STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315374	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	**810 NEWMAN SPRINGS RD , LINCROFT, New Jersey, 07738**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Standard Survey: 5/12/2026 to 5/15/2026 Census: 27 Sample Size: 12 + 3 closed records The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities, deficiencies were cited.	F0000		05/28/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and review of facility provided documents, it was determined that the facility failed to maintain proper kitchen sanitation practices by keeping the kitchen door	F0812	F0812 Corrective Actions: The Administrator, Maintenance Director and Food Service Director inspected the kitchen door on 05/18/2026. The door has an automatic door closure but required an adjustment by the Maintenance Director in order to make the door self-close. The U. S. FOIA (b) (2) was instructed that the door was to remain closed when not in use. The [redacted] was also instructed to provide in-service training to the dietary staff regarding the use of the doorway and that the door is to remain closed when not in use. New signs shall be attached to both sides of the door that read, “Door Must Remain Closed at All Times.” The signs will be attached the week of 06/08/2026. On 05/18/2026, the Administrator and Food Service Director reviewed the temperature logs for the dishwashing machine and the three compartment sink along with the chemical sanitizer logs. The logs reviewed were found to be untidy with illegible handwriting. The logs were kept near the dishwashing machine and the three compartment sink on a clipboard. The U. S. FOIA (b) (2) was instructed to use small three ring binders for the logs to protect them from water damage. The [redacted] was also instructed to review the logs daily and to instruct staff to use legible handwriting when recording temperatures and the chemical sanitizer concentration levels. Identification of Other Potentially Affected Areas:	07/01/2026

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

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

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F0812 SS = F	Continued from page 1 closed and consistently recording water temperatures and chemical sanitizer levels, to prevent the potential development of food borne illness. This deficient practice was evidenced by the following: On 5/12/26 at 5:23 PM, during the initial tour of the facility, the surveyor walked past a door to the kitchen which was completely open to a hallway used by residents, staff, and/or visitors. The surveyor observed a staff member in the kitchen putting food onto plates. A sign on the open door indicated to keep the door closed at all times. The surveyor observed the door was held open by a magnet attached to the bottom of the door. On 5/12/26 at 5:25 PM, the surveyor toured the kitchen with the cook, who acknowledged the kitchen door to the hallway should have been closed. The cook stated he prepared the food and plated it for dinner for the residents, and another staff member used that door to take meal trays to the units, and then would bring the trays back and wash the dishes. The surveyor observed a dishwasher which the cook stated was a high-temp dishwashing machine (a type of dishwasher that uses extremely hot water during its wash and rinse cycles to clean and sanitize dishes more effectively than standard dishwashers), and a 3-bay sink (3 deep sinks specifically designated and labeled for washing, rinsing, and sanitizing, used for pots and other items that were hand washed). The dishwashing machine and 3-bay sink were currently not being used. On 5/13/26 at 10:20 AM, the surveyor toured the kitchen with the U. S. FOIA (b) (2)) in the presence of the U. S. FOIA (b) (2). The U. S. FOIA confirmed the dishwashing machine was high-temp, and the staff running the machine checked the water temperatures at least 3 times a day. The U. S. FOIA (b) (2) added that the water temperatures were checked before starting to wash dishes after each meal. The U. S. FOIA stated she checked the log each evening to confirm there were no issues with the function of the machine. The U. S. FOIA provided a clipboard with temperature log sheets for each month, for the surveyor to review. In the presence of the U. S. FOIA (b) (2) , the surveyor observed the log sheet for May 2026. The U. S. FOIA asked the cook if he checked the water temperatures yesterday, and he replied that he forgot. The U. S. FOIA	F0812	Continued from page 1 The facility identified all residents, staff, and visitors in the facility as having the potential to be affected by this deficient practice. On 06/05/2026, The Food Service Director completed an inspection of all temperature logs for completeness and legibility. The inspection included food temperature logs and appliance temperature logs. All doors leading into the kitchen food prep area were inspected to determine that doors closed properly. Preventive Measures: The Administrator and the Food Service Director reviewed the facility's policies for dietary sanitation. The policies contained appropriate guidance for safe water temperatures for dishwashing and for the use of chemical sanitation. The policies were updated to include provisions for daily record keeping of temperatures and sanitizer concentration levels for the dishwashing machine and the three compartment sink. The policies were also updated to include specific instructions that kitchen doorways shall be kept closed when not in use. In addition, high-visibility signs reading "Door Must Remain Closed at All Times" were permanently affixed to both sides of the door. The Food Service Director on 06/05/2026 initiated in-service training for all dietary staff regarding the kitchen doorways. On 05/18/2026, the Food Service Director conducted an in-service training for dietary staff regarding the recording of temperatures and sanitizer concentration levels for the dishwashing machine and three compartment sink. Dietary staff were educated on recording temperature levels, the reasons why temperatures are required, and their responsibilities if or when temperatures do not meet the minimum standards. The Director of Nursing shall conduct in-service training for other staff pertaining to the use of kitchen doorways and the necessity of maintaining closed doors to prevent cross-contamination. The in-service is scheduled for 06/12/2026. Quality Assurance: The Food Service Director or assigned cook, shall conduct daily inspections of the kitchen corridor door three times daily for four weeks, and then once daily for the next three months to ascertain compliance. Their findings shall be recorded in a log. In addition, the Food Service Director or assigned cook, shall review all water temperature and chemical sanitizer logs for the dishwashing machine	07/01/2026

