyor, Resident #1 stated that they only received one towel for the entire week and that their sheets were not changed often. 6. On 7/29/25 at 11:39 AM, the surveyor observed in the room of Resident #113, a NJ Ex Order 26, 4B1 The surveyor observed that the pump and the pole was NJ Ex Order 26, 4B1 . The surveyor further observed the floor behind the head of the bed was heavily NJ Ex Order 26, 4B1 The NJ Ex Order 26, 4B1 that was also in the room was observed to have had splatters of a substance and a layer of dust. On 7/30/25 at 8:45 AM, the surveyor observed in Resident #113's room a NJ Ex Order 26, 4B1 The surveyor observed that the NJ Ex Orde was NJ Ex Order 26, 4B1 , and the NJ Ex Order 26, 4B1 . there was a NJ Ex Order 26, 4B1 connected to the NJ Ex Order 26, 4B1 not in use and not stored in a plastic bag. NJ Ex Order 26, 4B1 assigned to Resident #113 the NJ Ex Order 26, 4B1 The RN stated that Resident #113 no longer used the NJ Ex Order 2 and that it should have been removed from their room. The RN acknowledged that the NJ Ex Order 26, 4B1 were NJ Ex Order 26 The surveyor asked the U. S. FO who was responsible for cleaning the pump and pole. The U. S. F	F0584		10/15/2025

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F0584 SS = D	Continued from page 39 replied that she was not sure. 7. On 7/29/2025 at 10:30 AM, the surveyor observed the NJ Ex Order 26, 4B1 of Resident #70's were splattered with NJ Ex Order 26, 4B1. The legs of the pole were also heavily crusted with thick reddish-brown substance. On 7/30/2025 at 12:30 PM The Surveyor made a second observation of Resident #70's NJ Ex Order 26 and the NJ Ex Order 26, 4B1 was mounted to remained splattered with NJ Ex Order 26, 4B1 The legs of the pole remained heavily crusted with thick reddish-brown substance. On 8/4/2025 at 1:40 PM, the survey team met with the U. S. FOIA (b) (2) for the exit conference. No further pertinent information provided. NJAC 8:39-31.4(a)(b)(f) NJAC 27.1 (a)	F0584		10/15/2025
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that NJ Ex Order 26.4(b)(1) care was provided to NJ Ex Order 26.4(b)(1 residents in a timely manner for 3 of 4 residents (Resident #47, 63 and 64) observed for NJ Ex Order 26, 4B1 or NJ Ex Order 2 units (NJ Ex O floor Nursing Unit). This deficient practice was evidenced by the following: On 7/31/25 at 8:15 AM, the surveyor completed an NJ Ex Order 26, 4B1 tour on the NJ Ex O floor NJ Ex Order 26, 4 Unit and observed the following: 1. On 7/31/25 at 8:25 AM, the surveyor, accompanied by the U.S. FOIA (b)(6) observed Resident #64 in bed. The exposed Resident #64's NJ Ex Order 26, 4B1 and the surveyor observed that it was NJ Ex Order 26, 4B1 . The U.S. FOIA (b) (4 confirmed that the NJ Ex Orde was	F0677	Resident #47, #63 and #64 immediately received NJ Ex Order 26, 4B1 Certified Nursing Assistants assigned to residents #47, #63 and #64 on 11-7 shift received in-service training regarding NJ Ex Or care and NJ Ex Order 26.4(b)(1 care to NJ Ex Order 26.4(b)(1 residents All other residents have the potential to be affected by this deficient practice. Nursing Administration audited all dependent residents who require ADL Care/Incontinent care to determine if they were affected by the deficiency. No other residents were identified to be affected. The Administrator and Director of Nursing reviewed the center's policy and procedure regarding ADL Care The policy and procedure was review and no changes were needed. All Certified Nursing Assistants received in-service training on ADL Care and incontinent care to dependent residents in a timely manner to maintain good hygiene Findings will be presented to the Quality Assurance Performance Improvement (QAPI) committee The Nursing Administration/Designee will check 5	10/10/2025

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F0677 SS = D	Continued from page 40 NJ Ex Order 26, 4B1 A review of Resident #64's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but NJ Ex Order 26, 4 limited to, NJ Ex Order 26, 4B1 . A review of Resident #64's Quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, revealed Resident #64 had a Brief Interview for Mental Status (BIMS) score of 'NJ Ex Order 26, 4B1' which indicated Resident #64 had a NJ Ex Order 26, 4B1 . The MDS further revealed that the resident was NJ Ex Order 26, 4B1 A review of Resident #64's Individualized Care Plan (CP) initiated on NJ Ex Order 26 and revised on NJ Ex Order 26 had a focus area that included the resident was at risk for development of a NJ Ex Order 26, 4B1 due to NJ Ex Order 26, 4B1 with interventions that included but were not limited to; provide NJ Ex Order 26, 4B1 every N hours. 2. On 7/31/25 at 8:30 AM, the surveyor, accompanied by U. S. FOIA (b) (2), observed Resident #63 in bed. The U. S. FOIA (b) (2) exposed Resident #63's NJ Ex Order 26, 4B1 which was NJ Ex Order 26, 4B1 The surveyor observed that the sheets were NJ Ex Order 26, 4B1 . The U. S. FOIA (b) (2) confirmed that the NJ Ex Order 26, 4B1 A review of Resident #63's Admission Record revealed Resident #63 was admitted to the facility with diagnoses which included but were not limited to, NJ Ex Order 26, 4B1 . A review of Resident #63's quarterly MDS, dated NJ Ex Order 26, 4 revealed Resident #63 had a BIMS score of NJ Ex Order 26, 4B1 , which indicated a NJ Ex Order 26, 4B1 . The MDS further revealed that the resident was dependent on staff for NJ Ex Order 26, 4B1 A review of Resident #63 CP initiated on NJ Ex Order 26, 4B and revised on NJ Ex Order 26 had a focus area that included the resident was at risk for the development of a NJ Ex Order 26, 4B1 due to decrease NJ Ex Order 26, 4B1 with interventions that included but were not limited to; provide NJ Ex Order 26 3. On 7/31/25 at 8:40 AM, the surveyor, accompanied by the U. S. FOIA (b) (2), observed Resident #47	F0677	Continued from page 40 random dependent residents weekly x 4 then monthly x 3 to determine the level of compliance with ADL and incontinent care for dependent residents. All findings will be reported to the Administrator for any additional corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of correction.	10/10/2025

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F0677 SS = D	Continued from page 41 in bed. The U. S. FOIA (b) (2) exposed Resident #47's incontinence brief, which was NJ Ex Order 26, 4B1 The U. S. FOIA (b) (2) confirmed that the NJ Ex Order 26, 4B1 A review of Resident #47's Admission Record revealed the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26, 4B1 A review of Resident #47's Quarterly MDS dated 5/22/25 revealed Resident #47 had a BIMS score of NJ Ex Order 26, 4B1 which indicated Resident #47 had a NJ Ex Order 26, 4B1. The MDS further revealed that the resident required NJ Ex Order 26, 4B1 and he/she was always NJ Ex Order 26, 4B1 A review of Resident #47's CP initiated on NJ Ex Order 26, 4 and revised on NJ Ex Order 26, had a focus area that included that the resident was at NJ Ex Order 26, 4B1 development related to NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1 with interventions that included to always keep skin dry by providing NJ Ex Order 26, 4B1 every shift and as needed. On 7/31/25 at 8:50 AM, during an interview with the surveyor, the U. S. FOIA (b) (2) was not sure what the facility policy was on providing NJ Ex Order 26, 4B1 but confirmed that the CNAs on the 11-7AM shift should provide NJ Ex Order 26, 4B1 before the end of the shift between 5 AM-7 AM. On 7/31/25 at 8:58 AM, during an interview with the surveyor, the U. S. FOIA (b) (2)) stated that she was not sure of the facility's policy on NJ Ex Order 26, 4B1 but confirmed that best practice would be to provide NJ Ex Order 26, 4B1 every two hours and when needed. The CNAs assigned to the above residents on the 11-7 AM shift were unavailable for interviews. On 8/4/2025 at 10:00 AM, the survey team discussed the above observations and concerns with the U. S. FOIA (b) (2) . The U. S. FOIA (b) (2) confirmed that NJ Ex Order 26, 4B1 should be provided every 2-3 hours. A review of the facility's Activities of Daily Living (ADL) policy dated as reviewed 5/2025 reflected…the purpose of this policy is to establish guidelines for providing comprehensive assistance with ADLs to residents or patients. It aims to ensure that each individual's basic needs are met while promoting dignity, independence, and comfort…monitor for	F0677		10/10/2025

