STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHABILITATION AND NURSING CENTER	**151 NINTH AVENUE , LITTLE EGG HARBOR TW, New Jersey, 08087**

(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: 12/10/25 Complaints: 2656141, 2594141, 2592640 Census: 96 Sample Size: 19 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. THE FACILITY WAS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		01/12/2026
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.	F0550	A. Corrective Action for the Affected Resident The facility immediately addressed the identified concern related to the cleanliness and dignified appearance of Resident #80's [redacted]. Upon identification, Environmental Services (EVS) staff completed thorough cleaning and disinfection of Resident #80's [redacted], including [redacted] Nursing leadership verified that the wheelchair was clean, safe, and maintained in a manner that supports the resident's dignity and quality of life. The resident's care plan was reviewed and updated to include assistance and monitoring related to the use, upkeep, and cleanliness of the motorized wheelchair. The [redacted] verified completion of corrective actions. B. Identification of Other Residents Potentially Affected	01/12/2026

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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F0550 SS = D	Continued from page 1 §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 observation, interview, review of medical records and other pertinent facility documents, it was determined that the facility failed to treat each resident with respect and dignity in an environment that promotes maintenance or enhancement of their quality of life by maintaining cleanliness and dignified appearance of the resident's [redacted] wheelchair. This deficient practice was identified in one of one resident (Resident #80) reviewed for dignity and was evidenced by the following: On 12/4/2025 at 10:57 AM, during the initial tour of the facility, the surveyor observed Resident #80 [redacted] in the hallway on a [redacted]. The surveyor observed the [redacted] to be heavily [redacted] with fresh and dried food crumbs, dusts, and other unidentified debris on the [redacted] footrest, seat board, [redacted]. The resident was [redacted] to [redacted] when the [redacted] was last cleaned. The surveyor reviewed the medical record for Resident #80. A review of the Admission Record revealed Resident #80 was admitted to the facility with diagnoses which included but not limited t [redacted] A review of the resident's most recent comprehensive Minimum Data Set (MDS), an	F0550	Continued from page 1 To ensure no other residents were impacted by similar concerns related to dignity and equipment cleanliness, the facility conducted a broader review. A 100% audit of all residents utilizing wheelchairs and motorized mobility devices was completed on 12/11/2025. The audit verified: Cleanliness and condition of mobility equipment Presence of documented cleaning schedules Nursing oversight and reporting processes Any additional equipment identified as needing cleaning was addressed immediately. C. Systemic Changes to Prevent Recurrence The facility implemented the following measures on 12/12/2025 to ensure ongoing dignity and respect related to resident mobility equipment: The wheelchair and mobility equipment cleaning process was revised to clearly identify routine and as-needed cleaning responsibilities, including documentation of resident-specific equipment. A Wheelchair & Mobility Equipment Cleaning Log was implemented to track cleaning frequency, date, and staff completion. [redacted] were re-educated by the [redacted] on promptly identifying and reporting mobility equipment requiring cleaning. [redacted] were re-educated by the [redacted] on expectations outlined in the Routine Cleaning and Disinfection Policy, including attention to visibly soiled and high-touch surfaces. Unit Managers were instructed to include wheelchair cleanliness checks during routine rounds. Coordination with the QAPI program was established to monitor compliance related to resident dignity and equipment cleanliness. D. Monitoring and Ongoing Compliance	01/12/2026

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F0550 SS = D	Continued from page 2 assessment tool dated [NJ Ex Order 26, 4B1], revealed a Brief Interview for Mental Status (BIMS) score of [NJ Ex Order 26, 4B] which indicated an [NJ Ex Order 26, 4B1]. The MDS also indicated that the resident had [NJ Ex Order 26, 4B1] and that the resident [NJ Ex Order 26, 4B1]. A review of the resident's comprehensive care plan did not include a focus for usage of [NJ Ex Order 26, 4B1] On 12/9/2025 at 9:02 AM, during an interview with the surveyor, the [U. S. FOIA (b) (2)] stated that the housekeeping department maintained the cleanliness of the wheelchairs in the facility by power washing them monthly or on as needed schedule. The [U. S. FOIA] stated that the nurses would let the [U. S. FOIA (b) (2)] know about the need for more frequent cleaning of the wheelchairs and the [U. S. FO] would let the [U. S. FOIA (b) (2)] know about it. On 12/9/2025 at 12:18 PM, during an interview with the surveyor, the [U. S. FOIA (b) (2)] stated that all the wheelchairs in the facility are scheduled on a monthly or on as needed basis. The surveyor asked the [U. S. FOIA (b) (2)] for a list of residents whose wheelchairs were cleaned monthly for the past 6 months. A review of the monthly list of units whose wheelchairs were cleaned revealed that Resident #80's wheelchair was last cleaned in [NJ Exec Order 26.4b1]. On the wheelchair cleaning schedule for November and December 2025, a cross mark on the resident's unit was indicated under week 1 with no specific name of the residents whose wheelchairs were cleaned. No further information was provided. A review of the facility-provided undated policy titled "Routine Cleaning and Disinfection" revealed the following under Policy Explanation and Compliance Guidelines: 4.) Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include but not limited to … i.) Resident chairs. N.J.A.C. 8:39 – 4.1 (a) (11) (12)	F0550	Continued from page 2 The facility will monitor compliance with resident dignity and equipment cleanliness as follows: Unit Managers or designees will conduct weekly audits of wheelchair and mobility equipment cleanliness for a period of 90 days. Audit results will be reviewed by the DON and reported through the QAPI Committee monthly. Any identified deficiencies will be corrected immediately, with re-education provided as needed. Sustained compliance will be ensured through ongoing routine monitoring thereafter.	01/12/2026
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality.	F0583	A. Corrective Action for the Affected Resident The facility immediately addressed the identified concern related to the confidentiality of Resident #21's personal and medical information during medication administration.	01/12/2026

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F0583 SS = D	Continued from page 3 The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of medical record and other pertinent facility documents, it was determined that the facility failed to respect the resident's right to confidentiality of personal and medical records from unauthorized disclosure without the resident's consent by leaving the resident's private health information exposed on an open and unattended computer screen in an area accessible to the public. This deficient practice was identified for one of four unsampled residents (Resident #21) during medication administration observation. The deficient practice was evidenced by the following: On 12/5/2025 at 7:54 AM, during the medication administration observation in the long-term care	F0583	Continued from page 3 Upon identification, licensed nursing staff secured the medication cart computer screen and ensured the screen was placed in locked mode when unattended. Nursing leadership reinforced with the involved staff member the requirement to lock computer screens whenever stepping away from the medication cart to prevent unauthorized viewing of resident information. The U. S. FOIA (b) (2)) verified that immediate corrective actions were completed and that resident information was secured. B. Identification of Other Residents Potentially Affected To ensure no other residents were impacted by similar confidentiality concerns, the facility conducted a broader review on 12/11/2025. On 12/11/2025, A 100% education of medication administration practices was completed by the U. S. FOIA (b) (2) and the U. S. FOIA (b) (2) across all shifts. The education focused on: Proper use of computer screen lock functions Positioning of medication carts to prevent public viewing Protection of resident-identifiable information during medication administration C. Systemic Changes to Prevent Recurrence The facility implemented the following measures to strengthen resident privacy and confidentiality protections: On 12/11/2025 Nursing staff were re-educated by the U. S. FOIA (b) (2) on resident privacy rights and confidentiality requirements, including the proper use of screen lock functions during medication administration. The Medication Administration Policy was reinforced with emphasis on providing privacy and	01/12/2026

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F0583 SS = D	Continued from page 4 unit, the surveyor observed Licensed Practical Nurse (LPN) #1 administer medications to Resident #21. After administering NJ Ex Order 26, 4B1 [redacted] of the resident, LPN #1 returned to the medication cart located in the hallway, to place the NJ Ex Order 26, 4B1 inside the top drawer. The surveyor observed LPN #1 leave the medication cart with the computer screen open on the page showing the resident's photograph, name, location, gender, date of birth, age, physician, allergies, code status, physician orders, current vital signs including weight, and medical condition. LPN #1 went inside the resident's room to speak to the resident with their back facing the doorway. The medication cart was not on LPN #1's line of vision. The computer screen on top of the medication cart faced the hallway. There were no residents or staff in the hallway at that time. The surveyor called the attention of LPN #1 and asked the nurse if the computer screen showing the resident's private health information is supposed to be left exposed in the hallway while the medication cart was unattended. LPN #1 stated that the computer screen should be on locked mode at all times while unattended meaning it should be on a blank page and not showing the resident's information. On 12/9/2025 at 8:57 AM, during an interview with the surveyor, the U. S. FOIA (b) (2)) stated that during medication administration, the nurses should be pressing the computer screen lock button to protect the residents' private information from being viewed by other people when they leave the cart. A review of facility- provided policy titled "Medication Administration" revised on November 11, 2024, included under Policy Explanation and Compliance Guidelines: … 7.) Provide privacy. NJAC 8:39-4.1(a)18 NJAC 8:39-35.2(i)	F0583	Continued from page 4 safeguarding electronic health information. Medication cart workflow expectations were clarified, requiring screens to be locked whenever carts are unattended, regardless of duration. Unit Managers were instructed to monitor medication passes for compliance with privacy standards. Coordination with the QAPI program was established to track and trend compliance with confidentiality practices. D. Monitoring and Ongoing Compliance The facility will monitor compliance with resident privacy and confidentiality requirements as follows: Unit Managers or designees will conduct weekly medication administration audits for a period of 90 days, with specific attention to screen locking and cart positioning. Audit findings will be reviewed by the DON and reported through the QAPI Committee monthly. Any identified deficiencies will be corrected immediately, with re-education provided as needed. Sustained compliance will be maintained through ongoing routine monitoring thereafter.	01/12/2026
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	F0584	A. Corrective Action for the Affected Area The facility immediately addressed the environmental concerns identified on the NJ Ex Order 26 [redacted] Unit to ensure a clean, safe, and homelike environment for residents. Upon identification, Maintenance and Environmental Services staff immediately corrected environmental deficiencies in bedroom NJ Ex [redacted], including removal of	01/12/2026

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F0584 SS = D	Continued from page 5 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to maintain a homelike environment that was clean, safe, and sanitary. This deficient practice was identified for 1 of 4 units ([redacted] Unit). This deficient practice was evidenced by the following:	F0584	Continued from page 5 debris, repair of torn wall coverings, and completion of spackling and wall surface repairs in the bathroom. The shower room on the [redacted] Unit was immediately addressed, including repair and repainting of the entrance door and surrounding molding to eliminate exposed wall spaces and restore a clean, homelike appearance. The sharps container observed in the shower room was immediately replaced with an empty, properly secured container to eliminate safety risk and exposure. The [redacted] and [redacted] verified that all immediate corrective actions were completed. B. Identification of Other Areas Potentially Affected To ensure no other areas were impacted by similar environmental concerns, the facility conducted a broader review. On 12/11/2025, A 100% environmental inspection was completed on all resident rooms, bathrooms, and shower rooms facility-wide. The inspection focused on: Wall integrity and surface conditions Door frames, molding, and paint integrity Safety of sharps containers and proper fill levels Any additional concerns identified during the inspection were corrected immediately. C. Systemic Changes to Prevent Recurrence The facility implemented the following measures on 12/12/2025, to strengthen environmental oversight and maintenance practices: Maintenance rounds were reinforced to include focused monitoring of resident rooms and shower areas for wall integrity, peeling paint, unfinished repairs, and safety hazards.	01/12/2026