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F0812 SS = F	Continued from page 2 asked the server/utility staff member (Server #1), who was currently running the dishwasher, if he checked the water temperatures this morning. He stated he checked the temperatures and stated they were 155 degrees Fahrenheit (155 F) for the wash and 182 F for the rinse. He acknowledged he wrote the temperatures in the space for 5/12 breakfast and stated he should have written them on the 5/13 breakfast space. In the presence of the surveyor and the U. S. FOIA (b) (2) acknowledged that the dishwashing machine water temperatures had not been logged for 5/11 dinner, and 5/12 breakfast, lunch, and dinner. At that time, the surveyor, in the presence of the U. S. FOIA (b) (2), observed the log sheet for May 2026 for the 3-bay sink. The U. S. FOIA stated the temperature of the water for washing, and the chemical levels for sanitizing, were checked before the pots were washed after each meal. There were blank spaces on 5/11 dinner time, and 5/12 breakfast, lunch, and dinner times, and 5/13 breakfast time. The U. S. FOIA asked Server #1 if he checked the water temperature and chemical levels in the 3-bay sink that morning. Server #1 acknowledged he did but did not log the results. On 5/14/26 at 8:49 AM, the surveyor observed the door to the kitchen completely open to the hallway used by residents, staff, and/or visitors. The cook in the kitchen acknowledged to the surveyor that the door should have been closed and closed it. On 5/14/26 at 9:07 AM, the surveyor entered the kitchen and observed a rack of utensils next to the high temp dishwashing machine. Server #2 acknowledged the utensils had been washed but she had not yet checked and logged the water temps for the dishwashing machine. She stated the temps were checked by looking at thermometers on top of the machine which indicated the wash and rinse water temperatures. Server #2 stated she checked the 3-bay sink water temperature and sanitizer level this morning but had not logged it yet. Server #2 acknowledged the reason for checking water temperatures and sanitizer levels was to "be sure the dishes were all cleaned properly." Server #2 returned the rack of utensils to the area with the dirty dishes. She acknowledged she needed to check the temperatures for the water in the dishwashing machine and re-wash the utensils. Server #2 provided the log sheets to the surveyor for March 2026, April 2026, and May 2026. The surveyor observed several blank spaces on each month's log sheets, in addition to those noted above, for the	F0812	Continued from page 2 and three compartment sink, three times daily for four weeks, and then once daily for the next three months to ascertain compliance. Their findings shall be recorded in a log. Thereafter, the Food Service Director shall inspect the temperature and chemical sanitizer logs for completeness and legibility weekly. The Food Service Director will compile the findings into a monthly compliance report and present it directly to the Quality Assurance Performance Improvement (QAPI) Committee. Based upon the findings, the QAPI committee will determine the need for continuing evaluation. In addition, for the next four weeks, the Administrator shall inspect kitchen doorways and the dishwashing machine and three compartment sink temperature and chemical sanitation logs twice weekly to determine compliance. The findings shall be reviewed at the QAPI committee meeting. Date of Completion: 07/01/2026	07/01/2026

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F0812 SS = F	Continued from page 3 dishwashing machine and the 3-bay sink, as follows: Dishwashing machine blank spaces: 3/21 breakfast 3/31 dinner 4/23 lunch 4/27 dinner 4/28 breakfast, lunch and dinner 4/29 breakfast, lunch, and dinner 4/30 breakfast and lunch 3-bay sink blank spaces: 3/31 dinner 4/9 lunch 4/16 lunch 4/27 dinner 4/28 breakfast, lunch, and dinner 4/30 breakfast, lunch, and dinner 4/30 breakfast and lunch On 5/14/26 at 11:38 AM, the surveyor met with the U. S. FOIA in the presence of the U. S. FOIA (b) (2), to present the above concerns. The U. S. FOIA (b) (2) acknowledged the surveyor's findings. The U. S. FOIA acknowledged it was important to check the water temperatures and sanitizer levels to ensure proper sanitation of kitchen dishes and utensils. She acknowledged the temperatures, and sanitizer should have been checked and logged before washing the dishes from breakfast, lunch, and dinner every day. The U. S. FOIA acknowledged the log sheets were important because if the temperatures or sanitizer were out of acceptable range, she checked them again and notified the maintenance department if the machines were not working properly. The U. S. FOIA acknowledged that even if her staff visually checked the temperatures and sanitizer levels, if it was not logged there was no evidence of proper cleaning or sanitation for her to review.	F0812		07/01/2026

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F0812 SS = F	Continued from page 4 On 5/14/26 at 1:53 PM, the survey team met with the U. S. FOIA (b) (2) who acknowledged the surveyor's above concerns regarding the dishwashing machine, the 3-bay sink, and the kitchen door propped open to the hallway. On 5/15/26 at 8:58 AM, the surveyor observed the door to the kitchen completely open to the hallway used by residents, staff, and/or visitors. There were no staff in the kitchen visible to the surveyor from the doorway. On 5/15/26 at 9:57 AM, the survey team met with the U. S. FOIA (b) (2). The U. S. FOIA (b) (2) acknowledged he observed the kitchen door open to the hallway this morning and acknowledged it must be kept closed because the kitchen is a hazardous area, in addition to many "other reasons the door shouldn't be left open." The U. S. FOIA (b) (2) did not provide any further information. A review of the facility provided job description titled "Dishwasher" reflected a summary: Maintains china/dishes, pots, pans, trays, kitchen, work areas, equipment and utensils in clean and orderly and sanitary condition. One of the essential duties and responsibilities reflected…"Maintain and track temperatures and chemical (sanitizer) levels as outlined by provided standards. Let supervisor know in a timely manner if levels are off." A review of the facility provided job description titled "Cook" reflected an essential duty and responsibility: "Perform job safely while maintaining a clean and safe work environment and following correct procedures at all times." A review of the facility provided job description for the U.S. FOIA titled "Chef Manager", reflected key responsibilities including "maintains sanitation of equipment, supplies, and utensils…" and "supervise hourly food service associates." A review of the facility provided policy with the subject: "Food and supply storage", revised 1/26, reflected "All food, non-food items and supplies used in food preparation shall be stored in such a	F0812		07/01/2026

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F0812 SS = F	Continued from page 5 manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption." The procedures included..."Restrict access to storage areas to only those associates whose job responsibilities require them to retrieve items from these areas." NJAC 8:39-17.2(g), 19.7(d)	F0812		07/01/2026
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to complete reference checks on new	F0607	F0607: Corrective Actions: Employees #3, #7, and #9 are no longer employed by the facility. Employee #4 was hired on [NJ Ex Order 26, 4B1] and the facility received and verified the employee's reference check on 10/29/2025. This reference check confirmed no history of abuse or neglect and was placed in the employee's permanent personnel record. Identification of At-Risk Residents and Personnel Audit: Residents assigned to employees #3, #7, #9, and #4, have the potential to be affected by this deficient practice. The Social Services Director shall interview the residents to determine if any were affected by the deficient practice. The 10 newly hired employees during the year not review by the surveyors also have the potential be affected by this deficient practice. To identify any affected employees, on 06/05/2026, the Business Office Manager conducted a review of the remaining 10 new hires from the date of the prior annual survey of 12/31/2024. Reference checks were found for all remaining 10 employees hired since the date of the prior survey 12/31/2024. Preventive Measures: The Administrator reviewed the facility's Abuse policy and the New Hire Background Screening policy with the Director of Nurses and the Business Office Manager. The policies were found to be acceptable with no need for revisions. Upon review of the processes involved with new hires, it was determined that the deficiency resulted from a breakdown in communication which caused some newly hired employees to begin work prior to receiving the appropriate reference checks. Going forward, the responsibility for tracking and receiving reference checks and criminal background reports	07/01/2026