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F0677 SS = D	Continued from page 42 signs of incontinence and ensure the use of appropriate hygiene products. NJAC 8:39-27.1 (a), 27.2 (h)	F0677		10/10/2025
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide a safe [redacted] environment for 2 of 2 residents (Resident #3 and #72). This deficient practice was identified in the [redacted] by the entrance to the facility, and was identified by the following: On 7/29/25 at 9:15 AM, the surveyor observed that the area near the facility's covered entryway had [redacted] on the ground in several areas. The surveyor observed that there were no receptacles or ashtrays in the area to safely [redacted]. The surveyor also observed that there were no fire extinguishers or fire blankets. 1. On 7/29/25 at 10:50 AM, the surveyor observed Resident #3 in their room. The alert and oriented Resident stated that he/she was [redacted] and the facility staff permitted him/her to keep [redacted] and [redacted] locked in their top drawer. On 7/30/25 at 11:00 AM, the surveyors observed Resident #3 in the portico near the front entrance [redacted] The surveyors observed [redacted] on the ground in several areas. The surveyor asked Resident #3 if this area was designated for smoking. The Resident replied that the staff told him/her that this was where she/he [redacted]. The surveyor asked the resident where he/she [redacted] and [redacted] of the [redacted]	F0689	Fire extinguisher was installed in the designated smoking area on 8/5/25. An [redacted] was provided in the designated [redacted] on 8/4/25. The fire blanket was placed by the security desk on 8/27/25. Resident #72 [redacted] on file completed on [redacted]. The [redacted] immediately cleaned the [redacted] on the ground. Resident #3 and resident #72 were informed of the revised [redacted] or [redacted] Resident #3 and resident #72 were advised of the assigned designated [redacted]. A [redacted] area signage was posted in the [redacted] area. Resident #3 and resident #72 were educated regarding [redacted] by adhering to [redacted] in the designated smoking area and utilizing the [redacted] provided to [redacted] and discard the left-over portion of the [redacted] or [redacted] All other residents who smoke have the potential to be affected by this deficient practice. The Nursing Administration audited all residents who smoke on 8/15/25. The Nursing Administrator reviewed the Policy and Procedure on Smoking Policy "Smoke Free Facility". The Policy was revised on 8/22/25. All staff were given Inservice on the revised Smoking Policy on 8/27/25. Findings will be presented to the Quarterly Quality Assurance Performance Improvement Committee to ascertain effectiveness of the corrective action and preventive measures. The Nursing Administration/Designee will conduct random audit weekly to ensure residents who smoke are compliant with Safe Smoking policy. The Housekeeper Maintenance Director or designee will conduct weekly audit x 4 weeks then monthly x 3 months to determine compliance of corrective actions. All findings will be reported to the Administrator for additional corrective or disciplinary actions	10/10/2025

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F0689 SS = D	Continued from page 43 The resident replied that he/she extinguished it on the outside of the trash can and then threw the butt into the trash can. The surveyor reviewed the medical record for Resident #3. A review of the Admission Record reflected Resident #3 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26, 4B1 [redacted] A review of the Admission Minimum Data Set, an assessment tool dated [redacted], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated [redacted]. The MDS further assessed under section [redacted] that the resident was NJ Ex Order 26, 4B1. A review of Resident #3's Care Plan Report had a focus area that included: the resident is a [redacted] with the goal that the resident [redacted] safely within the NJ Ex Order 26, 4B1 x 90 days initiated on [redacted] and revised on [redacted] with interventions that included but were not limited to; review the smoking policy with the resident as needed. A review of the NJ Ex Order 26, 4B1 Agreement signed and dated [redacted] reflected…[Resident #3] is aware of the [redacted] and has been informed and accompanied to the designated [redacted] residents who NJ Ex Order 26, 4B1 must do so off premises in a public domain…I understand that it is my responsibility to keep all [redacted] secured in a locked drawer in my room or secured on my person… A review of Resident #3's NJ Ex Order 26, 4B1 dated [redacted] reflected… Resident demonstrates an accurate understanding of [redacted] and [redacted] 2. On 08/5/2025 at 9:15 AM, the surveyor observed Resident #72 NJ Ex Order 26, 4B1 by the facility entrance. During an interview with the surveyor, Resident #72 stated that he/she was admitted to the facility [redacted] Resident #72 stated that he/she was informed at that time that this was the NJ Ex Order 26, 4B1 and that he/she had been [redacted] in this space since admission. He/she further stated that there used to be a [redacted] and now there is an [redacted] The resident further stated that when	F0689		10/10/2025

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F0689 SS = D	Continued from page 44 there was no bucket or ashtray, he/she extinguished them on the ground. The surveyor observed that there were no fire extinguishers or fire blankets in the area. The surveyor reviewed the medical record for Resident #72. A review of the Admission Record reflected Resident #72 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1 [redacted] A review of the most recent Minimum Data Set, dated NJ Ex Order 26 revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B [redacted], which indicated NJ Ex Order 26, 4B1. The MDS further assessed under section [redacted] that the resident was currently using NJ Ex Order 26, 4 [redacted] A review of Resident #72's Care Plan Report had a focus area that included: resident is a known NJ Ex Order 26, 4B1 initiated NJ Ex Order 26, [redacted] with the goal that the resident will NJ Ex Order 26, 4B1 NJ Ex [redacted] within the NJ Ex Order 26, 4B1 initiated on NJ Ex Order 26 [redacted] and revised on NJ Ex Order 26 [redacted] with interventions that included but were not limited to NJ Ex Order 26, 4B1 NJ Ex Order [redacted] with resident as needed and allow resident to NJ Ex Order 26 [redacted] n designated NJ Ex Order 26.4 [redacted] area with supervision as needed. A review of Resident #72's NJ Ex Order 26, 4B1 dated NJ Ex Order 26, [redacted] reflected…Resident demonstrates an accurate understanding of NJ Ex Order 26, 4B1 [redacted] On 8/5/25 at 9:30 AM, the surveyor requested from the U. S. FOIA (b) (2) the NJ Ex Order 26, 4B1 Agreement for Resident #72. NJ Ex Order 26, 4B1 Agreement was provided for Resident #72. On 7/30/25 at 11:10 AM, during an interview with the surveyors, the U. S. FOIA (b) (2) t confirmed that there was no fire extinguisher in the front lobby. On 7/30/25 at 12:00 PM, during an interview with the surveyor, the U. S. FOIA (b) [redacted] stated that the designated NJ Ex Order 26, 4B1 was located off to the side near the building's entrance. The surveyor asked the U. S. FOIA (b) where the residents were supposed to extinguish their NJ Ex Order 26, 4B1. The U. S. FOIA (b) [redacted] replied, "In the ashtray." The surveyor informed the U. S. FOIA (b) [redacted] that no ashtrays were observed on NJ Ex Order 26, 4B1. The U. S. FOIA (b) [redacted] replied, "Someone must have stolen it." The	F0689		10/10/2025

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F0689 SS = D	Continued from page 45 surveyor asked the U. S. FOIA (b) if there was a fire extinguisher in the area. The U. S. FOIA (b) replied that she would have to get back to the surveyor. On 7/31/25 at 12:35 PM, the surveyor discussed the above observation and concerns with the U. S. FOIA (b) and U. S. FOIA (b) (2). The U. S. FOIA (b) stated that the facility was smoke-free and that residents needed to go off the premises if they wanted to NJ Ex Order 26 On 7/31/25 at 1:15 PM, the surveyor observed two unsampled residents smoking in the area near the facility entrance. The surveyor observed there were no receptacles or ashtrays for the residents to safely extinguish their NJ Ex Order 26, 4B1, and there were no fire extinguishers. On 8/4/25 at 8:10 AM, the surveyor observed by the facility entrance a large bucket filled with sand and several NJ Ex Order 26, 4B1. At that time, the surveyor observed the U. S. FOIA (b) (2) U.S. FOIA (b)(6) used a dolly to remove the large bucket and replace it with NJ Ex Order 26.4(b)(1). On 8/4/25 at 8:20 AM, during an interview with the surveyor, the U. S. FOIA stated that he had gone to the NJ Ex Order 26, 4B1 to get the bucket and sand "this weekend". He just got the ashtray today, so he was replaced it with the sand bucket. The U. S. FOIA further stated that the area where he placed the ashtray was, in fact, the designated NJ Ex Order 26.4(b)(1). The U. S. FOIA acknowledged that the facility was responsible for providing a safe smoking environment. Specifically, it should have had an NJ Ex Order 26.4(b)(1) so that residents could safely NJ Ex Order 26.4(b)(and dispose of their NJ Ex Order 26.4(b)(and a fire extinguisher in the designated NJ Ex Order 26.4(b)(1). A review of the facility's undated Smoking Policy reflected…In accordance with New Jersey state law, this center shall maintain a smoke-free environment. Residents, visitors, and employees are prohibited from smoking within the building, including the center's parking area, delivery area, and portico covered entryway. Residents and visitors wishing to smoke shall be directed to do so off premises on the public domain…such as a sidewalk. NJAC 8:39-31.6(e)	F0689		10/10/2025
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F0690	Resident #113 was immediately provided with NJ Ex Order 26 and secured in a manner to prevent contamination, infection control and to enhance dignity. The RN identified on the deficient practice received	10/10/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0690 SS = D	Continued from page 46 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure a NJ Ex Order 26, 4B1 was secured in a manner to prevent contamination, infection control, and to enhance dignity for 1 of 1 resident reviewed for NJ Ex Order 26, 4B1. The deficient practice was evidenced by the following: On 8/4/25, at 9:45 AM, the surveyor observed Resident #113's NJ Ex Order 26, 4B1 not in a NJ Ex Order 26, 4B1 and visible from the hallway. A review of Resident #113's Admission Record reflected the resident was admitted to the facility	F0690	Continued from page 46 in-serviced training on Urinary catheter care and Urinary Drainage bag to prevent contamination, infection control and to enhance dignity. All other residents with Foley Catheter have the potential to be affected by this deficient practice. The Nursing Administration audited all residents with foley catheter to determine if they were affected by the deficiency. No other residents were identified to be affected by this deficient practice. The Administrator and Director of Nursing reviewed the center's Policy and Procedures regarding Catheter Care, Urinary. It was determined that the Policy and Procedure were sufficient and required no changes. In addition, all nursing staff received in-service training Findings will be presented to the Quality Assurance Committee The Nursing Administration will check 5 random residents on foley catheter weekly x 4 then monthly x 3 to determine the level of compliance with Catheter Care, Urinary. All findings will be reported to the Administrator for any additional corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of corrections.	10/10/2025