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F0584 SS = D	Continued from page 6 On 12/08/2025 at 10:00 AM, in bedroom [NJ Ex O] on the [NJ Ex Order 2] Unit, the surveyor observed multiple black debris scattered across the A-side wall. On the B-side, the cloth material behind the bed was torn in several places. In the bathroom, the heater vent had unfinished spackling around it, and five holes were noted on the bathroom wall, all with incomplete spackling. On 12/08/25 at 10:00 AM, in the [NJ Ex Order 26,] room on the [NJ Ex Order 2] Unit, the surveyor observed that the entrance door had brown, flaking metal with crumbling edges, and paint was peeling away. Molding on the wall adjacent to the entrance door showed missing and bulging paint, exposing open wall spaces. Additionally, a sharp container was tilted and hanging, filled to the top with multiple blue razors, with its top open, exposing the contents. During an interview with the surveyor on 12/09/25 at 1:20 PM, the [U. S. FOIA (b) (2)] stated that maintaining a homelike environment was important for residents' dignity and comfort. The [U. S. FOIA (b)] also explained that any environmental issues were addressed promptly by maintenance, with response times prioritized based on the [NJ Ex Order 26,] of the issue. During an interview with the surveyor on 12/10/25 at 11:15 AM, the [U. S. FOIA (b) (2)]) stated that he completed rounds around the facility three times daily and addressed issues promptly, depending on their [NJ Ex Order 26,] He stated that the maintenance department was responsible for emptying sharps containers and monitored them during rounds to determine when they needed to be emptied. The [U. S. FO] explained that he was unaware of the issues in bedroom [NJ Ex Or], shower room and that the sharps containers should have been emptied for safety reasons. He acknowledged that the environment was not homelike for residents and stated that he would address the issues immediately. A review of the facility's undated policy titled "Homelike Environment" revealed that "Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent as possible." N.J.A.C. 8:39-31.4(a)	F0584	Continued from page 6 Staff education was reinforced for nursing and housekeeping staff on promptly reporting environmental concerns to maintenance. Sharps container monitoring procedures were reinforced, including replacement prior to reaching maximum fill levels. Coordination with the QAPI program was established to monitor environmental trends and compliance with homelike environment standards. D. Monitoring and Ongoing Compliance The facility will monitor compliance with environmental safety and homelike standards as follows: Maintenance leadership or designee will conduct weekly environmental audits for a period of 90 days. Audit results will be reviewed by the LNHA and reported through the QAPI Committee monthly. Any identified deficiencies will be corrected immediately, with follow-up verification completed.	01/12/2026

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F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and pertinent facility documentation, it was determined that the facility failed to ensure that the resident was free from NJ Ex Order 26, 4B1 for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. This deficiency was identified for 1 of 1 resident reviewed for NJ Ex Order 26, 4B1 (Resident #9). This deficient practice was evidenced by the following: On 12/08/25 at 10:02 AM, the surveyor observed Resident #9 on the NJ Ex Order 26, unit in the day room, seated in a NJ Ex Order 26, 4B1	F0604	A. Corrective Action for the Affected Resident The facility immediately addressed the identified concern related to the use of a NJ Exec Order 26.4b1 for Resident #9. Upon identification, the NJ Ex Order 26, 4B1 was immediately removed from Resident #9 to ensure the resident was free from any NJ Ex Order 26, 4B1 not required to treat medical symptoms. Nursing leadership reviewed the resident's clinical status, safety needs, and history to determine appropriate non-restrictive interventions. The resident's comprehensive care plan was reviewed and updated to reflect appropriate safety interventions without the use of restraints. The U. S. FOIA (b) (2)) verified that the alarm was discontinued and that the resident's rights were protected. B. Identification of Other Residents Potentially Affected To ensure no other residents were impacted by inappropriate use of restraints or personal alarms, the facility conducted a comprehensive review. On 12/11/2025, A 100% audit of all residents was completed to identify the presence of any personal alarms, chair alarms, or similar devices. The audit verified the presence of: Physician orders Restraint or safety assessments Care plan interventions Appropriate MDS coding No other alarms identified without proper documentation during this audit. C. Systemic Changes to Prevent Recurrence The facility implemented the following measures to ensure compliance with restraint-free care	01/12/2026

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F0604 SS = D	Continued from page 8 NJ Ex Order 26, 4B1 watching television with peers. A NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 to Resident #9 According to the admission record, Resident #9 was admitted to the facility with diagnoses including, but not limited to, NJ Ex Order 26, 4B1 A review of Resident #9's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated NJ Ex Order 26, 4, included a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26 which indicated that the resident had NJ Ex Order 26 NJ E NJ Exec Order 26.4b and NJ Exec Order Further review of Section revealed that the resident did not use any NJ Exec Order 2 A review of Resident #9's individual comprehensive care plan (ICCP) revealed that the facility did not include a focus area or interventions for any NJ Exec Order 26.4b1. A review of Resident #9's medication administration record (MAR) and treatment administration records (TAR), dated as of NJ Ex Order 2 did not contain any physician orders for NJ Ex Order 26, 4B1. A review of Resident #9's electronic medical records (EMR) revealed that the facility did not perform a restraint assessment for the use of NJ Exec Order 26.4b1. There was no information in the resident's medical record for any type of assessment related to the use of NJ Exec Order 26.4b1. During an interview with the surveyor on 12/08/25 at 1:10 PM, the U. S. FOIA (b) (2) stated that she has worked at the facility for approximately NJ Ex Order 26, 4 and that Resident #9 had always had a NJ Ex O in place. The U. S. FOIA stated the resident NJ Exec O the NJ Exec Or at all times; however, there was no physician order for its use. The U. S. FO further stated that the resident should not be NJ Ex Order 26 the NJ Exec Or because it was considered a NJ Ex Ord , and that the facility did not use NJ Ex Order 26, 4B1	F0604	Continued from page 8 requirements on 12/11/2025: Nursing staff were re-educated on the facility's Use of Restraints Policy, including the definition of physical restraints and the regulatory requirements for personal alarms by the U. S. FOIA (b) (2) Education emphasized that personal alarms are considered restraints when they restrict freedom of movement or are used without appropriate clinical justification. A standardized process was implemented, requiring: Comprehensive assessment prior to use Physician order when indicated Care plan inclusion Ongoing reassessment and documentation Access to personal alarms was restricted and controlled to prevent unauthorized use. Coordination with the QAPI program was established to monitor restraint use and alarm compliance. D. Monitoring and Ongoing Compliance The facility will monitor compliance with restraint-free care practices as follows: Unit Managers or designees will conduct weekly audits of resident areas to verify the absence of unauthorized personal alarms for a period of 90 days. Audit findings will be reviewed by the DON and reported through the QAPI Committee monthly. Any identified issues will be corrected immediately, with re-education provided as needed. Sustained compliance will be ensured through ongoing routine monitoring thereafter.	01/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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F0604 SS = D	Continued from page 9 During an interview with the surveyor on 12/08/25 at 1:15 PM, the U. S. FOIA (b) (2) stated that Resident #9 had always had a NJ Exec Order 26.4B1. The U. S. FOIA (b) (2) indicated that she did not consider the NJ Ex Order 26, 4B to be a NJ Ex Order 26, 4B but however confirmed that a physician's order, care plan, consent, and MDS documentation should be in the resident's chart for the use of the NJ Ex Order 26, 4B1. During an interview with the surveyor on 12/08/25 at 1:25 PM, the U. S. FOIA (b) (2) stated that she had been working at the facility completing MDS assessments since NJ Ex Order 26,. She explained that the NJ Ex Order 26, 4B1 should have been coded as a NJ Ex Order 26, and noted that there was no physician order in place; therefore, it was not coded. She stated that a comprehensive assessment of the resident was completed quarterly and explained that the NJ Ex Order 26, 4B should have been included in the resident's comprehensive care plan so that it ensured all staff were aware of the required interventions. During an interview on 12/09/25 at 1:20 PM, the U. S. FOIA (b) (2)) stated that NJ Ex Order 26, 4B included anything that NJ Exec Order 26.4B a resident from NJ Exec Order 26.4b1 and that the facility did not use NJ Ex Order 26, 4B1. The U. S. FOIA explained that the personal NJ Ex Order 26, 4B1 were used for safety only after physician consultation. She stated that proper documentation should have been included in the care plan, nurse notes, and MDS. The U. S. FOIA stated that Resident #9's NJ Ex Order 26, 4B was previously discontinued on NJ Ex Order 2, because it was no longer needed, and the resident had not had an NJ Exec Or since. The U. S. FOIA noted that facility staff, including CNAs, could have placed the NJ Exec Or on the resident because NJ Ex Order 26, 4B1 were accessible to staff and were stored in the same supply closet as batteries and other equipment. She stated that she unsure why the NJ Exec Or had been placed on the resident but would continue to investigate and provide staff education. A review of the facility's undated policy titled "Use of Restraints" revealed that "Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.	F0604		01/12/2026

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F0604 SS = D	Continued from page 10 Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints." NJAC 8:39-4.1(a)6	F0604		01/12/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined that the facility failed to meet professional standards of nursing practice with respect to following physician's orders. This deficient practice was identified for one (1) of thirty-four (34) residents reviewed, Resident #56. This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. 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 or 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 well-being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." On 12/4/2025 at 10:56 AM, the surveyor observed Resident #56 sitting in their wheelchair (W/C) outside of the day room. The Resident was not wearing the NJ Ex Order 26, 4B1 The resident was not able to be interviewed due to NJ Ex Order 26, 4B1. On 12/4/25, at 10:20 AM, the surveyor reviewed the medical record for Resident #56 which revealed the	F0658	A. Corrective Action for the Affected Resident The facility immediately addressed the identified concern related to adherence to physician orders for Resident #56. Upon identification, nursing staff immediately reapplied all ordered NJ Ex Order 26, 4B1 for Resident #56, including NJ Ex Order 26, 4B1 in accordance with the physician's orders. Nursing leadership reviewed the resident's physician orders, treatment administration record (TAR), and comprehensive care plan to ensure alignment and clarity regarding required NJ Exec Order 26.4b1 interventions. U. S. FOIA were re-educated by the U. S. FOIA (b) (2) at the point of care regarding the requirement to reapply NJ Exec Order 26.4b1 if removed by the resident and to document any NJ Exec Orde or removal in the medical record. The U. S. FOIA (b) (2) verified that corrective actions were implemented and that physician orders were being followed. B. Identification of Other Residents Potentially Affected To ensure no other residents were impacted by similar failures to follow physician orders, the facility conducted a broader review. On 12/11/2025 A 100% audit of all residents with active physician orders for skin protectors or similar treatment devices was completed. The audit verified: Presence of current physician orders Care plan alignment with orders	01/12/2026

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F0658 SS = D	Continued from page 11 following information: Review of the Admission Record (admission summary) dated [redacted], reflected that Resident #56 was admitted to the facility with diagnoses which included but were not limited to: [redacted] Review of the quarterly Minimum Data Set (MDS), an assessment tool utilized to manage a resident's care dated [redacted], indicated that the resident displayed both [redacted]. Review of the Individual Comprehensive Care Plan (ICCP) reflected a focus area, dated [redacted] that Resident #56 was at [redacted] related to (r/t) [redacted]. Interventions included: always apply [redacted] except during care, [redacted] at all times except during (activities of daily living) ADLs, apply [redacted] at all times except during ADLs, and encourage resident to keep [redacted] reapply when removed. Subsequently, the surveyor observed Resident #56 not wearing the prescribed [redacted] on multiple occasions: [redacted] The physician Order Summary Report (OSR), dated as of [redacted] included the following physician orders (PO): (1). A PO dated [redacted], for [redacted] at all times except during care, every shift for [redacted] (2). A PO dated [redacted] at all times except during care, every shift for [redacted]. (3). A PO dated [redacted] for [redacted] every shift for [redacted].	F0658	Continued from page 11 Accurate TAR documentation Observation of resident compliance and staff reapplication when removed Any discrepancies identified during the audit were corrected immediately. C. Systemic Changes to Prevent Recurrence The facility implemented the following measures to ensure services meet professional standards of nursing practice on 12/12/2025: [redacted] were re-educated by the [redacted] on the importance of following physician orders as written, consistent with professional standards and the New Jersey Nurse Practice Act. Education reinforced the requirement to: Reapply ordered treatments if removed Document refusals or removals accurately in progress notes Ensure TAR documentation reflects actual care provided Unit Managers were instructed to verify compliance with physician orders during routine rounds. Treatment documentation expectations were reinforced, emphasizing that documentation must reflect actual observation and care delivered. Coordination with the QAPI program was established to monitor compliance with physician orders and treatment accuracy. D. Monitoring and Ongoing Compliance The facility will monitor compliance with professional standards and physician order adherence as follows: Unit Managers or designees will conduct weekly audits of residents with active treatment or skin protection orders for a period of 90 days.	01/12/2026

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F0658 SS = D	Continued from page 12 The Treatment Administration Record (TAR) for [redacted] indicated the [redacted] were documented as applied every shift. However, the surveyor observed Resident #56 multiple times not wearing the [redacted]. On 12/8/2025 at 1:10 PM, the surveyor interviewed the [redacted] who stated that "the Resident should wear the [redacted], and [redacted] at all times". On 12/8/25 at 1:20 PM the surveyor interviewed the [redacted]) who stated that "the Resident should wear th [redacted] at all the times. The [redacted] further reported that the resident sometimes removed the [redacted]. When asked about documentation to support the Resident's removal of the [redacted], the surveyor did not find any documentation verifying the Resident's removal of the [redacted]. On 12/9/2025 at 9:00 AM, the surveyor interviewed the [redacted] who confirmed that the Resident should wear the [redacted] at all times. The [redacted] further stated that if the Resident removed the [redacted] they should be reapplied, and staff should document any removal. On 12/9/25 at 12:12 PM, the surveyor interviewed the [redacted] who stated that "the [redacted] should be applied as ordered by the physician". The [redacted] further agreed that "staff should [redacted] the [redacted] if the Resident removes them and document the removal in the Progress Notes". A review of the facility's policy "Dressings, Dry/Clean", revised 9/23, indicated that staff were to verify that there was a physician's order, review the resident's care plan, current orders, and diagnoses and check the treatment record. NJAC 8:39-27.1(a)	F0658	Continued from page 12 Audits will include direct observation and review of TAR documentation. Audit results will be reviewed by the DON and reported through the QAPI Committee monthly. Any identified deficiencies will be corrected immediately, with re-education provided as needed. Sustained compliance will be maintained through ongoing routine monitoring thereafter.	01/12/2026
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F0688	A. Corrective Action for the Affected Resident The facility immediately addressed the identified concern related to the provision of services to	01/12/2026