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F0607 SS = D	Continued from page 6 hires. This deficient practice was identified for 4 out of 14 employees (Employee #3, #4, #7, and #9) hired since the last Department of Heath recertification survey date of 12/31/24. On 5/12/26 at approximately 5:45 PM, during the entrance conference, the surveyor requested from the U. S. FOIA (b) (2)), all newly hired employee files for active and inactive employees from 12/31/24 to the current date. A review of the employee personnel files revealed the following: For Employee #3, an U. S. FOIA (b) (2) with a date of hire (DOH) of NJ Ex Order 26, there was no evidence of a reference check prior to the start of employment. For Employee #4, a U. S. FOIA (b) (2) with a DOH of NJ Ex Order 26.4(b), there was no evidence of a reference check prior to the start of employment. For Employee #7, an U. S. FOIA (b) (2) with a DOH of NJ Ex Order 26, there was no evidence of a reference check prior to the start of employment. For Employee #9, a Registered Nurse with a DOH NJ Ex Order 26, there was no evidence of a reference check prior to the start of employment. On 5/14/26 at 12:47 PM, the U. S. FOIA (b) (2) were made aware of the above concerns regarding reference checks for newly hired employees. On 5/14/26 at 1:06 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that she was responsible for employee reference checks. She stated that during the initial interview the employee would provide references for whom they would like the facility to contact. She further stated that the importance of the reference checks was because it was a state guideline. She then stated that a reference inquiry should be completed prior to their date of hire. On 5/15/26 at 9:54 AM, the survey team met with the U. S. FOIA (b) (2). The U. S. FOIA (b) acknowledged the reference checks that were not completed and further stated reference checks should be completed prior to hire. The U. S. FOIA (b) then stated, "we could do better with employee files." The facility had no additional information to present for the above concerns.	F0607	Continued from page 6 shall remain with the Business Office. However, department supervisors will be restricted from approving a new employee's start date until all reference checks and criminal background reports are received and reviewed by the Business Office Manager, and then presented to the Administrator for review. An in-service for department supervisors shall be held 06/11/2026 to review the revised process. Quality Assurance: To ensure ongoing compliance, the Administrator shall review the personnel files for the next 10 newly hired employees to determine that the proper references and criminal background checks were obtained prior to the newly hired employee's official start date. The findings shall be presented to and reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee during the quarterly QAPI committee meetings. The QAPI committee shall determine the need for additional review. Completion Date: 07/01/2026	07/01/2026

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F0607 SS = D	Continued from page 7 A review of the facility's "Abuse" policy, revised 10/2022 revealed...The facility will not knowingly employ any individual who has a history of abusing other persons. Potential employees and volunteers shall be screened thoroughly through structured interviews, personal and employment reference checks, criminal background checks and contact with State licensing boards and registries, when applicable... NJAC 8:39-9.3(b)	F0607		07/01/2026
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, interviews, review of the medical record and other facility documentation, it was determined that the facility failed to ensure a resident's care plan, who was a known [NJ Ex Order 26, 4B1] and had [NJ Ex Order 26, 4B1] maintained documentation of the [NJ Ex Ord]. This deficient practice was identified for 1 of 2 residents (Resident #7) reviewed for [NJ Ex Order 26, 4B1] and was evidenced by the following: On 5/12/2026 at 6:24 PM, during initial tour, Resident #7 was observed in bed. The resident stated they had a [NJ Ex] in the past but couldn't remember when. The surveyor reviewed the electronic medical record (EMR) for Resident #7. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to: [NJ Ex Order 26, 4B1]	F0689	F0689 Corrective Actions: On 05/14/2026, the Director of Nursing (DON) corrected Resident #7's profile in the Electronic Medical Record (EMR) by removing the "resolved" status from past [NJ Ex] interventions, which instantly restored full visibility of the complete care plan. Following this software correction, the Interdisciplinary Team reviewed Resident #7's active care plan on 05/18/2026 to confirm that all required safety interventions were accurately displayed and available to the floor staff. Identification of Other At-Risk Residents: Residents categorized as high risk for falls have the potential to be affected by this deficient practice. On 05/18/2026, the Director of Nursing and the MDS Coordinator conducted a review of all residents currently categorized as high risk for falls. Care plans with "resolved" status were restored to full visibility. Preventive Measures: The facility adjusted its EMR charting guidelines to mandate that historical fall interventions for high-risk residents shall remain visible to support ongoing clinical decisions and regulatory oversight. An in-service pertaining to resolved care plan interventions is scheduled for 06/12/2026. The in-service will review the proper archiving protocols, specifically emphasizing that past interventions for high-risk residents must never be categorized in a way that hides them from the active care plan. The Director of Nursing will conduct the in-service which will be attended by the MDS Coordinator and members of the Interdisciplinary Care Planning (IDCP) team. Quality Measures:	07/01/2026