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F0690 SS = D	Continued from page 47 with diagnoses that included but were not limited to; NJ Ex Order 26, 4B1 [redacted] A review of the current Order Summary Report and transcribed onto the Treatment Administration Record (TAR) reflected a physician order to check NJ Ex Order 26, 4B1 [redacted] for proper placement, provide NJ Ex Order 26, 4B1, record NJ Ex Order 26, 4B1 at the end of each shift and maintain in privacy bag every NJ hours. A review of Resident #113's Admission Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26 reflected the resident had a NJ Ex Order 26, 4B1 [redacted] Section NJ F of the assessment revealed the resident had an NJ Ex Order 26, 4B1. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, initiated on NJ Ex Order 26, that the resident has a NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 with interventions that included but were not limited to; NJ Ex Order 26, 4B1 privacy cover at all times. On 8/4/25 at 9:45 AM, during an interview with the surveyor, the U. S. FOIA (b) (2)) stated that she was unsure whether the NJ Ex Order 26, 4B1 should be secured in a NJ Ex Order 26, 4B1 control prevention and dignity. On 8/4/25 at 10:00 AM, the survey team discussed the above observations and concerns with the U.S. FOIA [redacted] and th U. S. FOIA (b) (2) [redacted] The U. S. FOIA (b) (2) confirmed that the NJ Ex Order 26.4(b)(1) should be stored in NJ Ex Order 26.4(b)(1) for infection control and dignity. A review of a facility policy, "Catheter Care, Urinary" dated as reviewed 5/2025, revealed…cover urinary drainage bags with privacy covers. N.J.A.C. 8:39-27.1 (a)	F0690		10/10/2025

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F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure NJ Ex Order 26, 4B1 was stored in accordance with infection control measures for 1 of 1 residents (Resident #113) reviewed for NJ Ex Order 26, [redacted] The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 7/29/25 at 11:39 AM, the surveyor observed in	F0695	Resident #113 NJ Ex Order 26, 4B1 was immediately stored in the plastic bag when not in use to comply with infection control measures Oxygen concentrator was cleaned by the housekeeper RN assigned to residents #113 was given in-serviced on NJ Ex Order 26, 4B1 storage in plastic bag when NJ Ex Order 26, [redacted] is not in use. A comprehensive care plan was developed and implemented on residents #113 using NJ Ex Order 26, [redacted] Resident #113 was discharged NJ Ex Order [redacted] All other residents with Oxygen therapy have the potential to be affected by this deficient practice. The Nursing Administration audited all residents on Oxygen therapy. No other residents were identified to be affected by this deficient practice. The Administrator and Director of Nursing reviewed the center's Policy and Procedure on Cleaning of Medical Equipment and Oxygen Equipment Management. No changes needed. In addition, all nursing staff received in-service on training on Oxygen Equipment Management Housekeeping/Maintenance department will perform routine cleaning of commonly shared equipment such as concentrator every 2 weeks and upon resident discharge Findings will be presented to the Quality Assurance Performance Improvement (QAPI) committee to ascertain the effectiveness of the corrective action and preventive measures. The Nursing Administration will conduct random rounds weekly x 4, then monthly x 3 All findings will be reported to the Administrator for	10/10/2025

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F0695 SS = D	Continued from page 49 Resident #113's room an NJ Ex Order 26, 4B1, not in use, soiled with a brown and yellow substance and covered with dust. On 7/30/25 at 8:45 AM, the surveyor observed in Resident #113's room an NJ Ex Order 26, 4B1 soiled with a brown and yellow substance covered with dust and a NJ Ex Order 26, 4B1 connected to the NJ Ex Order 26, 4B1, not in use, not stored in a plastic bag. A review of Resident #113's Admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26, 4B1 A review of the current Order Summary Report revealed a Physician Order (PO) dated NJ Ex Order 26, and transcribed onto the Treatment Administration Record (TAR) to giv NJ Ex Order 26, 4B1 check s NJ Ex Order 26, 4ENJ Ex O NJ) every shift. A review of Resident #113's Admission Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26, reflected that the resident had NJ Ex Order 26, 4B1 Section NJ E of the assessment revealed the resident received NJ Ex Order 26, 4B1, which included NJ Ex Order 26, 4B1 A review of the resident's individual comprehensive care plans (CP) revealed that no care plan had been NJ Ex Order 26, 4B1 On 7/31/25 at 9:30 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) assigned to Resident #113's care stated that the NJ Ex Order 26, 4B1 should be stored in a plastic bag for NJ Ex Order 26, 4B1 On 8/4/25 at 10:00 AM, the survey team discussed the above observations and concerns with the MDS coordinator and the U. S. FOIA (b) (2) The U. S. FOIA (b) (2) confirmed that when the oxygen tubing was not in use, it should be stored in a plastic bag for NJ Ex Order 26,	F0695	Continued from page 49 any additional corrective and disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of corrections.	10/10/2025

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F0695 SS = D	Continued from page 50 NJ Ex Order 26, 4B1 A review of a facility policy, "Oxygen Administration" dated as reviewed 5/2025, revealed…the purpose of this procedure is to provide guidelines for safe oxygen administration…review the resident's care plan to assess for any special needs of the resident…store tubing that is not in use in plastic bags. NJAC 8:39-19.4(a); 27.1(a)	F0695		10/10/2025
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by:	F0755	Resident #16's order for NJ Ex Order 26, 4B1 was clarified with the physician Resident #16's supply of NJ Ex Order 26, 4B1 with label indicating to NJ Ex Order 26, 4B1 was removed from the unit immediately and replaced with supply indicating NJ Ex Order 26, 4B1 LPN #1 was immediately in-serviced on facility's policy for "Medication Administration" and a Medication Administration Competency was completed All residents with a physician's order for eye drops have the potential to be affected by the identified deficient practice. The DON conducted audit of all residents with physician's orders for eye drops. All findings were immediately corrected. The pharmacy policy titled "Consultant Pharmacist Provider Requirements" was reviewed. No changed needed. Consultant Pharmacist will conduct Drug Regimen Review Monthly. Any discrepancies with eye drops will be reported to DON/ designee upon discovery for immediate correction. The DON/ designee will conduct weekly audit of eye drops weekly x4 then monthly audit of eye drops monthly x3 Audit of findings will be presented to the QAA/QAPI committee All findings will be reported to the DON/ designee for possible additional corrective or disciplinary actions.	10/10/2025

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F0755 SS = D	Continued from page 51 Based on observation, interview, and record review, it was determined that the facility failed to ensure that medication was administered according to the physician's order (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in one (1) of six (6) residents (Resident #16) during medication observation pass. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 7/30/25 at 8:48 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN#1) in the room of Resident #16. The surveyor observed LPN#1 informing Resident #16 that she would be administering the resident's medications. The surveyor observed the resident in bed eating breakfast. On 07/30/25 at 8:52 AM, the surveyor observed LPN#1 preparing to administer NJ Ex Order 26, 4B1 for Resident #16 which include NJ Ex Order 26, 4B1 [redacted]	F0755	Continued from page 51 The Administrator/ designee will responsible for ensuring compliance with the plan of correction.	10/10/2025

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F0755 SS = D	Continued from page 52	F0755		10/10/2025

NJ Ex Order 26, 4B1 . The surveyor observed LPN #1 during medication administration observation NJ Ex Order 26, 4B1

After LPN#1 administered Resident #16's medications the surveyor reviewed the physician orders for NJ Ex Order 26, 4B1 with LPN#1. The surveyor in the presence of LPN#1 inspected the pharmacy packaging for both NJ Ex Order 26, 4B1 . The surveyor observed a label with administration directions fo NJ Ex Order 26, 4B1 The pharmacy label was dated NJ Ex Order 26, 4B A review of the NJ Ex Order 26, 4B1 revealed a label with administration directions to NJ Ex Order 26, 4B1 . After reviewing the packaging for NJ Ex Order 26, 4B1 the surveyor in the presence of LPN#1 reviewed Resident #16's Electronic Medication Administration Record (e-MAR) which contained a physician's order for NJ Ex Order 26, 4B1 and a physician's order for NJ Ex Order 26, 4B1

At that time, the surveyor interviewed LPN #1 who acknowledge that NJ Ex Order 26, 4B1 LPN#1 acknowledge that she was following the instructions of the pharmacy label and should have follow the instructions on the EMAR. LPN#1 further stated that the incorrect directions on the pharmacy label was confusing and had a potential to cause an error. She stated that whenever the instructions on the pharmacy label are different from the order on the EMAR, she should verify the order with the physician.

A review of the Admission Record (an admission summary) reflected that Resident #16 was admitted to the facility with diagnoses that included, but were not limited to: NJ Ex Order 26, 4B1

A review of the quarterly Minimum Data Set, an assessment tool, dated NJ Ex Order 26, 4B reflected that the resident's cognitive skills for NJ Ex Order 26.4(b)(1)

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F0755 SS = D	Continued from page 53 score was NJ Ex Order 26, 4B1 which indicated that the resident's NJ Ex Order 26, 4B1. A review of the NJ Ex Order 26, 4B1 Physician's Orders (PO) revealed a PO dated NJ Ex Order 26, 4, for NJ Ex Order 26, 4B1 and a PO dated NJ Ex Order 26, 4 for NJ Ex Order 26, 4B1 A review of the NJ Ex Order 26, 4B1 EMAR revealed a PO dated NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 and a PO dated NJ Ex Order 26, 4B1 On 07/31/25 at 1:00 PM, the surveyor discussed the above concerns with the U. S. FOIA (b) (2) that consisted of the U. S. FOIA (b) (2) and the Minimum Data Set (U. S. FOIA (b) (2), who was the U. S. FOIA (b) (2). There was no additional information provided. A review of the facility's policy for "Medication Administration" dated 6/2025, which was provided by the U.S. FOIA (b revealed the following: "3. Reads medication order on electronic Medication Administration Record (e-MAR)." "4. Removes medication from resident's drawer in the medication cart. Checks name of resident Checks name of drug Checks strength/dose of drug Frequency given." "5. Checks medication order again. Compares e-MAR to blister pack to ensure it reads the same." NJAC 8:39-11.2 (b), 29.2 (d)	F0755		10/10/2025
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F0756	U. S. FOIA (b) (2) was immediately notified about deficient practice Resident #89's medication was reviewed by U. S. FOIA	10/10/2025