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F0688 SS = D	Continued from page 13 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of the medical record, and other facility documents, it was determined that the facility failed to ensure that a resident who was identified as having a [redacted]) received recommended services to prevent further [redacted] This deficient practice was identified for 1 of 1 resident reviewed for [redacted] and [redacted] (Resident #4) and was evidenced by the following: On 12/4/2025 at 9:45 AM, during the initial tour of the facility, the surveyor observed Resident #4 in bed while being rendered morning care. On 12/4/2025 at 10:34 AM, the surveyor observed Resident #4 [redacted] in the hallway using their [redacted] the wheelchair. The resident's [redacted] . The resident's [redacted] and [redacted] . The resident's [redacted] . The resident did not [redacted] a [redacted] on the [redacted] and the [redacted] . The surveyor did not see any [redacted] or [redacted] in the resident's room. On 12/8/2025 at 9:40 AM, the surveyor observed Resident #4 [redacted] using their [redacted] to [redacted] the wheelchair. The resident's [redacted] .	F0688	Continued from page 13 prevent further [redacted] for Resident #4. Upon identification, the resident was assessed by the interdisciplinary team, including Nursing and Rehabilitation, to determine appropriate interventions to address the [redacted] . A [redacted] was provided to the resident, and nursing staff ensured the [redacted] was applied as tolerated in accordance with therapy recommendations. The resident's physician was notified, and the order for the [redacted] was reviewed and confirmed to ensure proper authorization. The resident's comprehensive care plan was reviewed and updated to reflect current [redacted] interventions, [redacted] use schedule, and [redacted] requirements. The [redacted] verified that corrective actions were completed and that the resident received appropriate services to address [redacted] needs. B. Identification of Other Residents Potentially Affected To ensure no other residents were impacted by similar gaps in ROM and mobility services, the facility conducted a broader review. On 12/11/2025, A 100% audit was completed of all residents identified with limited range of motion, contractures, or orthopedic/orthotic needs. The audit verified: Presence of active physician orders for splints or orthotics Therapy recommendations reflected in the care plan Availability and proper use of prescribed devices No further discrepancies identified during the audit. C. Systemic Changes to Prevent Recurrence	01/12/2026

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F0688 SS = D	Continued from page 14 The resident's NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1. The resident's NJ Ex Order 26, 4B1 and being NJ Ex Order 26, 4B1. The resident NJ Ex Order 26, 4B1 on the NJ Ex Order 26, 4B1. The surveyor did not see any NJ Ex Order 26, 4B1 in the resident's room. The surveyor reviewed the medical record for Resident #4. A review of the Admission Record revealed Resident #4 was admitted to the facility with diagnoses which included but not limited to NJ Ex Order 26, 4B1 A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, 4B1, revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B which indicated an NJ Ex Order 26, 4B1. The MDS also reflected that the resident had NJ Ex Order 26, 4B1 and was NJ Ex Order 26, 4B1. A review of the Clinical Physician Orders (CPO) active as of NJ Ex Order 26, 4B1 did not include any order addressing the resident's NJ Ex Order 26, 4B1. An order for NJ Ex Order 26, 4B1, on NJ Ex Order 26, 4B1 off NJ E, remove for NJ Exec Order 26, was ordered on NJ Ex Order 26, 4B1 and discontinued on NJ Ex Order 26, 4B1 A review of the resident's comprehensive care plan included a focus for the resident's NJ Ex Order 26, 4B1 revised on NJ Ex Order 26, 4B1. Interventions included the following: To NJ Exec Order 26,4 NJ Ex Order 26, 4B1 for NJ Ex Order 26, during daytime after morning care. A review of the NJ Ex Order 26, 4B1 evaluation and plan of treatment dated NJ Ex Order 26, 4B1 included recommendations for NJ Ex Order 26, 4B1, as NJ Exec Order 26,4 remove for NJ Exec Order 2 for NJ Ex Order 26, 4B1 On 12/9/2025 at 9:05 AM, during an interview with the surveyor, the U. S. FOIA (b) (2)) stated that the U. S. FOIA (b) (2) issued orders for NJ Exec Order 26 devices. On 12/9/2025 at 9:45 AM, during an interview with the surveyor, the U. S. FOIA stated that they issue the	F0688	Continued from page 14 The facility implemented the following measures to ensure services meet professional standards for ROM and mobility care12/12/2025: U. S. FOIA (b) (2) were re-educated by the U. S. FOIA (b) (2) on the Provision of Rehab Services Policy, emphasizing that physician orders are required for orthotics and ROM interventions. Communication between Nursing, Rehabilitation, and Medical Providers was reinforced to ensure timely order confirmation and documentation. Care plan review processes were strengthened to ensure ROM interventions are consistently reflected and updated. Coordination with the QAPI program was established to monitor compliance with ROM and mobility standards. D. Monitoring and Ongoing Compliance The facility will monitor compliance with ROM and mobility services as follows: Director of Rehab or designee will conduct weekly audits of residents with ROM limitations or orthotic devices for a period of 90 days. Audits will include observation of device use, review of physician orders, and care plan alignment. Audit results will be reviewed by the DON and reported through the QAPI Committee monthly. Any identified deficiencies will be corrected immediately, with re-education provided as needed. Sustained compliance will be maintained through ongoing routine monitoring thereafter.	01/12/2026

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F0688 SS = D	Continued from page 15 NJ Ex Order 26, 4B1 orders and had access to the resident's electronic medical record to write orders which would need to be confirmed and approved by the resident's physician. On 12/09/2025 at 11:10 AM, the surveyor observed Resident #4 inside their room facing the dresser. On top of the dresser was a NJ Exec Order 26.4b1 NJ Ex Order 26, 4B1. The resident pointed to the and stated to the surveyor that they were handed the NJ Exec O NJ Ex Order 26, 4B1 A review of the CPO active after the surveyor's inquiry about the resident's NJ Ex Order 26, 4B, revealed an unconfirmed physician order for applying NJ Ex Ord on daytime as NJ Exec Order 26 created on NJ Exec Order 26.4b by the U. S. FOIA but was backdated to NJ Exec Order 26.4b1 by the U. S. FOIA. A review of the facility-provided policy titled "Provision of Rehab Services" created in 2025, included the following under Policy: 2.) Physician orders are required, or there is a change in the resident/ patient's condition, the interdisciplinary team will contact the physician. Any changes in the plan of care must be approved by the physician and documented in the resident/ patient's record. N.J.A.C. 8:39 – 27.2 (m)	F0688		01/12/2026
F0692 SS = D	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;	F0692	A. Corrective Action for the Affected Resident The facility immediately addressed the identified concern related to weekly NJ Exec Orde monitoring and NJ Exec Order 26 documentation for Resident #1. Upon identification of the documentation gap, nursing leadership reviewed Resident #1's NJ Exec Orde history, physician orders, NJ Exec Orde recommendations, and care plan to ensure appropriate NJ Exec Order 26.4b monitoring and interventions were in place. A current NJ Exec Orde was obtained and documented to establish an accurate baseline. Nursing and NJ Exec Order services reviewed the documented variance and confirmed that the resident remained on weekly NJ Exec Order 2 per physician order and facility protocol. The U. S. FOIA (b) (2)) evaluated the resident's NJ Exec Order 26.4b status, NJ Exec Orde and NJ Exec Order 26.4b1 use, and ongoing interventions were reinforced.	01/12/2026

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F0692 SS = D	Continued from page 16 §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: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to follow facility policy and procedure for weekly [redacted] for 1of 2 residents (Resident #1) on 1 of 3 units [redacted] This deficient practice was evidenced by the following: On 12/05/2025 at 7:59 AM Resident#1 was observed in bed. Resident #1 was [redacted] and did not prefer to [redacted] with the surveyor. The breakfast tray was observed on the over the bed table. The tray was observed to be untouched. Resident 31 stated that he/she was [redacted] and had [redacted]. Resident #1 would not tell the surveyor how [redacted], then stated, "yesterday." Staff were observed to attend to Resident#1 after the surveyor had left the room. Staff were observed by the surveyor to provide assist with [redacted] A review of Resident #1's Admission Record revealed that Resident #1 was admitted to the facility with the following but not limited to diagnoses: [redacted] A review of Resident #1's comprehensive Resident Assessment Instrument Minimum Data Set (MDS, an assessment tool, dated [redacted] revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated [redacted] According to Section [redacted] of the MDS, Resident #1 required [redacted] or [redacted] assistance with [redacted] Section [redacted] of the MDS revealed that Resident #1 had [redacted] or [redacted], received a [redacted] while a resident and received a [redacted] while a resident. Section [redacted] did not reveal that Resident #1 had [redacted] or [redacted] Section indicated that Resident #1 received a daily [redacted]	F0692	Continued from page 16 The [redacted]) verified that corrective actions were implemented and that the resident's nutritional status was being actively monitored. B. Identification of Other Residents Potentially Affected To ensure no other residents were impacted by failures to follow the weekly weight and reweight process, the facility conducted a comprehensive review. On 12/11/2025 A 100% audit of all residents on weekly weights or weight monitoring protocols was completed. The audit verified: Weekly weights completed as ordered Reweights obtained and documented for weight changes ≥3 lbs in one week or ≥5 lbs in one month Timely notification to the Registered Dietitian when thresholds were met No missing or inconsistent documentation identified during this audit. C. Systemic Changes to Prevent Recurrence The facility implemented the following systemic improvements on 12/12/2025 to ensure professional standards for nutrition and hydration monitoring are met: Nursing staff and CNAs were re-educated by the Director of Nursing on the Weight Assessment and Intervention Policy, including reweight thresholds and documentation requirements. Education reinforced that reweights must be: Obtained within the required timeframe Accurately documented in the electronic medical record Communicated to the Registered Dietitian	01/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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F0692 SS = D	Continued from page 17 A review of Resident #1's Order Summary Report with active orders as of [redacted] revealed Resident #1 had the following physician orders: [redacted], consistency, order date [redacted]. one time a day for [redacted] by mouth, order date: [redacted] Weekly [redacted] every day shift every Wednesday for monitoring after [redacted] order date: [redacted] Dietary/Dietician consult [redacted] order date: [redacted]. on Admission and Weekly x 4 weeks every day shift every Friday for [redacted] protocol for 28 days, order date: [redacted]. [redacted] give [redacted] order date: [redacted]. [redacted] give [redacted] order date: [redacted] A review of the Medication Administration Record (MAR, dated [redacted] revealed the following weekly [redacted] and [redacted]. A review of the comprehensive, person-centered care plan revealed the following care plan Focus: I have a [redacted] or [redacted] r/t (related to) need for [redacted] need for [redacted] Interventions/tasks included but were not limited to the following: [redacted], then monthly per protocol. Date Initiated [redacted] On 12/05/2025 at 12:54 PM, the surveyor reviewed the medical record for Resident #1. The following were documented: [redacted] Resident #1 had a [redacted] over a one-week period from [redacted] On 12/09/2025 at 9:38 AM, the surveyor conducted an interview with the [redacted] When asked what her responsibility was concerning weekly [redacted] told the surveyor that she was responsible for obtaining the weekly [redacted] of Resident #1. [redacted] further explained that I get the [redacted] and write it down on a piece of	F0692	Continued from page 17 Clarification was provided regarding roles and responsibilities of CNAs, licensed nursing staff, and dietary services in the weight monitoring process. Unit Managers were instructed to review weekly weights and reweights during routine clinical oversight. The weight monitoring process was incorporated into QAPI oversight to ensure consistency and accountability. D. Monitoring and Ongoing Compliance The facility will monitor compliance with nutrition and hydration monitoring requirements as follows: Unit Managers or designees will conduct weekly audits of residents on weekly weight protocols for a period of 90 days. Audits will include review of documented weights, reweights, and dietary notifications. Audit results will be reviewed by the DON and Registered Dietitian and reported through the QAPI Committee monthly. Any identified deficiencies will be corrected immediately, with re-education provided as needed. Sustained compliance will be ensured through ongoing routine monitoring thereafter.	01/12/2026