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F0689 SS = D	Continued from page 8 NJ Ex Order 26, 4B1 A review of the annual Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, 4B revealed the resident had a Brief Interview for Mental Status of NJ Ex Order 26, 4B1, indicating the resident was NJ Ex Order 26, 4B1. A further review of the MDS revealed the resident had a NJ Ex since NJ Ex Order 26, 4B1. A review of the individual comprehensive care plan (ICCP) revealed a focus of High risk for NJ Ex Order 2 (related to) NJ Ex Order 26, 4B1. Date Initiated: NJ Ex Order 26, 4B1 Revision on: NJ Ex Order 26, 4B1. Further reveal of the ICCP, did not reveal the resident had an NJ Ex Order 26, 4B1. A review of the progress notes revealed the following: On NJ Ex Order 26.4(b)(1) at 9:54 PM, Nurse's Note text: U. S. FOIA) reported to this writer that resident was NJ Ex Order 26, 4B1 with NJ Ex Order 26, 4B between recliner and bed. On NJ Ex Order 26.4(b)(1) at 6:57 AM, Nurse's Note text: entered room to give AM meds (medications). Resident noted NJ Ex Order 26.4(b)(1) next to bed. fully clothed slippers on. On NJ Ex Order 26.4(b) at 7:35 PM, Nurse's Note Text: Called to the room by the U. S. FOIA (b) (2). Resident was located NJ Ex Order 26.4(b)(1), next to bed, on NJ Ex Order 26.4 Resident is NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4 but easily ...Care plan updated. A review of the "NJ Ex Order 26, 4B1" documents revealed the following: Effective date: NJ Ex Order 26, 4B1; Score: NJ Ex O Type: NJ Ex Order 26, 4 Effective dated: NJ Ex Order 26, 4B1; Score NJ Ex Type: NJ Ex Order 26, 4B Effective date: NJ Ex Order 26, 4B1; Score NJ Ex NJ Ex Ord Further review of the "NJ Ex Order 26, 4B1" documents (a tool for assessing a patient's likelihood of NJ Ex Order 2 revealed Section NJ E Scoring: NJ Ex Order 26.4(b)(scoring: High Risk NJ Ex Order 26.4(b)(1).	F0689	Continued from page 8 The Director of Nursing or a nurse management designee shall review three high-risk NJ Ex care plans weekly for four weeks and thereafter 3 such care plans monthly for two months. The reviews shall verify that all past and present NJ Ex O interventions are fully visible and active within the EMR system. The Director of Nursing will submit the results to the Quality Assessment and Performance Improvement (QAPI) Committee, which will review the data to ensure ongoing compliance and determine when the audits may safely be discontinued. Date of Completion: 07/01/2026	07/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315374	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	810 NEWMAN SPRINGS RD , LINCROFT, New Jersey, 07738

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F0689 SS = D	Continued from page 9 On 5/14/2026 at10:59 AM, the surveyor interviewed Registered Nurse (RN) #1, who stated he was Resident #7's assigned [redacted] He stated the resident was a [redacted] risk and had a [redacted] but was unsure of the date. He stated the purpose of the care plan was "to make sure needs are met." RN #1 stated a [redacted] should be in the care plan and should include the date of the [redacted] and any interventions. He accessed the EMR, in presence of surveyor, and reviewed the care plan. He was unable to locate the actual [redacted] During the interview, the [redacted]) came over to assist RN #1 in finding the documentation of the [redacted]. She was unable to, at that time. On 5/14/2026 at11:13AM, the [redacted] accessed the EMR on her computer, in the presence of the surveyor. She stated Resident #7 had a history of [redacted] and should have an actual care plan for [redacted] The [redacted] stated if you select the H(history) on the care plan for [redacted] you would see the resident has a [redacted]. She was unable to locate the [redacted] on the care plan. The [redacted] stated the purpose of the care plan was to provide a plan for care. She stated it would be important to keep the [redacted] on the care plan so "we (the facility staff) know not to do the same thing (interventions) over again." The [redacted] stated the [redacted] takes things off the care plan after 6 months. The [redacted] stated she had to check with the [redacted] for the [redacted]. On 5/14/2026 at 1145 AM, during a follow up interview, the [redacted] stated the care plan was updated at the time of the [redacted] for Resident #7. She stated you had to click resolved to see the [redacted]. The [redacted] showed the surveyor in the EMR, which showed the [redacted] had been on the care plan but were all resolved on [redacted]. The [redacted] stated she told the [redacted] she wanted to go "back to the old way on the care plan where we keep the dates of the [redacted] On 5/14/2026 at 1:53 PM, in the presence of the survey team, the [redacted] were made aware of the above concerns. A review of facility policy "Assessing Falls and Their Causes" updated 4/19/2026, revealed Purpose: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall…Preparation: 1.	F0689		07/01/2026

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F0689 SS = D	Continued from page 10 Review the resident's care plan to assess for any special needs of the resident. A review of facility policy "Care Plans-Comprehensive" updated 6/19/25, revealed Policy Interpretation and Implementation...7. The comprehensive, person-centered care plan:...d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions....9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. NJAC 8:39-27.1 (a)	F0689		07/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 62207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2026

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		06/09/2026
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure newly hired employees received a health examination (physical) by a Physician, Advanced Practice Nurse, or a Licensed Physician's Assistant prior to employment; or within thirty days of a Registered Nurse's (RN) completed initial assessment upon employment. This deficient practice was identified for 4 out of 14 employees (Employee #1, #4, #5, and #6) hired since the last Department of Heath recertification survey date of 12/31/24. On 5/12/26 at approximately 5:45 PM, during the entrance conference, the surveyor requested from	S1405	S1405 Corrective Actions: Employees #1, #4, #5, and #6, are scheduled to have repeat physical examinations completed by the facility's Medical Director on 06/10/2026. Any employee who misses their physical examination appointment will be prohibited from working until the repeat physical examination is completed. The Administrator and Director of Nursing met with the Medical Director to address the need for legible dates and signatures when documenting medical records and staff physical examinations. The Director of Nurses shall review completed physical examinations to ensure that the exams, signatures and dates are legible. Identification of Others at Risk: All residents have the potential to be affected by this deficient practice. In addition, employees hired within the last twelve months have the potential to be affected by this deficient practice. The Director of Nursing shall review the resident medical records to identify if any residents were affected by this deficiency. The Director of Nursing shall also review employee personnel files for staff members hired within the past twelve months in order to identify other staff members affected by this deficiency. This review shall specifically cross-reference dates of hire against the completion, signatures, legibility, and dating of all mandatory physical examinations and clinical assessments. Any individual file found during this review to contain missing information or	07/01/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 62207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2026