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F0756 SS = D	Continued from page 54 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the [redacted] identified and reported irregularities in the resident's medical record to the facility staff and attending physician. This deficient practice was identified for one (1) of six (6) residents observed during medication administration pass, (Resident #89) for medication management and was	F0756	Continued from page 54 [redacted] RN #1 was immediately in-serviced on facility's policy for "Medication Administration" and a Medication Administration Competency was completed All current residents with orders for [redacted] and Ferrous Sulfate have the potential to be affected by the identified deficient practice. DON/ designee conducted audit of all residents with physician orders for [redacted] and Ferrous Sulfate and cross-checked resident preferences for whole or crushed tablets All current residents identified on Ferrous Sulfate with preferences to crush their medications was changed to Ferrous Sulfate Liquid. All current residents identified on [redacted] with preferences to crush their medications will be assessed for continued need or alternative anti-diabetic treatment as determined by prescriber. All supplies of [redacted] tablets and Ferrous Sulfate tablets were marked with stickers indicating “DO NOT CRUSH” and all existing orders for Ferrous Sulfate Tablets was replaced with orders indicating “DO NOT CRUSH”. In-service was conducted with nurses regarding facility guidelines on Medication Administration and crushing of medications Consultant Pharmacist will review all [redacted] and Ferrous sulfate orders on a monthly basis x 6 to ensure resident preferences are specified and followed appropriately. The DON/ designee will conduct an audit of the monthly Drug Regimen Review findings related to [redacted] and Ferrous Sulfate to ensure that all discrepancies were addressed immediately monthly x 6 Audit of findings by Consultant Pharmacist and facility audit will be presented to the QAPI Meetings All findings will be reported to the DON/ designee and Medical Director/ designee for possible additional corrective or disciplinary actions. The Administrator/ designee will be responsible for ensuring compliance with the plan of correction.	10/10/2025

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F0756 SS = D	Continued from page 55 evidenced by the following: On 07/31/25 at 8:30 AM, during medication administration pass the surveyor observed a Registered Nurse (RN#1) entered into Resident #89 room. The resident was observed sitting up in bed and eating breakfast. RN #1 informed the resident that she would be taking their vitals and then would be administering their medications.On 7/31/25 at 8:32 AM, the surveyor observed RN#1 preparing to administer [redacted] medications for Resident #89 which included [redacted] surveyor observed RN#1 preparing the resident's medications for administration. She told the surveyor that the resident is administered their medications [redacted] and in [redacted]. The surveyor observed RN#1 [redacted] each medication including [redacted] and place each medication in a separate medication cup [redacted]. The surveyor then observed RN#1 enter Resident #89's room and administered the resident their medications which included [redacted] The surveyor reviewed Resident #89's medical records. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; [redacted] A review of the Annual Minimum Data Set, an assessment tool used to facilitate the management of care dated [redacted] reflected that the resident's cognitive skills for daily decision-making score was [redacted], which indicated that the resident' had [redacted]. A review of the [redacted] Order Summary Report (physician's order sheet) (OSR) revealed a	F0756		10/10/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0756 SS = D	Continued from page 56 physician's order (PO) dated NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 A review of the NJ Ex Order 26, 4B electronic medication administration record (eMAR) revealed a PO dated NJ Ex Order 26.4(b)(1) for NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 with both medications having a plotted time NJ Ex Order 26,4 A review of the Manufacturer's Specifications for both NJ Ex Order 26, 4B1 revealed the following: NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 A review of the U. S. FOIA (b) (2)) Monthly Reports from dated NJ Ex Order 26, 4B1 indicated that the U. S. reviewed the medication regimen for Resident #89 with no recommendation that both NJ Ex Order 26, 4B1 can't be NJ Ex Order They were also no recommendation making the physician or nurses aware that these two medications were not recommended to NJ Ex Order 26.4(b)(1) by the manufacture. On 7/31/25 at 9:00 AM, the surveyor in the presence of the RN#1 reviewed Resident#89's physician's orders and they were no instructions on the e-MAR instructing the nurse not to NJ Ex Orde NJ Ex Order 26, 4B1 The surveyor in the presence of RN#1 reviewed Resident #89's NJ Ex Order 26, medication card which contained no auxiliary label NJ Ex Order 26, 4B1. At that time, the surveyor interviewed RN#1 who stated that she was not aware that both NJ Ex Order 26 couldn't be NJ Ex Order She further stated if she was aware that both Ex Order 26 and NJ Ex Order 26, 4B1 couldn't be NJ Ex Orde that she would not NJ Ex Orde those two medications. On 7/31/25 at 1:15 PM, the surveyor presented the above concerns to the U. S. FOIA (b) (2)) and the Minimum Data Set U. S. FOIA (b) (2) who was covering for the U. S. FOIA (b) (2	F0756		10/10/2025

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F0756 SS = D	Continued from page 57 U. S. FOIA (b) (2). No further information was provided. On 8/5/25 at 8:50 AM, the surveyor interviewed the U.S. F via a telephone interview who acknowledge that both NJ Ex Order 26, 4B1 should be taken NJ Ex Order and should NJ Ex Order 26, 4B1. She stated that crushing both medications won't affect the activity or the distribution of the medication or harm the resident. The U. S. FO stated that the recommendation NJ Ex Order 26, 4B1 both NJ Ex Order 26, 4B1 was due to NJ Ex Order 26.4(b)(1 or NJ Ex Order 26. . She felt it was not necessary to make this recommendation when it won't affect the way the medication works or harm a resident. A review of the facility's policy for "Medication Administration Guidelines" undated, which was provided by the MDS coordinator included the following: 17. Observe for medications suitable and unsuitable for crushing. Stickers on blister packs will state "Do Not Crush" to indicate that the medication cannot be crushed. A review of the U. S. FOIA (b) (2) responsibilities that was undated and provided by the U. S. FOIA (b) (2) revealed the following: "U. S. FOIA (b) (2) would assure duration of therapy (adequate therapy) and Manufacturer's Recommendations." On 8/4/25 at 1:40 PM, the survey team met with the U. S. FOIA (b) (2) for exit conference, no further pertinent information provided. NJAC 8:39-29.3	F0756		10/10/2025
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F0761	LPN #1 was immediately in-serviced on the facility policy titled "Medication Return and Disposal of Medications Non-Controlled" All residents have the potential to be affected by the identified deficient practice. The facility policy titled "Medication Return and Disposal of Medications Non-Controlled" no changes needed. Staff Nurses was educated on the facility guidelines for disposal of non-controlled medications The DON/ designee will conduct weekly Medication Disposal Competency on 3 nurses weekly x4 then monthly	10/10/2025

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F0761 SS = D	Continued from page 58 controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly dispose of medications which was observed for one (1) of three (3) nurses during medication administration pass. This deficient practice was evidenced by the following: On 7/30/25 at 8:48 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN#1) in the room of Resident #16. The surveyor observed LPN#1 informing Resident #16 that she would be administering the resident's medications. The surveyor observed the resident in bed and eating breakfast. On 07/30/25 at 8:52 AM, the surveyor observed LPN#1 preparing to administer nine (9) medications to Resident #16 which included NJ Ex Order 26, 4B1 [redacted]. The surveyor observed LPN#1 during medication preparation added NJ Ex Order 26, 4B1 [redacted] instead of NJ Ex Order 26, 4B1 into the medication cup. The surveyor also observed LPN #1 adding a NJ Ex Order 26, 4B1 instead of a NJ Ex Order 26, 4B1 into the medication cup. The surveyor stopped LPN#1 just before she was going to administer the medications to Resident #16. The surveyor asked LPN#1 to leave the resident's room with all of the resident's medications. The	F0761	Continued from page 58 Medication Disposal Competency on 3 nurses monthly x3 to ensure that staff are in compliance with the facility policy titled "Medication Return and Disposal of Medications Non-Controlled". Any deficient practices will be corrected immediately. Audit of competencies will be presented to the QAPI committee quaterly All findings will be reported to the DON/ designee for possible additional corrective or disciplinary actions.	10/10/2025

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F0761 SS = D	Continued from page 59 surveyor informed LPN#1 of the observations and asked for her to take out a bottle of NJ Ex Order 26, 4B1 and a bottle of NJ Ex Order 26, 4B1 from the medication cart, so that she could identified the tablets. The surveyor observed LPN#1 pour NJ Ex O from a stock bottle and put them on a tissue paper. LPN#1 was observed handling these NJ Ex Order 26, 4B1 while reviewing the medications. LPN#1 acknowledge that she accidently added NJ Ex Order 26, 4B1 to the medication cup. At that time, the surveyor observed LPN#1 pick up the tissue paper that contained the NJ Ex Order 26, 4B1 and was going to throw them into the trash bin that was attached to the medication cart. At that time, the surveyor stopped LPN#1 and asked her if that was the proper way to dispose medications. LPN#1 stated that all medications should be dispose in a Drug Buster (medication disposal system) and that medication should not be dispose in a trash bin. The surveyor then observed LPN#1 remove a Drug Buster from her medication cart and dispose the NJ Ex Order 26, 4B1 and all the medications that were in the medication cup. The surveyor then observed the nurse re-prepared all of the resident's medications for medication administration. On 7/31/25 at 1:00 PM, the surveyor discussed the above concerns with the U. S. FOIA (b) (2) and the U.S. FOIA (b)(6) who was covering for the U.S. FOIA (b)(6) who was on vacation. No further information was provided by the facility. A review of the facility's policy titled "Medication Return and Disposal of Medications Non-Controlled" that was dated 05/2025 and was provided by the U.S. FOIA (b) indicated the following: "Policy: "Medications that cannot be returned to the dispensing pharmacy (e.g., non-unit-dose medications, medications refused by the resident, and/or medications left by residents upon discharge) shall be destroyed" "If a dose of a non-controlled prescription medication is refused, spit out and/or dropped during medication pass, the facility will utilized Drug Buster to dispose of said medication. When container is filled per manufacturer's instructions, it will be disposed of in a med room trash and replaced with a new Drug Buster container." NJAC: 8:39-29.4 (a) (h) (d)	F0761		10/10/2025