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F0692 SS = D	Continued from page 18 paper and give it to the [U. S. FOIA] on the unit. On 12/09/2025 at 9:47 AM, the surveyor conducted an interview with the U. S. FOIA (b) (2) assigned to Resident #1's unit. When asked to explain the weekly [NJ Exec Orde] process [U. S. FOIA (b)] told the surveyor that the [N] and [U. S. FOIA (b)] are responsible for obtaining weekly [NJ Ex Order]. Once the weight is obtained it is entered into PCC (Point Click Care, an electronic medical record) and it would then populate on the TAR (Treatment Administration Record) and in the [NJ Exec Order] /vitals section [U. S. FOIA (b) (2)] # further explained that they would compare the [NJ Exec Orde] to the previous weeks [NJ Exec Order] If there was a +/- [NJ Ex Order 26, 4B1] in one week we will conduct a re-[NJ Exec Orde] that day or the in the next 24 hours and document the re-[NJ Exec Order] If the [NJ Exec Orde] decline was accurate then I notify the [U. S. FOIA (b) (2)] verbally because I see him every day. The [NJ Ex Order 26,] will evaluate, and we also evaluate as a team. The surveyor then asked [NJ Ex Order 26,] # if a [NJ Exec Orde] decline of [NJ Ex Order 26, 4B1] in one week would require a [NJ Ex Order 26, 4B] [NJ Ex Order 26, 4B] stated, "Yes." A loss of [NJ Ex Or] [NJ Exec Order 26.4b1] would generate a [NJ Exec Order 26.4] The surveyor then asked [U. S. FOIA (b) (2)] why a [NJ Exec Order 26] was not conducted for Resident #1 for the documented weigh [NJ Ex Orde] of [N] [NJ Ex Order 26] from NJ Ex Order 26, 4B1. [U. S. FOIA (b) (2)] told the surveyor that the reweight was done but I didn't document it. The surveyor asked [U. S. FOIA (b) (2)] if the reweight should have been documented and [U. S. FOIA (b)] replied "Yes, it should have been documented so we can address the issue [NJ Ex Order 26, 4B1] right away." On 12/09/2025 at 10:46 AM, the surveyor conducted an interview with the facility U. S. FOIA (b) (2) [U. S. FOIA]. The [U. S. F] told the surveyor that Resident #1 was on weekly [NJ Exec Order 2] which we do for all new admissions. He further stated that the [U. S. FOIA (b) (2)] reports outlying [NJ Exec Order 2] to him, and I also review the [NJ Exec Order 2] myself for those who are on weekly [NJ Exec Order 26] The surveyor asked the [U. S. F] if Resident #1 should have had a [NJ Exec Order 26] conducted for the documented [NJ Ex Order 26, 4B1] [NJ Exec Order] from [NJ Ex Order 2] The [U. S. F] replied, "Yes, Resident #1 had a [NJ Exec Order] change of [NJ Exec Order] than [NJ Ex Order 26, 4B] and it should have been a [NJ Exec Order 26] and documented." The [U. S. FO] also explained that he also did [NJ Ex Order 26, 4B1], so it was not all on the nursing staff. The surveyor then asked the NJ Ex Order 26, 4B1 [ht] and the [U. S. F] responded that it was important so we can intervene and evaluate the resident to help prevent further [NJ Ex Order 26, 4B1]. On 12/09/202 at 1:10 PM, the surveyor conducted an interview with facility U. S. FOIA (b) (2) The	F0692		01/12/2026

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F0692 SS = D	Continued from page 19 surveyor asked the facility U. S. FOIA (b) (2) about the weekly NJ Exec Orde process. The U. S. FOIA told the surveyor that we go over the residents on weekly NJ Exec Order 2 and we have a weekly NJ Exec Orde meeting. She further explained that U. S. FOIA (b) was responsible, and the U. S. FOIA (b) (2) was responsible for documenting the NJ Exec Order 2 in the medical record. The surveyor asked the [redacted] if a NJ Ex Order 26, 4 should have been conducted and documented for the NJ Ex Order 26, 4B1 NJ Exec Orde decline in one week from NJ Ex Order 26, 4B1. The [redacted] responded, "I agree that we did not document the NJ Ex Order 26, 4B on NJ Ex Order 26, 4B1 when Resident #1 had a NJ Ex Order 26, 4B1." The surveyor reviewed the facility provided policy titled Weight Assessment and Intervention, Revision Date: December 1, 2025. The following was revealed under Weight Assessment: Residents are weighed upon admission and at intervals established by the interdisciplinary team. Weights are recorded in each unit's weight record chart and in the individual's medical record. Any weight change of 5lbs (pounds) or more (in 1 month) or 3lbs or more (in 1 week) will be retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietitian in writing. NJAC 18:39-27.1(a)	F0692		01/12/2026
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, and review of facility documents, it was determined that the facility failed to a.) ensure NJ Ex Order 26, 4B1 was maintained in NJ Ex Order 26, 4B1 while being used by the resident an NJ Ex Order 26, 4B1	F0695	A. Corrective Action for the Affected Residents The facility immediately addressed the identified concerns related to NJ Ex Order 26, 4B1 practices for Residents #83 and #56. Resident #83: NJ Ex Order 26, 4B1 was immediately repositioned to ensure it was maintained in a clean and sanitary condition and did not come into contact with trash or contaminated surfaces. NJ Ex Order 26, 4B1 was labeled appropriately, and required NJ Ex Order 26, 4B1 signage was placed in accordance with facility policy. The NJ Ex Order 26, 4B1 was cleaned and stored in a protective bag when not in use to prevent contamination. Nursing leadership reviewed NJ Exec Order and NJ Exec Order 26 orders, care plan interventions, and documentation expectations with staff. Resident #56: NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1 were immediately placed in the resident's room as ordered by the physician. Nursing staff verified availability of NJ Ex Order 26, 4B1 for emergency use, with emphasis on NJ Ex Order 26 status. Documentation was	01/12/2026

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F0695 SS = D	Continued from page 20 NJ Ex Order 26, 4B1) NJ Ex Order 26, 4B1 n and b.) follow physician orders and provide NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 of a resident ordered NJ Ex O in accordance with professional standards of practice. This deficient practice was identified for NJ Ex Order 26, 4B1 residents (Resident #83 and Resident #56) reviewed for NJ Ex Order 26, 4B1. This deficient practice was evidenced by the following: 1.) On 12/4/2025 at 11:02 AM, during the initial tour of the facility, Surveyor #1 observed Resident #83 from the hallway, sleeping in bed NJ Ex Order 26, 4B1 to an NJ Ex Order 26, 4B1 The surveyor observed the NJ Ex Order 26, 4B1 inside the trash bin located on the left side of the resident's bed. The NJ Ex Order 26, 4B1 was observed touching the trash inside the trash bin. The NJ Ex Order 26 was unlabeled. There was no signage inside or outside the resident's room indicating NJ Ex Order 26 is being used. On 12/5/2025 at 12:42 PM, the surveyor observed the resident in bed connected to the NJ Ex Order 26 . The surveyor observed an unbagged NJ Ex Order 26, 4B1 on the bedside table, lying sideways exposing it to air. The surveyor reviewed the medical record for Resident #83. A review of the Admission Record revealed Resident #83 was admitted to the facility with diagnoses which included but not limited t NJ Ex Order 26, 4B1 A review of the resident's most recent Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, 4B1 revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1 which indicated an NJ Ex Order 26, 4B1. The MDS also reflected that the resident received NJ Ex Order 26, 4B1 which included NJ Ex Order 26, 4B1. A review of the U. S. FOIA (b) (2) Orders (CPO) active as of NJ Ex Order 26, 4B1 included the following orders: NJ Ex Order 26, 4B1 a day for NJ Ex Order 26 ordered on NJ Ex Order 26, 4B1 and started on NJ Ex Order 26, 4B1.	F0695	Continued from page 20 corrected to reflect actual care provided, and staff were instructed not to sign off tasks that were not completed. The U. S. FOIA (b) (2)) verified that corrective actions were implemented for both residents. B. Identification of Other Residents Potentially Affected To ensure no other residents were impacted by similar respiratory care deficiencies, the facility conducted a comprehensive review. On 12/11/2025 a 100% audit was completed of all residents receiving oxygen therapy, nebulizer treatments, or other respiratory services. The audit verified: Proper storage and sanitation of oxygen tubing and nebulizer equipment Presence of oxygen tubing and bags in resident rooms as ordered Required oxygen signage in place Accurate TAR/MAR documentation reflecting actual care provided No additional issues identified during the audit. C. Systemic Changes to Prevent Recurrence The facility implemented the following systemic improvements to ensure respiratory care meets professional standards on 12/11/2025: U. S. FOIA (b) (2) were re-educated by the U. S. FOIA (b) (2) on the Oxygen Administration Policy, including equipment storage, signage, and documentation requirements. Education emphasized infection prevention practices related to respiratory equipment, including proper storage of nebulizer masks. Documentation expectations were reinforced, clarifying that tasks must only be signed as completed when care is actually provided.	01/12/2026

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F0695 SS = D	Continued from page 21 NJ Ex Order 26 PRN (as needed) NJ Ex Order 26, 4B1 e as needed for NJ Ex Order 26, 4B1). A review of the corresponding Medication Administration Record (MAR) in NJ Ex Order 26, 4B1 revealed that NJ Ex Order 26, 4B1 on the following dates and times was signed administered on NJ Ex Order 26, 4B1 . The order for NJ Ex Order 26 treatment as needed was not signed administered for the month of NJ Ex Order 26, 4B1. A review of the comprehensive care plan revised on NJ Ex Order 26 reflected a focus for NJ Ex Order 26, 4B1 related to NJ Exec Order 2 The interventions included the following: Give NJ Ex Order 26, 4B1 as ordered by physician. I NJ Ex Order 26, 4B1 . On 12/9/2025 at 8:58 AM, during an interview with the surveyor, the U. S. FOIA (b) (2)) stated that NJ Ex Order 26, 4B1 should be stored in plastic bag when not in use. The U. S. FOIA also stated that NJ Ex Order 26, 4B1 should not touch the trash bin. A review of facility provided policy titled "Oxygen Administration" revised in October 2010, indicated under Steps in the Procedure: …2.) Place an "Oxygen in Use" sign on the outside of the room entrance door. Close the door. 3.) Place an "Oxygen in Use" sign in a designated place on or over the resident's bed. Under Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record; 1.) The date and time that the procedure was performed, 2.) The name and title of the individual who performed the procedure. The policy did not address nebulization treatment and storage. 2.) On 12/5/2025 at 7:56 AM, the surveyor observed Resident #56 sitting in their wheelchair (W/C) in their room NJ Ex Order 26, 4B1 was observed in the Resident's room. On 12/4/25, at 10:20 AM, the surveyor reviewed the medical record for Resident #56. A review of the Admission Record (admission summary) dated NJ Ex Order 26, reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26, 4B	F0695	Continued from page 21 Care plan review processes were strengthened to ensure alignment with physician orders related to respiratory care. The respiratory equipment process was incorporated into QAPI oversight for ongoing monitoring. D. Monitoring and Ongoing Compliance The facility will monitor compliance with respiratory care standards as follows: Unit Managers or designees will conduct weekly audits of residents receiving respiratory treatments for a period of 90 days. Audits will include observation of equipment storage, presence of tubing and bags, signage, and review of TAR/MAR documentation. Audit findings will be reviewed by the DON and reported through the QAPI Committee. Any identified deficiencies will be corrected immediately, with re-education provided as needed. Sustained compliance will be maintained through routine monitoring thereafter.	01/12/2026

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F0695 SS = D	Continued from page 22 NJ Ex Order 26, 4B1 [redacted] .	F0695		01/12/2026

A review of the quarterly Minimum Data Set (MDS), an assessment that facilitates the management of a resident's care, dated [redacted], indicated that the Resident had both NJ Ex Order 26, 4B1 [redacted]

A review of the Individual Comprehensive Care Plan (ICCP) included a focus area dated [redacted] that the Resident was to have [redacted] as needed for NJ Ex Order 26, 4B1. The ICCP did not include any interventions related to [redacted].

A review of the physician Order Summary Report (OSR), dated [redacted] included the following physician orders for Resident #56 (PO):

A PO dated [redacted] for AHC: [redacted] storage. Keep [redacted] when not in use, every shift, for NJ Ex Order 26, 4B1

A PO dated [redacted], for [redacted]: [redacted] change. Change and date bag every night shift, every Tuesday, for NJ Ex Order 26, 4B1 %.