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S1405	Continued from page 1 the Licensed Nursing Home Administrator (LNHA), all newly hired employee files for active and inactive employees from 12/31/24 to the current date. A review of employee personnel files revealed the following: For Employee #1, a Licensed Practical Nurse with a date of hire (DOH) o[NJ Ex Order 26, 4] the physical examination was completed November 2025 (date is illegible). For Employee #4, a Certified Nursing Assistant (CNA) with a DOH of[NJ Ex Order 26, 4], the RN assessment was done on 10/17/25 and the physical examination form was signed by the physician dated 8/4/25. For Employee #5, a CNA with a DOH o[NJ Ex Order 26, 4] the physical examination form was signed by the RN but was not dated. For Employee #6, a CNA with a DOH[NJ Ex Order 26, 4], the RN assessment was dated 11/10/25 and the physical examination form was dated 11/20/26. On 5/14/26 at 12:47 PM, the LNHA and Director of Nursing (DON) were made aware of the above concerns regarding physicals for newly hired employees. On 5/14/26 at 12:55 PM, the surveyor interviewed the DON, who stated that physicals should be completed prior to the employee's hire date. On 5/15/26 at 9:54 AM, the survey team met with the LNHA and the DON. The LNHA acknowledged the RN assessment should be dated, and physical examinations should be completed prior to hire. The LNHA then stated, "we could do better with employee files". The facility had no additional information to present for the above concerns.	S1405	Continued from page 1 dating discrepancies shall be required to complete or repeat a physical examination with the facility's Medical Director. Preventive Measures: The Administrator reviewed the facility's policies for new Employee Hiring regarding physical examinations. The policy was found to be acceptable with no need for revisions. Upon reviewing the processes involved with new hires, it was determined that the deficiency resulted from a breakdown in communication which caused discrepancies in the timing of physical examinations for newly hired employees. Going forward, the responsibility for obtaining, tracking, and receiving all employee physical examinations, RN assessments and Mantoux tuberculin skin test shall be the responsibility of the Director of Nursing. An in-service for department supervisors shall be held 06/11/2026 to review the facility's health policies for newly hired employees. Quality Assurance: The Administrator shall review all new hire personnel files on a monthly basis for the next three consecutive months to determine compliance with its employee health policies. The review will focus on the employees' hire dates and the timely completion of physical examinations. The results of these monthly reviews shall be presented to the Quality Assurance and Performance Improvement (QAPI) Committee during their quarterly sessions for further review and tracking. Completion Date: 07/01/2026	07/01/2026
S1410	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(b)(1) (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a	S1410	S1410 Corrective Actions: Employee #2 is no longer employed by the facility. Employee #8 is scheduled to have a repeat[NJ Ex Order 26.4] test administered by the facility's RN Nurse on[NJ Ex Order 26.4(b)(1)] with the[NJ Ex Order 26] step to be administered one to three weeks later. The employee shall be prohibited from working if the employee fails to complete the test.	07/01/2026

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S1410	Continued from page 2 documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documentation it was determined that the facility failed to have a process in place to ensure all newly hired employees completed the required [NJ Ex Order 26.4(b)(1)] screening process timely for 2 out of 14 employees (Employee #2 and #8) hired since the last Department of Health recertification survey of 12/31/24. This deficient practice was evidenced by the following: On 5/12/26 at approximately 5:45 PM, during the entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA), all newly hired employee files for active and inactive employees from 12/31/24 to the current date. A review of employee personnel files revealed the following: Employee #2, a Physical Therapist with a date of hire (DOH) of [NJ Ex Order 26.] had a [NJ Ex Order 26.4(b)(1)] test administered on 1/19/26, but had no date read. A [NJ Ex Order 26.4(b)(1)] was not completed. Employee #8, a Certified Nursing Assistant with a DOH [NJ Ex Order 26.], had a [NJ Ex Order 26.4(b)(1)] test completed on 3/24/26. A [NJ Ex Order 26.4(b)(1)] test was administered on 4/10/26, but had no date read. On 5/14/26 at 12:47 PM, the LNHA and Director of Nursing (DON) were made aware of the above concerns regarding PPD test for newly hired employees. On 5/14/26 at 12:55 PM, the surveyor interviewed	S1410	Continued from page 2 Identification of Others at Risk: Residents assigned to Employee # 2 and #8 have the potential to be affected by this deficient practice. The Director of Nurses shall review resident medical records to determine if any residents were affected. Recently hired staff members also have the potential to be affected by this deficient practice. The Director of Nursing shall review all employee personnel files for staff members hired within the past twelve months in order to identify other staff members affected by this deficiency. This review shall specifically cross-reference dates of hire against the completion of the two step Mantoux skin test verifying dates of testing and dates of results. Any individual file found during this review to contain missing information, missing test results or missed testing shall be required to complete or repeat the two step Mantoux skin test. Preventive Measures: The Administrator reviewed the facility's policies for new Employee Hiring regarding physical examinations. The policy was found to be acceptable with no need for revisions. Upon reviewing the processes involved with new hires, it was determined that the deficiency resulted from a breakdown in communication which caused discrepancies in the timing of the two step Mantoux testing for some newly hired employees. Going forward, the responsibility for obtaining, tracking, and receiving all employee Mantoux tuberculin skin test shall be the responsibility of the Director of Nursing. An in-service for department supervisors shall be held 06/11/2026 to review the facility's health policies for newly hired employees. Quality Assurance: The Administrator shall review all new hire personnel files on a monthly basis for the next three consecutive months to determine compliance with its employee health policies. The review will focus on the employees' hire dates and the timely completion of a two-step Mantoux test and the results. The results of these monthly reviews shall be presented to the Quality Assurance and Performance Improvement (QAPI) Committee during their quarterly sessions for further review and tracking. Completion Date: 07/01/2026	07/01/2026

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S1410	Continued from page 3 the DON, who stated that the [NJ Ex Order 26.4(b)(1)] should be completed prior to the employee's hire. On 5/15/26 at 9:54 AM, the survey team met with the LNHA and the DON. The LNHA stated, "we could do better with employee files". The facility did not provide any additional information to present for the above concerns.	S1410		07/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315374	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/08/2026 in relation to the 5/15/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 62207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 07/08/2026 in relation to the 05/15/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315374	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/15/2026