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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 REGULATIONS.	S0000		10/27/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 7 out of 21 day shifts reviewed. Findings Include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021:	S0560	All residents have the potential to be affected by this deficient practice Staffing Coordinator has been education on staffing ratios and the importance of staffing at proper ratios Administrator/Designee will meet and communicate with staffing coordinator to review schedules to ensure facility meets New Jersey staffing requirements Staffing Coordinator has been education on staffing ratios and the importance of staffing at proper ratios The facility has implemented multiple strategies to improve staffing levels, retain current employees, and recruit new team members: Offering sign-on bonuses to new hires for targeted positions. Providing employee referral bonuses for current staff who refer qualified candidates. Posting job openings on multiple online platforms, and local job boards Staffing levels are reviewed daily and weekly by the Administrator and DON Administrator/Designee will audit staffing ratios daily to ensure it meets New Jersey staffing requirements Results of all audits will be reported quarterly to the	10/10/2025

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

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S0560	Continued from page 1 One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility as documented below: For the 3 weeks of AAS-11 staffing, the facility was deficient as follows: 1.For the week of Complaint staffing from 08/25/24 to 08/31/24, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: 08/25/24 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. 08/26/24 had 4 CNAs for 107 residents on the day shift, required at least 13 CNAs. 08/27/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. 08/30/24 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. 08/31/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. 2. For the 2 weeks of staffing prior to survey from 07/13/25 to 07/26/25, the facility was deficient in CNA staffing for 2 of 14 day shifts as follows: 07/17/25 had 13 CNAs for 109 residents on the day	S0560	Continued from page 1 QAPI committee, and corrective actions will be taken immediately if issues are identified. Responsible party: Administrator	10/10/2025

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S0560	Continued from page 2 shift, required at least 14 CNAs. 07/20/25 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 8/4/25 at 9:32 AM, the surveyor interviewed the Staffing Coordinator (SC), who stated that she scheduled the Nurses and the Certified Nursing Assistances (CNA's). She stated that she staffed the facility according to the census. She further stated that she was aware of the staffing ratios for CNA's; 1 CNA to 7-8 residents on day shift, 10 to 11 residents on 3-11 shift and 14 residents on 11-7 shift. The SC stated that she was able to meet the staffing ratios, the facility does not have agency staff, the facility offers overtime and had staffing bonuses. On 08/05/25 at 10:40 AM, the surveyor met with the Licensed Nursing Home Administrator, who stated that they are aware of the minimum staffing requirements for CNA's and acknowledged that the dates reviewed for staffing were short. A review of the facility's policy, titled, "Staffing Policy" revealed, that the facility shall maintain minimum direct care staff-to-resident ratio in accordance with N.J. Stat.... to meet the daily care needed of all residents.	S0560		10/10/2025
S2120	Mandatory Physical Environment CFR(s): 8:39-31.1(c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, PO Box 809, Trenton, New Jersey 08625-0809. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 07/31/2025 in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure quarterly Uniform Fire Code inspections were conducted in accordance with N.J.A.C 5:70. This deficient practice had the potential to affect all	S2120	The facility immediately contacted the Authority Having Jurisdiction (AHJ) and requested completion of the required Uniform Fire Code inspection. The inspection was conducted, and set back into compliance. No residents were harmed as a result of this deficient practice. A review of all documentation related to Uniform Fire Code compliance was completed to determine whether any other required inspections or certifications were overdue or missing. No additional issues were identified. All current Life Safety documentation was organized and verified to ensure accuracy and completeness. The Maintenance Director or designee will be responsible for ensuring that all future quarterly Uniform Fire Code inspections are completed on	11/02/2025

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S2120	Continued from page 3 residents and was evidenced by the following: A record review at 1:22 PM revealed that the New Jersey Uniform Fire Code Certificate of Inspection that was provided was conducted on 06/08/2019 and expired on 09/08/2019. No further documentation was provided regarding subsequent quarterly inspections. In an interview at 1:39 PM, the facility's Administrator stated, "Authority Having Jurisdiction (AHJ) could not provide certifications until elevators repair had been complete." The facility's Administrator was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2025 at 1:42 PM.	S2120	Continued from page 3 time and that updated certificates are received and filed. The Maintenance Department will receive education regarding • Required inspection frequencies under N.J.A.C 5:70 • Proper tracking and filing of AHJ-issued certificates • Immediate escalation if scheduled inspections are delayed due to repairs or other barriers. A tracking log has been implemented to monitor due dates for all required fire code inspections. The Maintenance Director or designee will review the Uniform Fire Code inspection log to ensure inspections remain current and all documentation is on file. The results of this monthly audit will be reported and reviewed during the facility's monthly quality assurance meeting	11/02/2025

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F0000	INITIAL COMMENTS An offsite/desk review was conducted on 11/13/2025 to verify the facility's Plan of Correction for the 8/5/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		12/21/2025

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

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S0000	Initial Comments An offsite/desk review was conducted on 11/13/2025 to verify the facility's Plan of Correction for the 8/5/2025 State of New Jersey Re-Licensure survey. The facility was found to be not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		12/21/2025
S2120	Mandatory Physical Environment CFR(s): 8:39-31.1(c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, PO Box 809, Trenton, New Jersey 08625-0809. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview it was determined that the facility failed to ensure quarterly Uniform Fire Code inspections were conducted in accordance with N.J.A.C 5:70. This deficient practice had the potential to affect all residents and was evidenced by the following: The facility was cited on the 8/5/25 Re-licensure survey due to the last New Jersey Uniform Fire Code Certificate of Inspection was conducted on 06/08/2019 and expired on 09/08/2019. The Licensed Nursing Home Administrator (LNHA) stated that the "Authority Having Jurisdiction (AHJ) could not provide certifications until elevators repair had been complete." The facility submitted a Plan of Correction which documented that the following correction would be completed by 11/2/25: "The facility immediately contacted the Authority Having Jurisdiction (AHJ) to schedule the overdue Uniform Fire Code inspection. A request for inspection was submitted, and the inspection will be completed once elevator renovations are finalized."On 11/13/25, the surveyor requested evidence that the inspection was completed. The LNHA stated that the inspection	S2120	The facility immediately contacted the Authority Having Jurisdiction (AHJ) and requested completion of the required Uniform Fire Code inspection. The Fire Marshal conducted the on-site Uniform Fire Code inspection. The facility is currently awaiting receipt of the official Certificate of Inspection documentation from the AHJ. Upon receipt, the certificate will be filed in the Life Safety compliance binder and maintained on site for surveyor review. At the time of inspection, no immediate life safety hazards were identified by the Fire Marshal. No residents were harmed as a result of this deficient practice. A review of all documentation related to Uniform Fire Code compliance was completed to determine whether any other required inspections or certifications were overdue or missing. No additional issues were identified. The Maintenance Director or designee is responsible for ensuring that all future quarterly Uniform Fire Code inspections are completed on time and that updated certificates are received and filed. The Maintenance Department received education regarding: • Required inspection frequencies under N.J.A.C. 5:70 • Proper tracking and filing of AHJ-issued certificates • Immediate escalation to administration if scheduled	11/14/2025

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S2120	Continued from page 1 had not yet occurred.	S2120	Continued from page 1 inspections are delayed due to repairs or other barriers A tracking log has been implemented to monitor due dates for all required fire code inspections. The Maintenance Director or designee will review the Uniform Fire Code inspection log monthly to ensure inspections remain current and all documentation is on file. Results of the monthly review will be reported and discussed during the facility's Quality Assurance and Performance Improvement (QAPI) meeting.	11/14/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 1/27/2026 in relation to the 11/13/2025 revisit State of New Jersey Re-Licensure survey of the 8/5/2025 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: 315375	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **08/05/2025**

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 07/29/25 to 07/31/25 and Forest Hills Center for Rehabilitation and Healing 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. Forest Hill Healthcare Center is a five-story building with a basement that was built in 1997. It is a Type II (222) construction. The facility is divided into 12 smoke zones. The exterior 800 KW diesel generator powers approximately 90% of the building. The facility is licensed for 120 beds and currently occupies 104.	K0000		10/27/2025
K0293 SS = F Bldg. 01	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 07/29/2025 and 07/30/2025 in the presence of the U. S. FOIA (b) (2) it was determined that the facility failed to ensure that exit signs were maintained in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1and7.10. This deficient	K0293	The facility immediately repaired and/or replaced all non-illuminated exit signs identified during the life safety inspection. All repairs were completed No residents were directly impacted by this deficient practice. The facility conducted a building-wide audit of all exit signs to verify illumination and function. No additional issues were identified. The facility implemented the following measures to ensure ongoing compliance: · The Maintenance Director/designee will conduct quarterly audits of all exit signage to ensure proper illumination and function. · Exit sign checks will be incorporated into routine monthly environmental rounds.	10/22/2025

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

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K0293 SS = F Bldg. 01	Continued from page 1 practice had the potential to affect all residents and was evidenced by the following: Observations on 07/29/2025 from 9:20 AM to 3:05 PM revealed the following: 1. The exit sign by dining room (A) had no illumination. 2. Two of 2 exit signs by dining room (B) had no illumination. 3. The exit sign above the door between the lobby and the locker area had no illumination. In an interview at that time, the [redacted] confirmed the observations and stated, "we are in the process of replacing with LEDs". Observations on 07/30/2025 revealed the following: 1. The exit sign by the first floor stairwell to the maintenance office and storage area had no illumination. 2. The exit sign by the food storage service area had no illumination. 3. The exit sign above exit door in the receiving area had no illumination. 4. The exit sign above the emergency exit door to the parking deck had no illumination. 5. The exit sign to the patio area had no illumination. In an interview at that time, the [redacted] confirmed the observations. The facility's [redacted] was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2025 at 1:42 PM. N.J.A.C 8:39-31.2(e)	K0293	Continued from page 1 · All staff will receive in-service education on the importance of reporting any observed exit sign that is not illuminated. Maintenance Director/designee will monitor compliance with exit signage requirements weekly × 4 weeks. · Results will be reported quarterly QAA/QAPI committee; corrective action taken immediately if issues are found. · All findings will be reported to the Administrator for any additional corrective or disciplinary actions. · The Administrator will be responsible for ensuring compliance with the plan of correction.	10/22/2025
K0321 SS = F Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101	K0321	The soiled utility room door was repaired to ensure it self-closes and positively latches. Door closure arms were reinstalled on the resident storage room, food service storage room, and central supply room	10/22/2025