A review of the Treatment Administration Record (TAR) for NJ Ex Order 26, 4B1 showed that the [redacted] tasks were documented as completed every shift. However, during observations conducted on [redacted] at NJ Ex Order 26, 4B1 and [redacted] the surveyor did not observe any [redacted] in Resident #56's room.

On 12/9/2025 at 9:00 AM, the surveyor interviewed the U. S. FOIA (b) (2) who confirmed that Resident #56 had an active order for [redacted] but did not have the [redacted] in their room. When asked about the [redacted] task being signed off on the TAR, the [redacted] stated that the task should not have been signed off because the Resident did not have [redacted] in their room.

On 12/8/25 at 1:20 PM the surveyor interviewed the

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F0695 SS = D	Continued from page 23 U. S. FOIA (b) (2)) who stated that "based on PO, Resident #56 should have NJ Ex Order 26, 4B1 stored in a bag in the room". When asked about the importance of following the PO for NJ Ex Order 26, 4B1, the U. S. FOI responded that it was important to have the NJ Ex in the Resident's room in case of an emergency, particularly because the Resident NJ Ex Order 26, 4B1 On 12/9/25 at 12:12 PM, the surveyor interviewed the U. S. FOIA (b) (2)). The U. S. FOIA acknowledged that the NJ Ex Order 26, 4B1 should have been stored in the Resident's room as ordered and agreed that staff should not document completion of the NJ Ex Order 26, 4B1 on the TAR as the NJ Ex Order 2 was not present. The U. S. FOIA also affirmed that it is especially important for a NJ Ex Order 26, resident to have U. S. FOIA (b) (2) readily accessible in the event of an emergency. A review of the facility's policy and procedure titled "Oxygen Administration," revised October 2024, indicated that the purpose of the procedure was to provide guidelines for the safe oxygen administration. N.J.A.C. 8:39 - 27.1 (a)	F0695		01/12/2026
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 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	F0761	A. Corrective Action for the Affected Area The facility immediately addressed the identified concern related to unsecured medication storage during medication administration. Upon identification, nursing leadership immediately re-educated the involved nurse on the requirement to keep medication carts locked at all times when unattended. The medication cart observed during the medication pass was secured, and staff were reminded that medications must remain under direct supervision or locked at all times. The U. S. FOIA (b) (2)) verified compliance with medication storage requirements on the unit. B. Identification of Other Areas Potentially Affected To ensure no other unsecured medication storage practices were present, the facility conducted a broader review. On 12/11/2025 A 100% audit of all medication carts and medication rooms was completed. The audit	01/12/2026

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F0761 SS = D	Continued from page 24 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 review of pertinent facility documents, it was determined that the facility failed to store medications securely inside the medication cart by keeping it locked while unattended. The deficient practice was identified for 1 of 4 unsampled residents (Resident #21) observed during medication administration. The deficient practice was evidenced by the following: On 12/5/2025 at 7:54 AM, during the medication administration observation in the long-term care unit, the surveyor observed Licensed Practical Nurse (LPN) #1 administer medications to Resident #21. After administering NJ Ex Order 26, 4B1 and applied NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 to both [redacted] of the resident, LPN #1 returned to the medication cart located in the hallway, to place the [redacted] bottle inside the top drawer. The surveyor observed LPN #1 push the drawer close but did not lock the medication cart. LPN #1 went inside the resident's room to speak to the resident with their back facing the doorway. The medication cart was not on LPN #1's line of vision. The opening of the medication cart faced the hallway. There were no residents or staff in the hallway at that time. The surveyor called the attention of LPN #1 and asked the nurse if the medication cart is supposed to be left unattended unlocked in the hallway. LPN #1 stated that the medication cart should be locked at all times. On 12/9/2025 at 8:57 AM, during an interview with the surveyor, the U. S. FOIA (b) (2)) stated that medication carts should be locked at all times. A review of facility- provided policy titled "Medication Storage" revised on 5/30/2023, included under Policy General Guidelines: a.) All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) ….c.) During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/ cart.	F0761	Continued from page 24 verified: Medication carts were locked when unattended Controlled substances were stored in separately locked compartments as required Access to medications was limited to authorized personnel only No additional issues identified during this audit. C. Systemic Changes to Prevent Recurrence The facility implemented the following systemic measures to ensure compliance with medication labeling and storage standards on 12/11/2025: U. S. FOIA (b) (2) were re-educated by the U. S. FOIA (b) (2) on the Medication Storage Policy, emphasizing secure storage requirements during medication administration. Education reinforced that medication carts must be locked whenever not under direct supervision. Unit Managers were instructed to monitor medication storage practices during routine rounds and medication pass observations. Medication storage compliance was incorporated into the QAPI program for ongoing oversight. D. Monitoring and Ongoing Compliance The facility will monitor compliance with medication storage standards as follows: Unit Managers or designees will conduct weekly medication storage audits for a period of 90 days. Audit findings will be reviewed by the DON and reported through the QAPI Committee monthly. Any identified deficiencies will be corrected immediately, with re-education provided as needed. Sustained compliance will be ensured through ongoing routine monitoring thereafter.	01/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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F0761 SS = D	Continued from page 25 N.J.A.C. 8:39 – 29.4 (h)	F0761		01/12/2026
F0880 SS = D	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 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	F0880	A. Corrective Action for the Affected Area The facility immediately addressed the identified hand hygiene concerns observed in the [NJ Ex Order 29] Unit dining room. Upon identification, the [U. S. FOIA] involved was immediately educated by the U. S. FOIA (b) (2) on proper hand hygiene practices, including the requirement to perform hand hygiene between resident contact. Alcohol-based hand sanitizer containing at least 70% alcohol and access to soap and water were made readily available in the dining area. Nursing leadership reinforced that folded wet napkins that do not contain alcohol are not an acceptable method for hand hygiene for residents or staff. The U. S. FOIA (b) (2) and U. S. FOIA (b) (2) verified that appropriate hand hygiene products were available and in use during meals. B. Identification of Other Areas Potentially Affected To ensure no other dining or care areas were impacted by similar hand hygiene deficiencies, the facility conducted a comprehensive review. On 12/11/2025 A 100% audit was completed of all dining rooms and meal service areas across the facility. The audit verified: Availability of appropriate hand hygiene supplies for residents and staff Staff hand hygiene compliance between resident contact Proper products used for resident hand hygiene prior to meals No further deficiencies identified during the audit. C. Systemic Changes to Prevent Recurrence	01/12/2026

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F0880 SS = D	Continued from page 26 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 review of pertinent facility documentation, it was determined that the facility failed to ensure a safe, and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to provide residents with appropriate products for hand hygiene during mealtime, and staff did not follow hand hygiene practices consistent with accepted standards of practice. This deficiency was identified in 1 of 4 dining room observations ([NJ Ex Order 2] Unit dining room). This deficient practice was evidenced by the following: On 12/08/25 at 11:10 AM, the surveyor observed dining for lunch on the [NJ Ex Order 2] Unit dining room. The [U. S. FOIA (b) (2)] assisted two residents with hand hygiene before lunch using a folded wet napkin for each resident. However, the [U. S. FOIA] did not perform hand hygiene herself between assisting each resident.	F0880	Continued from page 26 The facility implemented the following systemic improvements on 12/11/2025 to strengthen infection prevention practices: All staff received re-education by the [U. S. FOIA (b) (2)] on the [U. S. FOIA (b) (2)] Program, with emphasis on hand hygiene during mealtime assistance. Education reinforced accepted standards of practice, including: Use of soap and water when hands are visibly soiled Use of alcohol-based hand sanitizer (≥70% alcohol) when appropriate Mandatory hand hygiene between assisting different residents Hand hygiene expectations during meals were incorporated into CNA competency and ongoing training. Dining room hand hygiene compliance was incorporated into QAPI monitoring. D. Monitoring and Ongoing Compliance The facility will monitor compliance with hand hygiene and infection prevention standards as follows: Infection Preventionist or designee will conduct weekly hand hygiene audits during meal observations for a period of 90 days. Audit results will be reviewed by the IP, DON, and LNHA and reported through the QAPI Committee monthly. Any identified deficiencies will be corrected immediately, with re-education provided as needed. Sustained compliance will be ensured through ongoing routine monitoring thereafter.	01/12/2026

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F0880 SS = D	Continued from page 27 During an interview with the surveyor on 12/08/25 at 11:14 AM, the [U. S. FOIA] stated that during mealtimes she uses folded wet napkins, which do not contain alcohol, to perform hand hygiene for residents. She further reported that she also uses the same folded wet napkins to perform hand hygiene on herself. During an interview with the surveyor on 12/09/25 at 1:20 PM, the [U. S. FOIA (b) (2)]) stated that hand hygiene should be performed using soap and water when hands are visibly soiled and alcohol-based hand sanitizer when appropriate, including between contact with residents. During an interview with the surveyor on 12/10/2025 at 11:02 AM, the [U. S. FOIA (b) (2)] stated that the folded wet napkins used by the [U. S. FOIA] did not contain alcohol. She explained that hand hygiene wipes should contain at least 70% alcohol. The [U. S. F] noted that the [U. S. FOIA] should not have performed hand hygiene on residents using the folded wet napkins and should have used either 70% alcohol-based hand gel or soap and water between residents for proper [NJ Ex Order 26.] control. A review of the facility's undated policy titled "Infection Prevention and Control Program" revealed that "All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures." N.J.A.C. § 8:39-19.4(a)	F0880		01/12/2026

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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		01/12/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift, as mandated by the State of New Jersey. This was evident for 3 of 14 day and was evidenced as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a	S0560	A. How the facility identified the issue Through surveyor interview and review of staffing schedules, CNA assignment sheets, and census reports, it was determined that the facility did not consistently meet the required minimum Certified Nurse Aide (CNA)-to-resident ratio of 1:8 on the day shift for 3 of 14 reviewed days, in accordance with N.J.S.A. 30:13-18 and NJDOH memo. B. How the facility corrected the issue Corrective action was initiated and completed on 12/11/2025. A comprehensive review of census and staffing schedules was conducted to ensure compliance with the required 1:8 CNA-to-resident day shift ratio. Staffing adjustments were made immediately to meet or exceed the required minimum ratio. The master staffing schedule was reviewed and updated to reflect required minimum CNA coverage based on daily census tiers. A contingency staffing protocol was implemented to address call-outs and unplanned absences prior to the start of each shift to ensure required ratios are met. All residents may have been affected by this deficient practice. A review of resident care documentation revealed no adverse outcomes related to staffing levels on the identified dates. The facility has remained in compliance with required day shift staffing ratios since 12/11/2025. C. How the facility will prevent recurrence Effective 12/12/2025, the facility formally revised its	01/05/2026

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

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S0560	Continued from page 1 CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of staffing prior to survey from 11/16/2025 to 11/29/2025, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -11/16/25 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -11/ 22/25 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/24/25 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. On 12/10/2025 at 10:40 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding facility staffing. The SC stated that the facility is currently meeting staff requirements. She explained the staffing levels were determined on a daily based and on the resident census, staff-to-resident ratios, and resident acuity, with additional staff provided as needed, included during emergencies. She stated that these levels were reassessed every day to ensure adequate coverage. She added that the facility census directly impacted staffing, and unanticipated shortages or callouts were managed by maintaining staff on standby, sending staffing alerts, and occasionally offering incentives such as extra pay or gift cards. The facility used agency nurses when necessary, prioritizing those who worked there regularly and required all agency staff to complete an education packet before starting. She added that ongoing training was provided to staff as needed to ensure competency and proper care for residents.	S0560	Continued from page 1 Staffing and Scheduling Policy to include mandatory daily census-based staffing ratio verification prior to the start of each day shift, required Administrator and Director of Nursing notification if staffing ratios fall below state-mandated levels, and immediate activation of contingency staffing resources, including per diem or agency staff, prior to shift start when needed to ensure compliance. Education was provided on 12/15/2025 regarding New Jersey minimum staffing requirements under N.J.S.A. 30:13-18, including required CNA-to-resident ratios, census-based staffing calculations, documentation requirements, escalation procedures, and daily compliance monitoring expectations. The education was provided by the Licensed Nursing Home Administrator to the Director of Nursing, Staffing Coordinator, Human Resources personnel, and unit managers responsible for staffing oversight. Education was completed upon correction and will be provided upon hire for individuals responsible for staffing oversight and annually thereafter. Attendance was documented via sign-in sheet and is maintained in the facility's education records. D. How the facility will monitor ongoing compliance Beginning 12/15/2025, the Administrator or designee initiated daily staffing ratio audits to verify compliance with the 1:8 CNA-to-resident day shift requirement. Audit findings are documented and reviewed weekly with the Director of Nursing, and results are presented at the monthly QAPI meeting to ensure sustained compliance. After 90 days of sustained compliance, monitoring will transition to weekly review as part of routine regulatory readiness oversight.	01/05/2026
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	S1405	A. How the facility identified the issue During surveyor interview and review of newly hired employee health records, it was identified that 13 of 120 employee files did not contain completed and properly signed Employee Health Assessment Forms (EHAF) within the required timeframe. The facility	01/05/2026