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/13/2026 and 05/14/2026, De La Salle Hall was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies De La Salle Hall is a single-story Type II (000) construction that was originally built in 1978. The facility is divided into 3 smoke zones. The facility is sprinklered on public water supply. The facility has a 208 KW Exterior natural gas Emergency Generator that supplies emergency power to the entire building. The facility has 32 certified beds. At the time of the survey the census was 27.	K0000		05/28/2026
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on documentation review and interviews on 05/14/2026 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to conduct functional testing of emergency lighting systems in accordance with NFPA 101, 2012 Edition, Section 19.2.9.1 and 7.9. This deficient practice had the potential to affect all residents and was evidence by the following: On 05/14/2026, Documentation review at	K0291	K0291 Corrective Actions: The U. S. FOIA (b) (2) [redacted] developed a new Emergency Lights Test Log which provides for the recording and distinguishing between monthly and annual testing. The log will record the functional testing of every emergency light unit. Monthly the units shall be tested for thirty seconds and annually the units shall be tested for one and half hours. On 06/04/2026, the U. S. FOIA (b) (2) re-tested all emergency lighting units that lacked the appropriate documentation during the survey. The testing included the full 1.5-hour annual battery load discharge test. All lighting units functioned properly during the testing. The testing outcomes were recorded on the facility's updated Emergency Lights Test Log.	07/15/2026

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315374	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/15/2026

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K0291 SS = F Bldg. 01	Continued from page 1 approximately 12:17PM, revealed that the Untitled documents dated 2025 and 2026, provided by the [redacted] regarding Emergency battery backup lighting system functional testing. The documents did not document the functional testing of emergency lighting system monthly for not less than thirty seconds, and annually for one and half hours. In an interview at 12:15PM, the [redacted] stated the functional testing will be completed and recorded for the required testing duration for all battery powered emergency lighting equipment. The facility's [redacted] were informed of the deficient practices at the Life Safety Code exit conference on 05/14/2026 at 1:58 PM. N.J.A.C 8:39-31.2(e)	K0291	Continued from page 1 Identification of Other Potentially Affected Individuals: The facility identified all residents, staff, and visitors as having the potential to be affected by this deficiency, as well as all emergency lighting units. Therefore, the Maintenance Director conducted a facility-wide inspection of all emergency lighting units on June 4, 2026. All units were found to be operating properly. Preventive Measures: The Administrator and Maintenance Director reviewed the facility's policies regarding the testing of emergency lights. The policies were found to be acceptable with no need for revisions. The current Emergency Lights Test Log was also reviewed. Although the log was completed, the information recorded on the log failed to provide the actual date of and the type of testing that was performed. A new log was developed which provides for the recording and distinguishing between monthly and annual testing. The log requires written verification of a 30-second functional test every 30 days and a 1.5-hour load test annually. The [redacted] received training and instructions from the Administrator on the proper completion of the new log. The log was placed in use on June 4, 2026. Quality Performance: The Administrator shall review the Emergency Lights Testing Logs monthly for the next three months, and thereafter every three months to verify compliance. In addition, the Administrator shall conduct thirty second testing on three emergency light units weekly for the next four weeks. The findings shall be presented to the Quality Assurance and Performance Improvement (QAPI) Committee at its regularly scheduled meeting. The QAPI Committee will review the findings to ensure sustained compliance and determine if further tracking is required. Completion Date: 07/15/2026	07/15/2026
K0321 SS = F Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K0321	K0321 Corrective Actions: On 06/04/2026, the Maintenance Director inspected and installed self-closing door hardware on the doors to the storage room adjacent to resident room #24 and the treatment room identified in the	07/15/2026

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K0321 SS = F Bldg. 01	Continued from page 2 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 interviews on 05/13/2026 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, Section 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following: On 05/13/2026, Observation at 10:19 AM, revealed that the door to the combustible storage room adjacent to Room #[redacted] was not Self- closing or automatic closing. On 05/13/2026, Observation at 10:44 AM, revealed	K0321	Continued from page 2 Statement of Deficiencies. Self-closing mechanisms were installed and tested successfully to ensure that the doors fully close from an open position and securely latch into the door frames. Identification of Other Potentially Affected Individuals: The facility identified all residents, staff, and visitors in the facility as having the potential to be affected by this deficient practice, as well as all other combustible storage areas. To address this widespread risk, on 06/04/2026, the Maintenance Director conducted a physical inspection of all designated hazardous area doors (including all soiled utility rooms, laundry, boiler rooms, and combustible storage rooms over 50 sq. ft.). Every door was physically tested to verify that the self-closing and positive-latching hardware function properly without human intervention. All doors requiring self-closing hardware were found to be operating properly. Preventive Measures: The Administrator and Maintenance Director reviewed the facility's policies regarding door inspections and the use of self-closing door closures. The policies were found to be acceptable with no need for revisions. In addition, the Administrator and Maintenance Director reviewed NFPA 101:2012 Edition, Section 19.3.5.9 requirements. The U.S. FOIA (b)(6) was instructed to inspect the facility storage areas to identify other doors that may require self-closing hardware in accordance with NFPA 101:2012Edition, Section 19.3.5.9. On 06/16/2026, the Administrator will conduct in-service training with the U. S. FOIA (b) (2), nursing staff, and environmental services team regarding the requirement that doors to hazardous areas shall be closed when not in use, and that the doors to the hazardous areas must be self-closing in accordance with NFPA 101 Section 19.3.2.1 hazardous area standards. Quality Assurance: The Maintenance Director will physically inspect all doors leading to hazardous areas weekly for 4 weeks, and monthly thereafter for three consecutive months. The inspections will verify that the door adjacent to room [redacted] and all other hazardous doors,	07/15/2026