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K0321 SS = F Bldg. 01	Continued from page 2 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 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observations and interview on 07/29/2025 and 07/30/2025 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 07/29/2025 at 9:30 AM revealed that the door to the soiled utility room did not	K0321	Continued from page 2 doors. Repairs were completed immediately following surveyor observation, and all doors were tested to ensure proper operation. A facility-wide audit of all hazardous area doors was conducted by the Maintenance Director. No additional deficient conditions were identified during this audit. The Maintenance Director/designee has incorporated hazardous area door inspections into routine life safety and environmental safety checks. Maintenance staff were educated on the requirement to keep door closure arms intact and to report any issues with door self-closing or latching immediately to the Maintenance Director. Maintenance Director/designee will monitor compliance with Hazardous Area Enclosures 4 weeks, then monthly for 3 months. Results will be reported quarterly to QAA/QAPI committee; corrective action taken immediately if issues are found. All findings will be reported to the Administrator for any additional corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of correction.	10/22/2025

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K0321 SS = F Bldg. 01	Continued from page 3 self-close and positive latch when tested by the [U. S. FO] An observation on 07/29/2025 at 10:15 AM revealed that residents storage room contained combustibles, and the door closure arm was removed. In an interview at that time, the [U. S. FO] confirmed the findings. An observation on 07/30/2025 at 12:10 PM revealed that food service storage room contained combustibles, and the door closure arm was removed. An observation on 07/30/2025 at 12:25 revealed that the central supply room contained combustibles, and the door closure arm was removed. In an interview at that time, the [U. S. FO] confirmed the findings. The facility's [U. S. FOIA (b) (2)] was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2025 at 1:42 PM. NJAC 8:39-31.2(e)	K0321		10/22/2025
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K0324	The 3 of 3 kitchen suppression nozzles were repositioned immediately to provide proper coverage of the cooking equipment. The fire suppression vendor was contacted to inspect the system and confirm proper alignment. A facility-wide review was conducted. No other areas in the facility contain kitchen suppression systems or commercial cooking equipment. Therefore, no other residents were affected. The Maintenance Director/Designee will perform and document monthly inspections of the kitchen fire suppression system, including nozzle alignment, in accordance with NFPA 96. Maintenance inspections have has been updated to	10/22/2025

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K0324 SS = F Bldg. 01	Continued from page 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 interview on 07/29/2025 in the presence of the U. S. FOIA (b) (2) it was determined that the facility failed to ensure that A) the kitchen hood suppression system was inspected monthly and B) 3 of 3 kitchen cooking equipment Wet Chemical fire suppression systems nozzles were in the proper position to protect against fire in accordance with NFPA 101:2012 edition, Section 19.3.2.5.3*(10) and NFPA 17 and NFPA 96. These deficient practices had the potential to affect all residents and were evidenced by the following: An observation at 12:27 PM revealed that the 3 of 3 suppression spray nozzles for the kitchen were not positioned to protect the cooking equipment. Further observations revealed that the monthly tag to the kitchen fire suppression system lacked documentation of monthly visual inspection. In an interview at the time, the U. S. FO confirmed the observations. The facility's U. S. FOIA (b) (2) was notified of the deficient practices at Life Safety Code survey exit conference on 07/21/2025 at 1:42 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 10,17, 96	K0324	Continued from page 4 include monthly nozzle inspections. Maintenance staff and kitchen staff will be educated on the importance and safety of maintaining proper nozzle positioning. Maintenance Director/designee will monitor compliance nozzles on hood suppression weekly × 4 weeks, then monthly for 3 months. Results will be reported quarterly QAA/QAPI committee; corrective action taken immediately if issues are found. All findings will be reported to the Administrator for any additional corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of correction.	10/22/2025
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.	K0345	The blue tape was immediately removed from the kitchen and elevator heat detectors. The fire alarm vendor inspected and confirmed proper functionality of the detectors. All other heat and smoke detectors in the facility were inspected to ensure they were not covered, obstructed, or disabled. No additional issues were identified. The vendor has been contacted and scheduled to complete fire alarm inspections every six months as required by NFPA 72.	10/22/2025

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K0345 SS = F Bldg. 01	Continued from page 5 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observation, interview, and document review on 07/29/25,07/30/25 and 07/31/25, in the presence of the [U. S. FOIA (b) (2)], it was determined that the facility failed to ensure a.) that their fire alarm system was inspected semi-annually and b.) that the operational reliability of the fire alarm system was maintained in accordance with NFPA 72 (2010 edition) section 14.1.1. These deficient practices had the potential to affect all residents and were evidenced by the following: An observation on 07/29/25 at 12:25 PM with the [U. S. FO], revealed that the heat detector in the kitchen by the dishwashing area was covered with blue tape. An observation at 12:35 PM with the [U. S. FO], revealed that the heat detector by the first floor elevator #3 was covered with blue tape. In an interview at that time, the [U. S. FO] confirmed the findings. A documentation review on 7/31/2025 revealed that the semi-annual fire alarm inspection reports dated 12/19/2023, 11/01/2024 and 7/15/2025, provided by the [U. S. FO] were missing the first semi-annual inspection report for 2024. In an interview at 10:10 AM, the [U. S. FO] stated the inspection was not conducted and could not provide documentation. The facility's [U. S. FOIA (b) (2)] was notified of the deficient practices at Life Safety Code survey exit conference on 07/31/2025 at 1:42 PM. NJAC 8:39 31.1(c), 31.2 (e) NFPA 70, 72	K0345	Continued from page 5 The Maintenance Director has implemented a calendar system to track inspection due dates. Maintenance staff have been educated on the importance of not covering detectors and on the procedure to report if a detector is found obstructed. Maintenance Director/designee will monitor compliance with smoke Detectors requirements weekly × 4 weeks, then monthly for 3 months. Results will be reported quarterly to QAA/QAPI committee; corrective action taken immediately if issues are found. All findings will be reported to the Administrator for any additional corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of correction.	10/22/2025
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K0353	No residents were directly affected by the deficient sprinkler system maintenance/testing. The facility contacted the vendor to schedule the missing sprinkler inspection and ongoing repairs to	10/22/2025

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K0353 SS = F Bldg. 01	Continued from page 6 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 record review and interview on 07/31/2025 in the presence U. S. FOIA (b) (2)), it was determined that the facility failed to ensure that fire sprinkler systems were inspected tested and maintained in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.6, 9.7.7, 9.7.8 and NFPA 25:2010 Edition, Sections 4.4, 4.5,4.7, 4.1.4, 5.2.1 and 14.2. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review at 1:10 PM revealed the following: 1. Quarterly sprinkler reports dated 07/09/2024 (Q1) and 01/06/2025 (Q3) were provided, missing October (Q2) and April (Q4). 2. The annual sprinkler inspection report dated 10/25/2024, the vendor deficiency report indicates “Reliable B-1 Accelerator was out of service upon arrival. Attempted numerous times to reset and place back in service but was unsuccessful. Recommend replacement.” No documentation was provided regarding repairs when request was made at 1:15 PM. 3. The fire sprinkler 5-year fire department connection hydrostatic test report was not provided. 4. The fire sprinkler dry system 3-year air leak test report was not provided.	K0353	Continued from page 6 ensure all systems are fully operational A review of all sprinkler system locations and reports was conducted by the Maintenance Director in conjunction with the vendor. No additional deficiencies were identified. The facility updated its vendor communication process to ensure timely follow-up for all inspections and maintenance. The U. S. FOIA (b) (2) was educated on the requirement to follow up with vendors to confirm that all sprinkler system inspections and testing are completed in accordance with NFPA 25 standards. A tracking log will be created to document all sprinkler system inspections, testing, and maintenance Results will be reported quarterly to QAA/QAPI committee; corrective action taken immediately if issues are found. All findings will be reported to the Administrator for any additional corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of correction.	10/22/2025

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K0353 SS = F Bldg. 01	Continued from page 7 5. The 5-year wet and dry internal 5-year inspection was not provided. In an interview at that time, the [redacted] acknowledged the findings. The facility's [redacted] was informed of the deficient practices during the Life Safety Code exit conference at 1:42 PM. N.J.A.C. 8:39-31.2(e) NFPA 13. 25	K0353		10/22/2025
K0355 SS = F Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observations, record review and interview on 07/29/2025, 07/30/2025 and 07/31/2025 in the presence of [redacted] it was determined that the facility failed to a). perform and document a monthly visual examination for 4 of 56 fire extinguishers and b). ensure an annual inspection was conducted for all portable fire extinguishers in accordance with NFPA 101:2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10:2010 Edition, Sections 7.2.2(3) and 7.2.3. These deficient practices had the potential to affect all residents and were evidenced by the following: Observations from 9:15 AM to 3:05 PM with the [redacted], revealed the following: 1. The ABC portable fire extinguisher in the occupational therapy room had inspection tag last dated 02/27/2024. 2. The ABC portable extinguisher in the day room had inspection tag last dated 02/27/2024.	K0355	No residents were directly affected by the missing or outdated fire extinguisher inspections. The vendor was immediately contacted to perform the required inspections, testing, and maintenance. Corrective actions are ongoing to ensure all fire extinguishers are inspected and documented according to NFPA 10 standards. A complete review of all fire extinguishers in the facility was conducted by the Maintenance Director and the vendor. No additional deficiencies were identified during this review. The Maintenance team has been educated on the importance of timely inspection and documentation of all fire extinguishers. Staff were trained on conducting monthly visual inspections and ensuring annual inspections are completed by the vendor in accordance with NFPA 10. Extinguishers will be monitored monthly. Results will be reported monthly to QAA/QAPI committee; corrective action taken immediately if	10/22/2025