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S1405	Continued from page 2 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 interviews, record reviews, and the review of pertinent facility documents, it was determined that the facility failed to ensure that newly hired employees completed a health history and received a physical health examination by a physician, advanced practice nurse (APN), or physician assistant (PA) within the required timeframe, either within two weeks prior to employment, upon employment, or within 30 days if a Registered Nurse (RN) completed the health history assessment upon employment. This deficiency was identified in 13 of 120 employee files reviewed (Employee #1 through Employee #13). The deficient practice was evidenced by the following: On 12/04/25 at 9:27 AM, during the entrance conference, the surveyor requested health records for all newly hired facility employees, including pre-employment physical examinations, from the Licensed Nursing Home Administrator (LNHA). The request included all newly hired employees, whether currently employed or terminated, since the last annual recertification survey. On 12/05/25, the surveyors reviewed the health records of 120 newly hired employees. Of these, 13 files indicated that the health examinations were not completed within the required timeframe. The review for health records and physical examinations on [redacted], for all new employees revealed the following: Employee #1 was hired and began working at the facility on [redacted]. An RN completed the Employee Health Assessment Form (EHAF) upon hire; however, the form was not signed by the RN until	S1405	Continued from page 2 failed to ensure that newly hired employees completed a health history and received a physical examination performed by a physician, advanced practice nurse (APN), or physician assistant (PA) within two weeks prior to employment, upon employment, or within 30 days when an RN completed the initial health assessment, in accordance with N.J.A.C. 8:39-19.5(a). B. How the facility corrected the issue Corrective action was initiated on 12/11/2025. A comprehensive audit of all active employee health files was conducted between 12/11/2025 and 12/13/2025. The 13 identified employee files were individually reviewed and corrected. Missing signatures, incomplete forms, and absent provider documentation were obtained and placed in the respective personnel files. Where necessary, verification from the examining physician/APN/PA was secured to confirm medical clearance. In addition, all employee files were reviewed to ensure compliance with required health history documentation, physical examination requirements, Mantoux testing, and completeness standards. No employee is permitted to work without documented medical clearance meeting regulatory timeframes. All residents may have been affected by this deficient practice. A review of infection control surveillance data and employee health records revealed no evidence of communicable disease transmission or resident harm associated with this deficiency. C. How the facility will prevent recurrence Effective 12/13/2025, the facility reviewed its hiring policy to ensure it establishes written criteria for determining completeness of physical examinations, including required provider signature, date, and verification of medical clearance prior to assignment or within the allowable 30-day timeframe when applicable. A standardized pre-employment compliance checklist was implemented within Human Resources to ensure all required health documentation is completed and verified prior to scheduling an employee to work. The checklist requires documented confirmation of health history completion, physical examination within required timeframe, required provider signature, Mantoux	01/05/2026

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S1405	Continued from page 3 01/16/24. Employee #2 was hired and started working at the facility on [redacted] A RN, physician, APN, or PA did not sign or date the EHAF. Employee #3 was hired and started working at the facility on [redacted] An RN completed the EHAF upon hire; however, the RN did not sign the form, and the physician signed it on [redacted]. Employee #4 was hired and started working at the facility on [redacted] An RN completed the EHAF upon hire; however, the RN did not sign the form, and the physician signed it on [redacted]. Employee #5 was hired and started working at the facility on [redacted] A RN, physician, APN, or PA did not sign or date the EHAF. Employee #6 was hired and began working at the facility on [redacted]. EHAF completed upon hire was incomplete, and it was not signed or dated by an RN, physician, APN, or PA. Employee #7 was hired and began working at the facility on [redacted] EHAF completed upon hire was incomplete, and it was not signed or dated by an RN, physician, APN, or PA. Employee #8 was hired and began working at the facility on [redacted] EHAF completed upon hire was incomplete, and it was not signed or dated by an RN, physician, APN, or PA. Employee #9 was hired and began working at the facility on [redacted] EHAF completed upon hire was incomplete, and it was not signed or dated by an RN, physician, APN, or PA. Employee #10 was hired and began working at the facility on [redacted] EHAF completed upon hire was incomplete, and it was not signed or dated by an RN, physician, APN, or PA. Employee #11 was hired and began working at the facility on [redacted] EHAF completed upon hire was incomplete, and it was not signed or dated by an RN, physician, APN, or PA. Employee #12 was hired and began working at the facility on [redacted] EHAF completed upon hire was incomplete, and it was not signed or dated by an RN, physician, APN, or PA. Employee #13 was hired and began working at the	S1405	Continued from page 3 testing, and file review sign-off by Human Resources. Education was provided on 12/16/2025 regarding employee health clearance requirements under N.J.A.C. 8:39-19.5(a). The education included required timeframes, signature requirements, RN assessment allowances, documentation standards, infection control implications, and onboarding verification procedures. Education was provided by the Licensed Nursing Home Administrator and the Infection Preventionist to the Human Resources Director, Staffing Coordinator, and all personnel responsible for employee onboarding and file maintenance. Education was completed upon correction and will be provided upon hire for Human Resources personnel and annually thereafter. Attendance was documented via sign-in sheet and is maintained in the facility's education records. D. How the facility will monitor ongoing compliance Beginning 12/16/2025, the Administrator or designee initiated weekly audits of newly hired employee health files to verify compliance with required timeframes and documentation completeness standards. Audit findings are documented and reviewed with the Human Resources Director. Results will be presented monthly at the QAPI meeting to ensure sustained compliance. After 90 days of sustained compliance, monitoring will transition to monthly review as part of routine infection control and regulatory readiness oversight.	01/05/2026

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S1405	Continued from page 4 facility on [redacted]. EHAF completed upon hire was incomplete, and it was not signed or dated by an RN, physician, APN, or PA. During an interview with the surveyor on 12/09/25 at 1:20 PM, the LNHA stated that the facility tries to ensure that background checks, health physicals, and Mantoux testing (a simple skin test used to see if a person has been exposed to a germ that can affect the lungs) are completed within the required timeframe for safety reasons before employees begin working. However, the LNHA explained that, unfortunately, these requirements sometimes slip through the cracks. During an interview with the surveyor on 12/10/25 at 10:35 AM, the Staffing Coordinator/Human Resources Director stated that human resources complete applications, background checks, schedules physicals and Mantoux testing, maintains employee files, and coordinates onboarding. Staff must complete a physical and Mantoux test prior to working for safety reasons. If the physical is delayed, an RN may complete the initial assessment; however, a physician must complete and sign the physical within 30 days. All required forms must be completed in full. A review of the facility's undated policy titled "Infection Prevention and Control Program" revealed that "Direct care staff shall comply with physical examinations and immunization screening requirements upon employment, and annually."	S1405		01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHABILITATION AND NURSING CENTER	**151 NINTH AVENUE , LITTLE EGG HARBOR TW, New Jersey, 08087**

(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 An offsite/desk review of the facility's Plan of Correction was conducted on 2/27/2026 in relation to the 12/10/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		12/26/2025

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 656004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 2/27/2026 in relation to the 12/10/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		12/26/2025

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: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - BUILDING** B. WING	(X3) DATE SURVEY COMPLETED **12/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHABILITATION AND NURSING CENTER	**151 NINTH AVENUE , LITTLE EGG HARBOR TW, New Jersey, 08087**

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K0000 Bldg. 02	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/8/25 and 12/9/25. Mystic Meadows Rehabilitation and Nursing Center 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.	K0000		01/31/2026
K0353 SS = F Bldg. 02	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, interview and record review on 12/8/25 and 12/9/25 in the presence of the U. S. FOIA (b) (2) it was determined the facility failed to ensure the electric fire pump was	K0353	A. How the facility identified the issue The deficient practice was identified through observation, interview, and record review on 12/8/25 and 12/9/25 in the presence of the U. S. FOIA (b) (2) . Observations occurred on 12/8/25 at 11:35 AM and record review occurred on 12/8/25 at 2:00 PM. The U. S. FO confirmed the record review during interview on 12/9/25 at 11:07 AM. The finding was reviewed with facility leadership during the Life Safety Code exit conference on 12/9/25 at 3:14 PM. B. How the facility will correct the issue The facility implemented corrective action to ensure monthly inspection and testing of the electric fire pump is completed and documented in accordance with NFPA 25 requirements. The facility established and secured documentation processes to ensure monthly fire pump inspections/testing records are maintained in a secure location and readily available for review. Education was provided to all maintenance personnel by the U. S. FOIA (b) (2) regarding sprinkler system fire pump maintenance and testing requirements. Education was completed immediately upon correction and will be provided upon hire and annually thereafter. C. How the facility will prevent recurrence The U. S. FOIA (b) (2) established a scheduled monthly fire pump inspection/testing process and documentation log to ensure ongoing compliance. A compliance tracking system was implemented to	01/05/2026

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: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - BUILDING** B. WING	(X3) DATE SURVEY COMPLETED **12/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0353 SS = F Bldg. 02	Continued from page 1 tested and inspected monthly in accordance with NFPA 101:2012 Edition, Section 9.7.5 and NFPA 25:2011 Edition, Sections 8.3.1, 8.3.1.2, 8.3.2, 8.3.2.1 to 8.3.2.3, 8.3.2.7 and 8.3.2.8(1)(a)(b)(c)(d)(e)(f)(2)(a)(b)(c). This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/8/25 at 11:35 AM of the fire sprinkler room, revealed the facility had a vertical in-line fire pump. A record review on 12/8/25 at 2:00 PM revealed there was no record of the monthly electric fire pump inspections and tests being performed in the last 12 months. In an interview on 12/9/25 at 11:07 AM, the [redacted] confirmed the record review. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 12/9/25 at 3:14 PM. N.J.A.C. 8:39-31.2(e) NFPA 25	K0353	Continued from page 1 identify missed monthly tests and trigger immediate follow-up. The [redacted] and applicable maintenance personnel were re-educated regarding NFPA 25 fire pump inspection/testing requirements and record retention expectations. D. How the facility will monitor ongoing compliance The Maintenance Director or designee will conduct weekly audits for 90 days to verify the monthly fire pump inspection/testing process is completed and documentation is present and current. Findings will be documented and addressed promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026
K0355 SS = F Bldg. 02	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 observation and interview on 12/8/25 in the presence of the [redacted], it was determined the facility failed to ensure Class K fire extinguishers had a placard conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher in accordance with NFPA 101:2012 Edition, Section 9.7.4.1 and NFPA 10:2010 Edition, Section 5.5.5.3. This deficient practice had the potential to affect all	K0355	A. How the facility identified the issue The deficient practice was identified on 12/8/25 during observation and interview in the presence of the [redacted] and [redacted], including observation of the kitchen at 10:37 AM. The finding was reviewed with facility leadership during the Life Safety Code exit conference on 12/9/25 at 3:14 PM. B. How the facility will correct the issue The facility ensured the Class K fire extinguisher in the kitchen area was provided with the required instructional placard conspicuously placed near the extinguisher stating that the fire protection system shall be actuated prior to using the fire extinguisher, consistent with NFPA 10 requirements. Education was provided to the maintenance and dietary personnel regarding portable fire extinguisher requirements. Education was completed immediately upon correction and will be provided upon hire and annually thereafter.	01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - BUILDING** B. WING	(X3) DATE SURVEY COMPLETED **12/10/2025**