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K0321 SS = F Bldg. 01	Continued from page 3 that the treatment room was being used for the storage of combustible materials, and the door to the room was neither self-closing nor automatic closing. In an interview at the time of the observations, the [U. S. FOIA (b) (2)] confirmed the findings The facility's [U. S. FOIA (b) (2)] were informed of the deficient practices at the Life Safety Code exit conference on 05/14/2026 at 1:58 PM. N.J.A.C 8:39-31.2(e)	K0321	Continued from page 3 self-close and latch completely. The written inspection results will be submitted to the Quality Assurance and Performance Improvement (QAPI) Committee to ensure sustained compliance and determine if further tracking is necessary. Completion Date: 07/15/2026	07/15/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 05/13/2026 in the presence of the [U. S. FOIA (b) (2)] it was determined that the facility failed to ensure that kitchen cooking equipment's wet chemical fire suppression systems nozzles were in the proper position to protect against fire in accordance with NFPA 101: 2012 Edition, Section 19.3.2.5.1, and NFPA 96. This deficient practice had	K0324	K0324 Corrective Actions: On 05/18/2026, the facility's contracted, licensed fire protection vendor arrived on-site to inspect the system. The technician physically realigned the one suppression spray nozzle that was not positioned properly. The technician verified that all nozzles are now positioned strictly in accordance with manufacturer specifications and NFPA 96 standards to ensure total suppression coverage over all active cooking surfaces. Identification of Others with Potential to be Affected: The facility identified all residents, staff, and visitors in the facility as having the potential to be affected by this deficient practice. To address this widespread risk, the [U. S. FOIA (b) (2)] conducted an inspection of the commercial cooking and warming equipment hoods on 05/18/2026. The inspection revealed no other misaligned nozzles or missing protective blow-off caps. Preventive Measures: On 06/11/2026 the [U. S. FOIA (b) (2)] shall conduct in-service training for all kitchen staff regarding NFPA 96 guidelines, the critical nature of nozzle placement, and the strict rule that cooking appliances must never be moved past their positions. Furthermore, the facility updated its Monthly Fire Safety Preventive Maintenance Log to include a specific line item requiring a visual inspection of kitchen hood nozzle alignment, structural integrity, and tamper seals. Quality Assurance: The Dietary Manager, or designated cook, shall perform visual inspections of the hood nozzles and	07/15/2026

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K0324 SS = F Bldg. 01	Continued from page 4 the potential to affect all residents and was evidenced by the following: On 05/13/2026 Observation in the facility kitchen at 10:01 AM, revealed that the wet chemical fire suppression system (over the cooking equipment) had one suppression spray nozzle not positioned to protect the cooking equipment. In an interview at the time of the observations, the [redacted] confirmed the finding. The facility's U. S. FOIA (b) (2) were informed of the deficient practices at the Life Safety Code exit conference on 05/14/2026 at 1:58 PM. N.J.A.C 8:39-31.2(e)	K0324	Continued from page 4 equipment alignment daily for one month. Following this period, the Maintenance Director will conduct weekly inspections of the kitchen suppression systems for the next two months, and then monthly thereafter. Any discovered nozzle misalignment will result in the immediate suspension of cooking on that appliance until the licensed fire protection vendor can verify compliance. The Maintenance Director will compile all daily and weekly inspection logs and submit these findings directly to the Quality Assurance Improvement (QAPI) Committee during its quarterly meetings for review before reducing any audit frequencies. Completion Date: 07/15/2025	07/15/2026
K0351 SS = F Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 05/13/2026 in the presence of the U. S. FOIA (b) (2) [redacted] it was determined that the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA	K0351	K0351 Corrective Action for Affected Residents: The small courtyard canopy cited during the survey was completely dismantled and removed from the facility exterior on 06/04/2026. The facility will reduce the size of the larger exterior-attached patio canopy and completely detach it from the facility's main building structure. The modification is scheduled to be completed 07/13/2026. Identification of Other At-Risk Areas: The facility identified all residents, staff, and visitors in the facility as having the potential to be affected by this deficient practice. The Maintenance Director conducted an inspection of the entire facility exterior on 06/05/2026, to determine if any other projections attached to the building were not in compliance. There were no other un-sprinklered, attached exterior projections exceeding four feet in width. Systemic Changes & Preventative Measures To address the systemic nature of this finding, the facility shall require that any planned future exterior structures, tents, or awnings be reviewed by a Life Safety expert prior to installation. Any planned exterior structures attached to the building and exceeding four feet from the building, shall require automatic sprinkler protection in accordance with NFPA 13 and NFPA 101:2012 Edition, Section 9.7 and 19.3.3.1. The deficiency was forwarded to the	07/15/2026

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K0351 SS = F Bldg. 01	Continued from page 5 13 and. NFPA 101:2012 Edition, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all residents and was evidence by the following: On 05/13/2026 at 8:15 AM, the surveyor and the [redacted] observed that the exterior patio canopy attached to the building, measuring approximately 23feet by 30 feet, was covered with combustible blue material and lacked fire sprinkler protection. On 05/13/2026 at 9:49 AM, the surveyor and the [redacted] observed that the courtyard canopy attached to the building, measuring approximately 14 feet by 314 feet, was covered with combustible white and blue material and lacked fire sprinkler protection. In an interview at the time of the observations, the [redacted] confirmed the findings. The facility's U. S. FOIA (b) (2) were informed of the deficient practices at the Life Safety Code exit conference on05/14/2026 at 1:58 PM. N.J.A.C 8:39-31.2(e)	K0351	Continued from page 5 Board of Directors for their future reference. The Administrator provided in-service training to the Board of Directors regarding the need to have any future plans for building attachments reviewed by a qualified building engineer/architect who has experience with NFPA regulations. The in-service was provided on June 11, 2026 during the Board of Directors scheduled quarterly meeting. Quality Assurance & Monitoring To ensure the systemic changes remain effective, the Maintenance Director shall perform monthly inspections of the entire facility exterior perimeter for the next three months to ensure no unauthorized or non-compliant canopies, tents, or awnings are attached to the building. The Maintenance Director will compile and submit the findings to the Quality Assurance and Performance Improvement (QAPI) Committee for ongoing oversight, review, and tracking of continued facility-wide compliance. Completion Date: 07/15/2026	07/15/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ 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.	K0353	K0353 Corrective Actions: The four dusty sprinkler heads located in the kitchen were cleaned by the facility's licensed fire protection vendor on 05/21/2026. To address the missing documentation, the facility's licensed fire protection vendor was immediately contracted to perform the required 5-year fire department connection hydrostatic test. The test was conducted 05/21/2026 with no findings or need of repair. Identification of Other with Potential to be Affected: The facility identified all residents, staff, and visitors in the facility as having the potential to be affected by this deficient practice, as well as all sprinkler heads throughout the building. On 05/18/2026, the Maintenance Director completed an inspection of all sprinkler heads located in the facility to ensure no other heads were loaded with dust, lint, grease, or paint. In addition, the Administrator and Maintenance Director completed a	07/15/2026