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K0355 SS = F Bldg. 01	Continued from page 8 3. The ABC portable fire extinguisher in the laundry washing area had inspection tag last dated 11/21/2024. 4. The tag to the ABC portable fire extinguisher in the laundry drying area lacked monthly visual inspection documentation. In an interview at that time, the [redacted] confirmed the observations. A documentation review on 07/31/2025 at 11:16 AM revealed that the annual fire extinguisher inspection report was not provided. In an interview at the time of record review, the [redacted] stated the annual fire extinguisher inspection was not conducted by the vendor and he could not provide any records. The facility's [redacted] was informed of the deficient practices during the Life Safety Code exit conference at 1:42 PM. N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 10	K0355	Continued from page 8 issues are found. All findings will be reported to the Administrator for any additional corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the plan of correction.	10/22/2025
K0372 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by:	K0372	No residents were directly affected by the unprotected smoke/fire barrier penetrations. Corrective actions are ongoing to ensure all penetrations are properly sealed. A full inspection of all smoke/fire barrier walls in the facility is being completed by the vendor in conjunction Maintenance Director/designee. No additional deficiencies have been identified to date. Fire/smoke barrier inspections will be incorporated into routine maintenance rounds and safety inspections. The [redacted] have been educated on proper inspection and repair procedures using approved fire/smoke rated materials.	10/22/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS CENTER FOR REHABILITATION AND HEALING	497 MT PROSPECT AVE , NEWARK, New Jersey, 07104

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K0372 SS = F Bldg. 01	Continued from page 9 Based on observation and interview on 07/29/2025 and 07/30/2025 in the presence of the [U. S. FOIA (b) (2)], it was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of fire/smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105, and NFPA 80:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation 07/29/2025 at 11:23 AM revealed that the fire barrier wall above the fire door by physical therapy had 2 unprotected penetrations and 3 penetrations sealed with non-listed yellow spray foam. An observation at 10:45 AM revealed that a penetration in the fire/smoke barrier wall above the exit door between the lobby and the locker area was sealed with non-listed yellow spray foam. In an interview at that time, the [U. S. FO] confirmed the observations. An observation on 07/30/2025 at 2:10 PM revealed that the fire/smoke barrier wall above the set of doors by room 408 had a penetration sealed with non-listed yellow spray foam. An observation on 07/30/2025 at 2:44 PM revealed that the fire/smoke barrier wall above the set of doors by room 505 had a penetration sealed with non-listed yellow spray foam. In an interview at that time, the [U. S. FO] confirmed the observations. The facility's [U. S. FOIA (b) (2)] was notified of the deficient practice at Life Safety Code survey exit conference on 07/31/2025 at 1:42 PM. N.J.A.C 8:39-31.2 (e)	K0372	Continued from page 9 Ongoing compliance will be monitored through monthly maintenance rounds and safety inspections. The Maintenance Director or designee is responsible for monitoring. Results of inspections and corrective actions will be reported into the QAPI Committee for review	10/22/2025
K0531 SS = F Bldg. 01	Elevators CFR(s): NFPA 101 Elevators	K0531	No residents were directly affected by the elevator deficiencies. The vendor was contacted immediately, and the process of replacing and installing new elevators has been initiated.	10/23/2025

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K0531 SS = F Bldg. 01	Continued from page 10 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: REPEAT DEFICIENCY Based on observations, interview and documentation review on 07/29/2025, 07/30/2025 and 07/31/2025 in the presence of the facility's U. S. FOIA (b) (2)), it was determined that the facility failed to repair, maintain, test and inspect the elevators annually with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division and/or AHJ. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 07/29/2025 revealed that elevator #1 and elevator #3 were not functioning and emergency communication phone line test could not be conducted when requested by the surveyor. In an interview at the time, the U. S. FO could not provide the last date both elevators began not functioning. A documentation review on 07/31/2025 revealed that the provided inspection report dated 09/12/19 and temporary certificate of occupancy/compliance for 3 of 3 elevators was issued on 09/13/2019 and expired 12/13/2019, over 6 years overdue. In an interview at 12:13 PM, the facility's U. S. FO stated	K0531	Continued from page 10 Elevator #2 remains operational and accessible for resident transport and emergency use. Emergency communication alternatives are available if needed. All residents and staff have the potential to be affected when elevators are out of service. The Maintenance Director and vendor completed a review of all elevators to ensure access and emergency procedures are in place while awaiting installation and certification of new elevators The facility is in the process of installing new elevators. Once installation is complete, the vendor and NJ Department of Community Affairs, Elevator Safety Division (AHJ), will conduct full inspections and issue a valid certification of compliance. The U. S. FOIA (b) (2) has been educated on the requirement for annual inspections and certifications by the AHJ. A tracking system/log has been implemented to monitor the due dates for all elevator inspections, testing, and certifications to ensure no lapse occurs in the future. The Maintenance Director or designee will review elevator inspection records monthly to verify testing, inspections, and certifications are current. Results will be reported to the quarterly QAA/QAPI Committee monthly. Any deficiencies identified will be corrected immediately and reported to the Administrator. The Administrator is responsible for overall compliance with elevator maintenance and certification requirements	10/23/2025

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K0531 SS = F Bldg. 01	Continued from page 11 the facility was in the process of installing new elevators. The observation of the signed off elevator certificate in the elevator room confirmed, the inspection was not up to date and last inspected was 12/13/19. No further documentation regarding repairs was provided. The facility's [U. S. FOIA (b) (2)] was informed of the deficient practice on 1:42 PM during the Life Safety Code exit conference. This deficient practice was also cited at the previous Recertification survey dated 12/12/2023. NJAC 8:39-31.2(e)	K0531		10/23/2025
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. 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: REPEAT DEFICIENCY Based on observation, documentation review and interview on 07/29/2025, 07/30/2025 and 07/31/2025 in the presence of the [U. S. FOIA (b) (2)] [redacted] it was determined that the facility failed to ensure that all fire door assemblies were inspected and tested annually in accordance with NFPA 80 Standard for Fire Door and Other Opening	K0761	No residents were negatively affected by the lack of documented fire door inspections and testing. A certified vendor was contacted to conduct a full facility-wide inspection and testing of all fire door assemblies in compliance with NFPA 80. All residents have the potential to be affected by improperly maintained fire doors. The vendor inspection included all fire-rated doors, including horizontal exits, hazardous enclosures, and exit doors, to ensure they are functioning as required. A written policy and procedure for annual inspection and testing of fire doors has been developed and implemented, in accordance with NFPA 80. The Maintenance Director and designee have been educated on the policy, requirements of NFPA 80, and documentation procedures. The Administrator and Maintenance Director will review the inspection log monthly to ensure annual testing is scheduled and completed. Vendor contracts have been updated to include annual fire door inspections to prevent recurrence of noncompliance	10/22/2025

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K0761 SS = F Bldg. 01	Continued from page 12 Protectives. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 07/29/2025 and 07/30/2025 revealed smoke and fire rated doors at various locations including, horizontal exit, hazardous enclosures and exits. A documentation review on 07/31/2025 at 12:25 PM revealed that facility did not provide a policy and procedures for fire door assemblies and no documentation to indicate fire door assemblies were inspected and tested annually. In an interview at the time, the [U. S. FOIA (b) (2)] confirmed the observation and documentation review. The facility's [U. S. FOIA (b) (2)] was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2025 at 1:42 PM. This deficient practice was also cited at the previous Recertification survey dated 12/12/2023. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K0761	Continued from page 12 The Maintenance Director or designee will maintain a tracking log of fire door inspections, including due dates, results, and any deficiencies identified. Audit results will be reviewed by the Maintenance Director and Administrator. Audits will be conducted weekly for three months, then monthly thereafter. Results of all audits will be reported quarterly to the QAA/QAPI committee, and corrective actions will be taken immediately if issues are identified	10/22/2025
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 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,	K0918	No residents were directly affected by the generator deficiencies. The facility has contacted a qualified generator service vendor to: -Conduct diesel fuel quality testing, -Verify generator transfer time to ensure it meets the 10-second requirement, -Perform a load bank test in accordance with NFPA 110. Any deficiencies identified during testing will be corrected immediately. Documentation of all inspections, testing, and corrective actions will be maintained in the Life	10/22/2025

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K0918 SS = F Bldg. 01	Continued from page 13 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: REPEAT DEFICIENCY Based on documentation review and interview on 07/31/2025 in the presence of the [redacted], it was determined that the facility failed to A). ensure that the emergency and standby power generator diesel fuel quality was maintained, B). ensure that the time needed by their generator to transfer power to the building was within the required 10-second time frame, and C). to provide documentation for a load bank test in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. and NFPA 99. These deficient practices had the potential to affect all residents and were evidenced by the following: A review of the facility's emergency generator documentation provided by the [redacted] at 10:10 AM revealed the following: 1. The annual diesel fuel quality test report was not provided. 2. The log for monthly load test for the previous twelve months indicated transfer of power to the building took 20 seconds. 3. The facility could not provide any documentation on the last load bank test. In an interview at the time of record review, the [redacted] confirmed the findings.	K0918	Continued from page 13 Safety compliance binder All residents have the potential to be affected by generator deficiencies. The vendor will inspect and test the facility's entire emergency and standby electrical system, including life safety and critical branch circuits. Any areas found deficient will be corrected immediately to ensure full compliance and resident safety A written policy and procedure has been implemented requiring annual diesel fuel quality testing, verification of generator transfer times, and load bank testing per NFPA 110 and NFPA 99 standards. The Maintenance Director and designee have been educated on the policy, NFPA standards, and proper documentation requirements. A Generator Maintenance Log has been created to track fuel testing, transfer times, load bank testing, and any corrective actions taken. Vendor contracts have been updated to include annual testing, verification, and reporting requirements. the Maintenance Director or designee will review generator inspection and maintenance documentation monthly to ensure compliance Audit results will be reviewed by the Maintenance Director and Administrator. Results of all audits will be reported quaterly to the QAA/QAPI committee, and corrective actions will be taken immediately if issues are identified.	10/22/2025