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K0355 SS = F Bldg. 02	Continued from page 2 residents and was evidenced by the following: Observations of the kitchen at 10:37 AM revealed the Class K fire extinguisher was not provided with the required instructional placard. In an interview at the time, the [NJ Ex Order 28, 4B1] confirmed the observation. The facility's [U. S. FOIA (b) (2)] were informed of the deficient practice at the Life Safety Code exit conference on 12/9/25 at 3:14 PM. N.J.A.C. 8:39-31.2(e) NFPA 10	K0355	Continued from page 2 C. How the facility will prevent recurrence The Maintenance Director will incorporate verification of required placards/signage for Class K extinguishers into routine safety rounds and fire extinguisher inspection processes. The [U.S. FOIA (b)(2)] and maintenance staff will be re-educated on the importance of maintaining required instructional placards for Class K extinguishers in food service areas. D. How the facility will monitor ongoing compliance The Maintenance Director or designee will complete weekly audits for 90 days of all Class K extinguishers to verify the required placards remain present and conspicuously placed. Findings will be documented and corrected promptly. Audit results will be reviewed monthly at the QAPI meeting.	01/05/2026
K0914 SS = F Bldg. 02	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: Based on observation, interview and record review on 12/8/25 and 12/9/25 in the presence of the [U. S. FOIA (b) (2)] it was determined the facility failed to ensure receptacles at patient bed locations that are not listed as hospital grade are	K0914	A. How the facility identified the issue The deficient practice was identified based on observation, interview, and record review on 12/8/25 and 12/9/25 in the presence of the [U. S. FOIA (b) (2)]. Observations occurred during a facility tour between 8:32 AM and 11:47 AM on 12/8/25. Record review occurred on 12/8/25 at 2:30 PM. The [U.S. FO] confirmed the record review during interview on 12/9/25 at 11:15 AM. The finding was reviewed with facility leadership during the Life Safety Code exit conference on 12/9/25 at 3:14 PM. B. How the facility will correct the issue The facility implemented corrective action to ensure receptacles at patient bed locations that are not hospital grade are tested at intervals not exceeding 12 months, including testing for physical integrity, polarity, ground continuity, and blade tension, in accordance with NFPA requirements. The facility updated the annual electrical inspection scope to include patient care area non-hospital grade receptacles and ensured documentation reflects required testing and results. Education was provided to all maintenance personnel by the [U. S. FOIA (b) (2)] regarding electrical system testing requirements for patient care areas. Education was completed immediately upon correction and will be provided upon hire and annually thereafter. C. How the facility will prevent recurrence The [U. S. FOIA (b) (2)] revised the electrical testing program to ensure inclusion of patient care	01/05/2026

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K0914 SS = F Bldg. 02	Continued from page 3 tested at intervals not exceeding 12 months for; physical integrity, polarity, ground continuity and blade tension in accordance with NFPA 99:2012 Edition, Section 6.3.3.2, 6.3.3.2.1 to 6.3.3.2.4, 6.3.4.1, 6.3.4.1.3, 6.3.4.2, 6.3.4.2.1, 6.3.4.2.2 and NFPA 70:2011 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 12/8/25 during a facility tour between 8:32 AM and 11:47 AM revealed most all of the outlets on the residents' head wall are not hospital grade. A record review on 12/8/25 at 2:30 PM of the annual electrical Inspection report revealed, it did not include the patient care area non-hospital grade receptacles and the visual, polarity, ground and tension tests. No further documentation was provided. In an interview on 12/9/25 at 11:15 AM, the [redacted] confirmed the record review. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 12/9/25 at 3:14 PM. N.J.A.C. 8:39-31.2(e) NFPA 70, 99	K0914	Continued from page 3 area receptacle testing requirements and established documentation standards for completed testing (date, room/area tested, and results). The facility ensured contracted inspection vendors are provided written scope expectations to include required receptacle testing and documentation. D. How the facility will monitor ongoing compliance The Maintenance Director or designee will conduct weekly audits for 90 days to verify documentation is maintained for required receptacle testing and that patient care areas are included in the electrical testing program. Findings will be documented and addressed promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026
K0918 SS = F Bldg. 02	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	K0918	A. How the facility identified the issue The deficient practice was identified through interview and record review on 12/8/25 and 12/9/25 in the presence of the [redacted]. Record review occurred on 12/8/25 at 3:00 PM and on 12/9/25 at 8:15 AM. The [redacted] confirmed the record reviews in interview on 12/9/25 at 11:07. The finding was reviewed with facility leadership during the Life Safety Code exit conference on 12/9/25 at 3:14 PM. B. How the facility will correct the issue The facility implemented corrective action to ensure: annual fuel quality testing is performed using ASTM-approved standards;	01/05/2026

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K0918 SS = F Bldg. 02	Continued from page 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on interview and record review on 12/8/25 and 12/9/25 in the presence of the U. S. FOIA (b) (2) [redacted] it was determined the facility failed to ensure 1.) a fuel quality test was performed annually using ASTM approved standards, 2.) that during the monthly 30 minute exercises, the percent load of the nameplate kilowatt (kW) rating was not determined and recorded, to determine if a 90 minute annual load bank test was required and if the 36 month 4 hour continuous run test has to have supplemental loads provided and 3.) the generator was tested every 36 months for 4 continuous hours at the required load in accordance with NFPA 110:2010 Edition, Sections 8.3, 8.3.8, 8.4, 8.4.2(1)(2), 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7. These deficient practices had the potential to affect all residents and were evidenced by the following: A record review on 12/8/25 at 3 PM revealed there was no annual fuel sample analysis provided. A record review on 12/9/25 at 8:15 AM revealed the percent of the nameplate kW rating load that the generator was exercised at monthly for 30 minutes was not recorded in the monthly load test log each month for the last 12 months. Further record review revealed there was no record that a 36-month 4-hour generator test was performed. In an interview on 12/9/25 at 11:07, the U. S. FD confirmed the record reviews.	K0918	Continued from page 4 monthly 30-minute generator exercise logs include the recorded percent load of the nameplate kilowatt rating to determine load bank testing needs; and the generator is tested every 36 months for 4 continuous hours at the required load, with supplemental loads provided when required, consistent with NFPA 110 requirements. Documentation processes were updated to ensure required records are maintained and readily available. C. How the facility will prevent recurrence The U. S. FOIA (b) (2) established a generator compliance tracking system to ensure required testing elements are scheduled, completed, and documented (annual fuel testing, monthly load documentation, and 36-month testing requirements). The facility ensured contracted vendors (as applicable) are provided scope expectations aligned with NFPA 110 requirements. U. S. FOIA (b) (2) and the U. S. FOIA (b) (2) were educated by U. S. FOIA (b) (2) [redacted] regarding essential electrical system maintenance and testing requirements. Education was completed immediately upon correction and will be provided upon hire for maintenance personnel and annually thereafter. D. How the facility will monitor ongoing compliance The Maintenance Director or designee will conduct weekly audits for 90 days to verify generator logs and supporting documentation reflect required testing elements (annual fuel testing, monthly percent load documentation, and 36-month testing documentation). Findings will be documented and corrected promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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K0918 SS = F Bldg. 02	Continued from page 5 The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference on 12/9/25 at 3:14 PM. N.J.A.C. 8:39-31.2(e) NFPA 110	K0918		01/05/2026
K0921 SS = F Bldg. 02	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on observations, interview and record review on 12/8/25 and 12/9/25 in the presence of the U. S. FOIA (b) (2), it was determined the facility failed to ensure electric hospital beds were Inspected, Tested and Maintained (ITM) based on policies and procedures of a Patient Care Related Electrical Equipment (PCREE) program that considered the manufacturers recommendations and a record of the ITM and repairs was maintained for a	K0921	A. How the facility identified the issue The deficient practice was identified through observations, interview, and record review on 12/8/25 and 12/9/25 in the presence of the U. S. FOIA (b) (2) Observations occurred during a facility tour between 8:32 AM and 11:47 AM on 12/8/25. Interview occurred on 12/8/25 at 9:26 AM, during which the U.S.F.O. confirmed there was no written program or ITM documentation for electric medical beds. Record review occurred on 12/9/25 at 11:20 AM, and the finding was reviewed with facility leadership during the Life Safety Code exit conference on 12/9/25 at 3:14 PM. B. How the facility will correct the issue The facility established and implemented a Patient Care Related Electrical Equipment (PCREE) program that includes electric medical beds, consistent with NFPA 99 requirements. The program includes inspection, testing, and maintenance protocols that consider manufacturer recommendations, and the facility established a recordkeeping process to maintain ITM documentation and repair records for the required retention period. The contracted service vendor scope was updated to include electric medical bed ITM, and documentation is maintained and readily available. Education was provided to the maintenance personnel and the U. S. FOIA (b) (2) by the U. S. FOIA (b) (2) regarding patient care related electrical equipment requirements, including electric medical beds. Education was completed immediately upon correction and will be provided upon hire for maintenance personnel and annually thereafter C. How the facility will prevent recurrence The U. S. FOIA (b) (2) implemented written policies and procedures outlining ITM requirements for PCREE, including electric medical beds, and established accountability for maintaining records of testing, repairs, and modifications. Maintenance and applicable staff were re-educated regarding the	01/05/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHABILITATION AND NURSING CENTER	151 NINTH AVENUE , LITTLE EGG HARBOR TW, New Jersey, 08087

(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
K0921 SS = F Bldg. 02	Continued from page 6 period of time to demonstrate compliance in accordance with NFPA 99: 2012 Edition, Section10.3 and 10.5. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during a facility tour on 12/8/25 between 8:32 AM and11:47 AM, revealed resident rooms were furnished with fully adjustable electric medical beds for each resident. In an interview on 12/8/25 at 9:26 AM, the surveyor asked the [redacted] what the facility's program or policy was for ITM of the medical beds. The [redacted] stated that housekeeping carbolizes the beds and if there is something wrong they tell maintenance and put it the maintenance log. Additionally, they do a room check before the room is occupied but they do not keep a record. The [redacted] confirmed there was no written program or ITM documentation based on NFPA 99 requirements for the hospital beds at the time. Record review on 12/9/25 at 11:20 AM of the facility's contracted service ITM reports for PCREE, revealed there was no documentation electric medical bed ITM was conducted by the service vendor. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 12/9/25 at 3:14 PM. N.J.A.C. 8:39-31.2(e) NFPA 99	K0921	Continued from page 6 PCREE program requirements, documentation expectations, and the process for removing equipment from service when concerns are identified. D. How the facility will monitor ongoing compliance The Maintenance Director or designee will perform weekly audits for 90 days to verify the PCREE program includes electric medical beds and that ITM and repair documentation is maintained and current. Findings will be documented and addressed promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026
K0222 SS = E Bldg. 02	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical	K0222	A. How the facility identified the issue The deficient practice was identified on 12/8/25 during observation and interview in the presence of the [redacted]). The finding was reviewed with facility leadership during the Life Safety Code exit conference on 12/9/25 at 3:14 PM. B. How the facility will correct the issue The facility ensured the delayed egress doors from the corridor to the lobby were provided with the required readily visible sign, located on the door leaf adjacent to the releasing device in the direction of	01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - BUILDING** B. WING	(X3) DATE SURVEY COMPLETED **12/10/2025**

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K0222 SS = E Bldg. 02	Continued from page 7 security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.	K0222	Continued from page 7 egress. The sign reads: “PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS” in letters not less than 1-inch on a contrasting background, consistent with NFPA 101:2012 Edition requirements. Education was provided to all Maintenance personnel by the Administrator. Education was completed immediately upon correction and will be provided upon hire and annually thereafter. C. How the facility will prevent recurrence The Maintenance Director will implement a standardized checklist for delayed egress doors to verify signage presence, placement, and visibility during routine life safety/environmental rounds. Maintenance staff will be re-educated on delayed egress locking system requirements, including signage requirements, placement, and visibility. D. How the facility will monitor ongoing compliance The Maintenance Director or designee will conduct weekly audits for 90 days of all delayed egress doors to verify required signage remains present and visible. Findings will be documented and any deficiencies corrected promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026

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K0222 SS = E Bldg. 02	Continued from page 8 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 12/8/25 in the presence of the [redacted], it was determined the facility failed to ensure delayed egress locking systems had a readily visible sign in letters not less than 1-inch on a contrasting background that read as follows and located on the door leaf adjacent to the releasing device in the direction of egress; PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, in accordance with NFPA 101:2012 Edition, Section 7.2.1.6.1.1(4). This deficient practice had the potential to affect 22 residents and was evidenced by the following: Observations at 10:20 AM of the double swinging doors from the corridor to the lobby revealed, the doors were equipped with a delayed egress locking system and had no sign that read; PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, located on the door leaf adjacent to the releasing device in the direction of egress. In an interview at the time, the [redacted] confirmed the observation, and stated the door was open from 8 AM to 8 PM and was locked with delayed egress from 8 PM to 8 AM. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 12/9/25 at 3:14 PM. N.J.A.C. 8:39-31.2(e)	K0222		01/05/2026
K0271 SS = E Bldg. 02	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	K0271	A. How the facility identified the issue The deficient practice was identified on 12/8/25 during observation and interview in the presence of the [redacted] including the exterior exit discharge by room [redacted]. The finding was reviewed with facility leadership during the Life Safety Code exit conference on 12/9/25 at 3:14 PM. B. How the facility will correct the issue The facility corrected the identified exit discharge hazard by addressing the uneven walking surface at the corridor exterior exit by room 200, including the	01/05/2026