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K0353 SS = F Bldg. 01	Continued from page 6 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observations and interviews and documentation review on 05/13/2026 and 05/14/202, in the presence of the U. S. FOIA (b) (2)), it was determined that the facility failed to ensure that fire sprinkler system inspection, testing and maintenance (ITM) was conducted in accordance with NFPA 101: 2012 Edition, Sections 9.7.5, 9.7.7,9.7.8 and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations in the Kitchen on 05/13/2026 at 8:44AM, revealed that 4 of 13 fire sprinkler heads were loaded with dust. In an interview at the time, the U. S. FO confirmed the findings An observation on 05/13/2026 at 9:45AM, revealed that the Fire Department Connection on site was located by the sprinkler room entrance. Documentation review on 05/14/2026 at 11:30AM, revealed that Fire department connection (FDC) 5-Year Hydrostatic testing were not among documents provided by the U. S. FO for review. No further document was provided regarding FDC -5 Year test was completed. On 05/14/2026, in an interview at 12:02PM, the U. S. FO stated, “our system does not require Fire department connection (FDC) 5-Year Hydrostatic testing”. The facility's U. S. FOIA (b) (2) were informed of the deficient practices at the Life Safety Code exit conference on 05/14/2026 at 1:58 PM. N.J.A.C 8:39-31.2(e)	K0353	Continued from page 6 comprehensive audit of the past five years of all fire protection vendor records to verify that no other multi-year or specialized National Fire Protection Association testing milestones were missed. Prevention Measures: The facility's U. S. FOIA (b) (2) established an inspection program of all sprinkler heads to proactively identify any debris accumulation. Under this newly implemented program, all sprinkler heads will be inspected quarterly, and the kitchen sprinkler heads will be inspected monthly. Sprinkler heads found to be dirty, loaded, or compromised will be reported to the facility's licensed fire prevention vendor for professional remediation. To eliminate future documentation gaps for inspections, the facility's service contract with the licensed fire prevention provider shall be updated to include the mandatory execution and tracking of the 5-year hydrostatic testing of the fire department connection. The facility’s Maintenance Director shall conduct on 06/11/2026an in-service training for all environmental services and kitchen staff regarding the inspection protocols for the sprinkler heads and reporting any dirty sprinkler heads to the Maintenance Director. Staff were instructed that the facility’s licensed fire prevention vendor is responsible for the cleaning of the sprinkler heads and staff should not attempt to clean sprinkler heads due to potentially damaging them. Quality Assurance Monitoring: The Maintenance Director shall inspect twenty-five sprinkler heads throughout the facility, including the kitchen, weekly for four weeks and then monthly for an additional three months to ensure dust-free compliance. The Administrator shall inspect monthly for three months fifteen sprinkler heads to determine the effectiveness of the inspections. The Administrator shall review the Maintenance Department’s maintenance tracking binder quarterly to verify that the physical, signed paperwork for the completed 5-year FDC hydrostatic test is securely on file along with other required inspections. The Maintenance Director shall present these inspection logs and vendor compliance certifications to the Quality Assurance Performance Improvement (QAPI) committee quarterly for six months, and the committee will review the data to ensure compliance is sustained before authorizing any reduction in monitoring frequency.	07/15/2026

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K0353 SS = F Bldg. 01		K0353	Continued from page 7 Completion Date: 07/15/2026	07/15/2026
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 05/13/2026 in the presence of the U. S. FOIA (b) (2)), it was determined that the facility failed to ensure that	K0923	K0923 Corrective Actions: On 05/15/2026, the Maintenance Director removed the three empty portable oxygen tanks from the "Full Tanks Only" rack and moved them to the “Empty Tanks Only” rack. Simultaneously, the five full oxygen tanks found inside the "Empty Tanks Only" rack were relocated to the “Full Tanks Only” rack. To enhance visual clarity, new high-visibility signs reading "FULL TANKS ONLY" and "EMPTY TANKS ONLY" were securely affixed directly above each distinct rack zone to provide unmistakable separation between the containers. Identification of Other Potentially Affected Areas The facility identified all residents in the facility as having the potential to be affected by this deficient practice, as well as other oxygen storage areas. The Maintenance Director conducted an inspection of all areas where oxygen tanks are stored, transported, or utilized. This inspection covered the main oxygen room, emergency crash carts, and physical therapy room. There were no incidents of tanks stored improperly. Preventive Measures: The Administrator interviewed the oxygen vendor delivery personnel on 06/04/2026. According to the vendor's employee, they complete a visual inspection of the oxygen storage room and ensure that the tanks are properly stored in the FULL TANKS ONLY rack. They remove all empty tanks upon their departure to be refilled back at their facility. The Director of Nursing shall conduct in-service training on 06/12/2026 for all licensed nurses, certified nursing assistants, and central supply personnel regarding the proper storage of full and empty portable oxygen tanks. In addition, the Director of Nurses will assign to a nursing staff member the task to inspect the oxygen storage areas daily to ensure that the tanks are properly stored. Quality Assurance: The Director of Nursing or designee shall inspect all	07/15/2026

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K0923 SS = F Bldg. 01	Continued from page 8 Empty portable oxygen cylinder tanks and Full portable oxygen cylinder tanks were stored in accordance NFPA 101:2012 Edition. Section 19.3.2.4,8.7 and NFPA 99. This deficient practice had the potential to affect all residents and was evidenced by the following: On 5/13/2026, Observations at 12:27PM in the oxygen storage room, revealed a storage rack with a sign indicating full tanks only, contained (3) three Empty portable tanks. Further observations revealed that the storage rack with a sign indicating Empty tank only, contained (5) five Full oxygen tanks In an interview, at the time of the observations, the [redacted] confirmed the findings. The facility's U. S. FOIA (b) (2) were informed of the deficient practices at the Life Safety Code exit conference on 05/14/2026 at 1:58 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K0923	Continued from page 8 facility oxygen storage areas daily, including weekends, for four weeks, followed by three weekly audits per week for four weeks, and then weekly for the next four weeks. These inspections shall verify that portable oxygen tanks are properly stored, and the signs remain intact. The Nursing Department shall compile these inspection logs into a compliance report and present it directly to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI committee shall determine the need for future inspections. Date of Completion: 07/15/2026	07/15/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 05/13/2026 and 05/14/2026. The facility was found to be in compliance with 42 CFR 483.73.	E0000		05/28/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315374	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/16/2026**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/16/2026 in relation to the 5/15/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	K0000		

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

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