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K0918 SS = F Bldg. 01	Continued from page 14 The facility's [redacted] was informed of the deficient practices during the Life Safety Code exit conference on 07/31/2025 at 1:42 PM. This deficient practice was also cited at the previous Recertification survey dated 12/12/2023. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K0918		10/22/2025
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on observation, documentation review and interviews on 07/29/2025, 07/30/2025 and 07/31/2025 in the presence of the [redacted]), it was determined that the facility failed to conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs for all the	K0921	No residents were directly affected by the lack of inspection and maintenance of electrical equipment. A qualified vendor was hired and has inspected and tested all fixed and portable patient-care related electrical equipment (PCREE) throughout the facility. Any deficient equipment identified during inspection has been repaired, replaced, or removed from service immediately. Inspection labels/stickers were applied to all equipment that passed testing, and documentation has been updated in the facility's maintenance log. -The vendor completed a facility-wide audit of all patient care equipment, ensuring compliance with NFPA 99. Any equipment not meeting standards was addressed immediately to prevent risk to residents. A written policy and procedure has been implemented for testing, inspection, and maintenance of all PCREE, including labeling of each item after inspection. Maintenance staff and clinical personnel have been educated on the new policy, NFPA 99 requirements, and proper documentation procedures. A PCREE Maintenance Log will be maintained to track all inspections, repairs, and modifications. Vendor contracts have been updated to ensure annual inspections, testing, and documentation of all	10/22/2025

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K0921 SS = F Bldg. 01	Continued from page 15 patient care related electrical equipment (PCREE), in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 07/29/2025 and 07/30/2025 revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility. In an interview at the time, the MD confirmed the findings. A documentation review on 07/31/2025 revealed the policy on patient care related electrical equipment was not provided. An interview at that time, the [redacted] confirmed the finding and acknowledged that no labels were provided on all equipment. The facility's [redacted] was informed of the deficient practices during the Life Safety Code exit conference on 07/31/2025 at 1:42 PM. NJAC 8:39-31.2(e) NFPA 99	K0921	Continued from page 15 equipment. The Maintenance Director or designee will review PCREE inspection and maintenance documentation monthly to ensure ongoing compliance Audit results will be reviewed by the Maintenance Director and Administrator. Results of all audits will be reported quaterly to the QAA/QAPI committee, and corrective actions will be taken immediately if issues are identified.	10/22/2025
K0223 SS = E Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and	K0223	The facility immediately re-installed and repaired the closure arms on the identified doors (computer room, staff coordinator office, clean linen room, medical records room, and treatment room). No residents were impacted by this deficient practice. The facility conducted a building-wide audit of all self-closing fire, smoke barrier, and hazardous area doors. No additional issues were identified. The facility implemented the following measures to ensure ongoing compliance: The Maintenance Director will conduct quarterly audits of all self-closing doors to ensure proper operation.	09/30/2025

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K0223 SS = E Bldg. 01	Continued from page 16 * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 07/29/2025 and 07/30/2025 in the presence of the [redacted] it was determined that the facility failed to ensure that self-closing doors were kept in the closed position in accordance with NFPA 101:2012 Edition, Sections 7.2.1.8 and 19.2.2.2.7. This deficient practice had the potential to affect limited residents and was evidenced by the following: An observation on 07/29/2025 at 9:55 AM revealed that the computer room fire door closure arm was removed. An observation at 10:15 AM revealed the first floor staff coordinator office door closure removed. An observation at 11:18 AM revealed the clean linen room door closure arm removed and was not latching. An observation on 07/30/2025 at 1:15 PM revealed the medical records room door closure arm was removed. An observation of the first floor treatment room fire door revealed the closure arm was removed. In an interview at the time, the [redacted] confirmed the observations. The facility's [redacted] was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2025 at 1:42 PM. NJAC 8:39-31.2(e)	K0223	Continued from page 16 Door closure checks will be incorporated into monthly environmental rounds. Maintenance will receive in-service education on the importance of maintaining door closure arms and the prohibition of disabling or removing them. Maintenance Director/designee will monitor compliance with self closing requirements weekly × 4 weeks. Results will be reported to QAA/QAPI committee; corrective action taken immediately if issues are found. All findings will be reported to the Administrator for any additional corrective or disciplinary actions. The Administrator will be responsible for ensuring compliance with the	09/30/2025
K0741 SS = E Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:	K0741	No residents were negatively affected by the deficient practice related to smoking regulations. Immediately upon identification, the smoking area was cleaned of all cigarette butts and combustible debris. Non-combustible ashtrays were placed in the designated smoking area, and a metal receptacle with a self-closing lid was provided for the disposal	10/22/2025

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K0741 SS = E Bldg. 01	Continued from page 17 (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview on 07/30/2025 and 07/31/2025 in the presence of the U. S. FOIA (b) (2)), the facility failed to maintain the smoking area in accordance with NFPA 101: 2012 Edition, Section 19.7.4 by failing to prohibit the practice of mixing cigarette butts and ash in trash cans with other combustibles and failing to provide ashtrays and a metal container with self-closing lid. This deficient practice was observed for 1 of 1 smoking areas and had the potential to affect all residents as evidenced by the following: An observation at 11:13 AM with the U. S. FO in the front of the building area revealed that residents and two staff members were smoking. The ground was littered with over 100 cigarette butts. The area was not provided with non-combustible ashtrays and metal can with self-closing device into which ashtrays can emptied. Further observation revealed that the black trash can provided in the area contained cigarette butts mixed with NJ Ex Order 26.4(b)(cups and other combustibles. Additionally, no signs were placed that prohibit smoking in that area. In an interview at that time the U. S. FO confirmed the	K0741	Continued from page 17 of cigarette butts. Smoking area signs were posted. The facility's smoking policy was reviewed and updated to reflect NFPA 101 requirements, including proper disposal and supervision. All residents who use the designated smoking area were identified as potentially at risk due to improper disposal of cigarettes and lack of proper equipment. There is only one smoking area, that area was immediately inspected to ensure that non-combustible ashtrays, a self-closing metal receptacle, and appropriate signage are in place and maintained. The smoking policy has been revised to require non-combustible ashtrays and a self-closing metal receptacle in the designated smoking area. The area will be cleaned and inspected daily to ensure compliance. The Maintenance Director or designee will be responsible for ensuring compliance with smoking area safety requirements. All staff were educated on the facility's smoking policy, and safe disposal of cigarettes. Residents who smoke were re-educated on the safe smoking policy and expectations. The updated smoking policy will be reviewed and revised as needed to ensure ongoing compliance. The Maintenance Director or designee will conduct weekly audits of the designated smoking area to verify presence of ashtrays, metal receptacles, signage, and cleanliness. Audit results will be reviewed by the U. S. FOIA (b) (2) .	10/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315375	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **08/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0741 SS = E Bldg. 01	Continued from page 18 observation, and the facility's smoking policy was requested. On 07/31/2025 at 10:18 AM smoking policy was provided by the [U. S. FOIA (b) (2)] which stated it was a smoke-free facility. In an interview at the time, the [U. S. FOIA (b) (2)] stated smoking is only permitted away off property at the public way. The facility's [U. S. FOIA (b) (2)] was informed of the deficient practices during the Life Safety Code exit conference on 07/31/2025 at 1:42 PM. NJAC 8:39-31.2(e)	K0741	Continued from page 18 Audits will be conducted weekly for three months, then monthly thereafter. Results of all audits will be reported quarterly to the QAA/QAPI committee, and corrective actions will be taken immediately if issues are identified.	10/22/2025
K0914 SS = E Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: REPEAT DEFICIENCY: Based on observations, interviews and documentation review on 07/30/2025 and 07/31/2025 in the presence of the facility's	K0914	The facility has contacted a qualified electrical vendor to complete receptacle testing of all non-hospital grade outlets in the 31 resident rooms on the 4th floor where the issue was observed. Testing for grounding, polarity, and blade tension is being scheduled and will be completed. Any deficient receptacles identified will be repaired or replaced immediately. All resident rooms throughout the facility have the potential to be affected. The vendor will conduct receptacle testing in all resident rooms and in any other areas containing non-hospital grade outlets to ensure compliance. The facility has developed and implemented a written policy and procedure for annual testing of non-hospital grade receptacles, including grounding, polarity, and blade tension, in accordance with NFPA 99. The Maintenance Director / designee have been educated on this policy and on the required documentation process A Receptacle Testing Log has been created to track dates, locations, results, and corrective actions. The vendor contract is being updated to include annual receptacle testing and reporting.	10/22/2025

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K0914 SS = E Bldg. 01	Continued from page 19 U.S. FOIA (b)(6) it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice had the potential to affect 60 residents and was evidenced by the following: An observation on 07/30/2025 between 9:15 AM and 3:05 PM revealed that all 31 resident rooms on the fourth floor were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. In an interview at that time, the [redacted] confirmed that the facility had non-hospital outlets installed in resident rooms. A documentation review on 07/31/2025 at 12:18 PM revealed that the provided annual electrical inspection report dated 11/01/2024 by the [redacted] was not indicating that residents room electrical outlets were tested for grounding, polarity, and blade tension. The [redacted] confirmed the electrical inspection report provided was not indicating residents' room outlets were tested. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2025 at 1:42 PM. This deficient practice was also cited at the previous Recertification survey dated 12/12/2023. N.J.A.C 8:39-31.2(e) NFPA 99	K0914	Continued from page 19 The Maintenance Director or designee will review vendor testing reports annually and verify completion of all required testing. Audit results will be reviewed by the Maintenance Director and Administrator. Audits will be conducted weekly for three months, then monthly thereafter. Results of all audits will be reported quarterly to the QAA/QAPI committee, and corrective actions will be taken immediately if issues are identified.	10/22/2025

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/29/25, 07/30/25 and 07/31/25. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		10/27/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315375	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **11/14/2025**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/14/2025 in relation to the 8/5/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		12/21/2025

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

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