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K0271 SS = E Bldg. 02	Continued from page 9 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 12/8/25 in the presence of the U. S. FOIA (b) (2) it was determined the facility failed to ensure abrupt changes in walking surfaces in the means of egress did not exceed 1/4-inch and were free of all obstructions in accordance with NFPA 101:2012 Edition, Section 19.2.7, 7.7, 7.1, 7.1.6.2 and 7.1.10. This deficient practice had the potential to affect 24 residents and was evidenced by the following: Observations of the corridor exterior exit by room 200, exit discharge revealed the concrete block path to the public way had a 2-1/2 inch lip where the third concrete block was depressed below the second block. Further observation revealed the last concrete block before the concrete ramp was broken up across the width of the block on the ramp side. In an interview at the time, the U. S. FOI confirmed the observations. The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference on 12/9/25 at 3:14 PM. N.J.A.C. 8:39-31.2(e)	K0271	Continued from page 9 depressed concrete block resulting in an abrupt change in elevation and the damaged concrete block adjacent to the ramp. Repairs were completed to ensure the exit discharge provides a level walking surface and is maintained free of obstructions in accordance with NFPA 101 requirements. Education was provided to all maintenance personnel by the Administrator regarding exit discharge requirements. Education was completed immediately upon correction and will be provided upon hire and annually thereafter. C. How the facility will prevent recurrence The Maintenance Director will incorporate exterior exit discharge walking surfaces into scheduled building rounds to identify uneven surfaces, cracks, broken sections, or elevation changes that could impede safe egress. Staff responsible for grounds and exterior maintenance will be re-educated on maintaining exit discharge areas as safe, level, and unobstructed. D. How the facility will monitor ongoing compliance The Maintenance Director or designee will conduct weekly audits for 90 days of all exit discharge routes to ensure walking surfaces are level, free of obstructions, and maintained as an all-weather travel surface. Findings will be documented and corrective actions implemented promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026
K0293 SS = E Bldg. 02	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 interview on 12/8/25 in the presence of the U. S. FOIA (b) (2) it	K0293	A. How the facility identified the issue The deficient practice was identified on 12/8/25 during observations and interview in the presence of the U. S. FOIA (b) (2) including courtyard areas observed at 8:56 AM and 9:18 AM. The finding was reviewed with facility leadership during the Life Safety Code exit conference on 12/9/25 at 3:14 PM. B. How the facility will correct the issue The facility ensured that required EXIT signs were provided and suitably illuminated by a reliable light source for exit access from enclosed courtyard areas, consistent with NFPA 101:2012 Edition requirements. Illuminated EXIT signage was placed to ensure at least two exits remote from each other are clearly identified for egress from the courtyards. Education was provided to all maintenance personnel by the Administrator regarding EXIT signage requirements. Education was completed	01/05/2026

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K0293 SS = E Bldg. 02	Continued from page 10 was determined the facility failed to ensure EXIT signs were suitably illuminated by a reliable light source in accordance with NFPA 101:2012 Edition, Section 19.2.10, 7.4, 7.10, 7.10.1.2.1, 7.10.1.2, 7.10.1.5, and 7.10.5.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 8:56 AM of the first enclosed courtyard, revealed 5 of the 6 doors to reenter the building had EXIT written on them, and there were no internally or externally illuminated EXIT signs. At least 2 exits remote from each other with illuminated EXIT signs would have been required for exit access from the area. Observations at 9:18 AM of courtyard #2 (enclosed courtyard), revealed 5 of the 5 doors to reenter the building had EXIT written on them, and there were no internally or externally illuminated EXIT signs. At least 2 exits remote from each other with illuminated EXIT signs would have been required for exit access from the area. In an interview at the time, the [redacted] confirmed the observations. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 12/9/25 at 3:14 PM. N.J.A.C. 8:39-31.2(e)	K0293	Continued from page 10 immediately upon correction and will be provided upon hire and annually thereafter. C. How the facility will prevent recurrence The Maintenance Director will update the facility's life safety inspection checklist to include verification of illuminated EXIT signage in enclosed courtyards and other exit access areas requiring identification. Maintenance staff will be re-educated on NFPA 101 requirements related to EXIT signage illumination and ongoing operational readiness. D. How the facility will monitor ongoing compliance The Maintenance Director or designee will complete weekly audits for 90 days of all EXIT signs throughout the facility, including enclosed courtyards, to ensure required signs are present and illuminated. Findings will be documented and any malfunctions corrected promptly. Audit results will be reviewed monthly at the QAPI meeting.	01/05/2026

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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 12/9/25. Mystic Meadows Rehabilitation and Nursing Center was found to be in non-compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		01/31/2026
E0006 SS = F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency	E0006	A. How the facility identified the issue The deficient practice was identified on 12/9/25 during record review and interview in the presence of the U. S. FOIA (b) (2) and U. S. FOIA (b) (2) Record review of the facility's Emergency Plan revealed there was no facility-based and community-based risk assessment utilizing an all-hazards approach, including missing residents. The U. S. FOIA (b) (2) and U. S. FO confirmed the record review. The finding was reviewed with facility leadership during the Life Safety Code exit conference at 3:14 PM. B. How the facility will correct the issue The facility completed and incorporated a documented facility-based and community-based all-hazards risk assessment into the Emergency Preparedness Plan, including risk considerations for missing residents and other emergency events likely to affect the facility. The emergency plan was updated to include strategies addressing emergency events identified by the completed risk assessment. The U. S. FOIA (b) (2) conducted education on the facility's Facility Assessment Policy, which includes the facility-based and community-based risk assessment. This education was conducted with the Administrator and Maintenance Director. All new hires will receive this education upon hire. C. How the facility will prevent recurrence The U. S. FOIA (b) (2) and U. S. FOIA (b) (2) will ensure the risk assessment and Emergency Preparedness Plan are reviewed and updated at least annually. The facility incorporated the risk	01/05/2026

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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E0006 SS = F	Continued from page 1 events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 12/9/25 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined the facility failed to ensure a facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents was performed and maintained as the bases for the emergency plan in accordance with CRF 483.73(a)(1)(2). This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facility's Emergency Plan revealed there was no risk assessment provided. In an interview at the time, the U. S. FOIA (b) (2) confirmed the record review.	E0006	Continued from page 1 assessment into the annual emergency preparedness review process to ensure the plan remains based on and includes an updated all-hazards assessment, including missing residents. D. How the facility will monitor ongoing compliance The Administrator or designee will conduct weekly audits for 90 days to verify the Emergency Preparedness Plan includes a current facility-based and community-based all-hazards risk assessment and corresponding strategies. Findings will be documented and any identified gaps corrected promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026

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E0006 SS = F	Continued from page 2 The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference at 3:14 PM. N.J.A.C. 8:39-31.6	E0006		01/05/2026
E0013 SS = F	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters	E0013	A. How the facility identified the issue The deficient practice was identified during record review and interview in the presence of the U. S. FOIA (b) (2) and U. S. FOIA (b) (2) Record review of the Emergency Plan revealed there were no Emergency Preparedness policies and procedures based on the emergency plan and facility-based/community-based risk assessment. The U. S. FOIA (b) (2) and U. S. FO confirmed the record review. The finding was reviewed with facility leadership during the Life Safety Code exit conference at 3:14 PM. B. How the facility will correct the issue The facility developed and implemented Emergency Preparedness policies and procedures aligned with the emergency plan and the facility-based/community-based all-hazards risk assessment. The updated EP policies and procedures were incorporated into the Emergency Preparedness program and made readily available to applicable staff. C. How the facility will prevent recurrence The U. S. FOIA (b) (2) conducted education on the facility's Emergency Management Plan, Emergency Management Policy, and the Facility Assessment Policy, which includes the facility-based and community-based risk assessment. This education was conducted with the U. S. FOIA (b) (2) and U. S. FOIA (b) (2). D. How the facility will monitor ongoing compliance The Administrator or designee will conduct weekly audits for 90 days to verify EP policies and procedures are present, current, and aligned with the emergency plan and risk assessment. Findings will be documented and gaps corrected promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026

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E0013 SS = F	Continued from page 3 likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 12/9/25 in the presence of the U. S. FOIA (b) (2) , it was determined the facility failed to ensure the development and implementation of Emergency Preparedness policies and procedures based on the emergency plan and facility-based and community-based risk assessment, utilizing an all-hazards approach, in accordance with CRF 483.73(b). This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facility's Emergency Plan revealed there were no Emergency Preparedness policies and procedures based on the emergency plan and facility-based and community-based risk assessment provided. In an interview at the time, the U. S. FOIA (b) (2) confirmed the record review. The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference at 3:14 PM. N.J.A.C. 8:39-31.6	E0013		01/05/2026
E0018 SS = F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)	E0018	The deficient practice was identified on 12/9/25 during record review and interview in the presence of the U. S. FOIA (b) (2) and U. S. FOIA (b) (2) Record review of the Emergency Plan revealed there	01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHABILITATION AND NURSING CENTER	151 NINTH AVENUE , LITTLE EGG HARBOR TW, New Jersey, 08087

(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
E0018 SS = F	Continued from page 4 §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or	E0018	Continued from page 4 were no EP policies and procedures for a system to track on-duty staff and sheltered residents during and after an emergency. The [redacted] and [redacted] confirmed the record review. The finding was reviewed with facility leadership during the Life Safety Code exit conference at 3:14 PM. B. How the facility will correct the issue The facility developed and implemented Emergency Preparedness policies and procedures establishing a system to track the location of on-duty staff and sheltered residents during and after an emergency, including documentation of the specific name and location of the receiving facility or other location if relocation occurs. The [redacted] conducted education on the facility's Emergency Management Plan, Emergency Management Policy, the Facility Assessment Policy, which includes the facility-based and community-based risk assessment, and the staff and resident tracking log. This education was conducted with the [redacted] and [redacted]. All new hires will receive this education upon hire. C. How the facility will prevent recurrence The Administrator and Maintenance Director will incorporate the staff/resident tracking process into emergency preparedness training and program review activities. The tracking procedure will be included in the facility's emergency preparedness documentation packet to ensure rapid implementation during an emergency. D. How the facility will monitor ongoing compliance The Administrator or designee will conduct weekly audits for 90 days to verify the tracking policies/procedures are present in the Emergency Preparedness program documents and available for implementation. Findings will be documented and corrected promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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E0018 SS = F	Continued from page 5 other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 12/9/25 in the presence of the U. S. FOIA (b) (2)), it was determined the facility failed to ensure emergency preparedness policies and procedures for a system to Track Staff and Patients was developed and implemented in accordance with CRF 483.73(b)(2). This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facility's Emergency Plan revealed there was no emergency preparedness policies and procedures for a system to track staff and patients provided. In an interview at the time, the U. S. FOIA (b) (2) confirmed the record review. The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference at 3:14 PM. N.J.A.C. 8:39-31.6	E0018		01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHABILITATION AND NURSING CENTER	**151 NINTH AVENUE , LITTLE EGG HARBOR TW, New Jersey, 08087**

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E0022 SS = F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 12/9/25 in the presence of the U. S. FOIA (b) (2) was determined the facility failed to ensure there were Emergency Preparedness (EP) policies and procedures to address a means to shelter in place for patients, staff and volunteers who remain in the facility in accordance with CRF 483.73(b)(4). This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facility's Emergency Plan revealed there were no EP policies and procedures to address a means to shelter in place for patients, staff and volunteers who remain in the facility provided.	E0022	A. How the facility identified the issue The deficient practice was identified on 12/9/25 during record review and interview in the presence of the U. S. FOIA (b) (2) and U. S. FOIA (b) (2) Record review of the Emergency Plan revealed there were no Emergency Preparedness policies and procedures to address sheltering in place for patients/residents, staff, and volunteers who remain in the facility. The U. S. FOIA (b) (2) and U. S. FO confirmed the record review. The finding was reviewed with facility leadership during the Life Safety Code exit conference at 3:14 PM. B. How the facility will correct the issue The facility developed and implemented Emergency Preparedness policies and procedures addressing shelter-in-place processes for residents, staff, and volunteers who remain in the facility, including operational procedures to maintain safety, continuity of care, communication, and supply/resource management during shelter-in-place events. The Regional Director of Operations conducted education on the facility's Emergency Management Plan, Emergency Management Policy, the facility's Shelter in Place Policy. This education was conducted with the Administrator and Maintenance Director. All new hires will receive this education upon hire. C. How the facility will prevent recurrence The Administrator and Maintenance Director will ensure shelter-in-place procedures are included in the annual Emergency Preparedness program review and incorporated into emergency preparedness training and drill planning to ensure staff familiarity and readiness. D. How the facility will monitor ongoing compliance The Administrator or designee will conduct weekly audits for 90 days to verify shelter-in-place policies and procedures remain present within the Emergency Preparedness program and are readily accessible. Findings will be documented and corrected promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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E0022 SS = F	Continued from page 7 In an interview at the time, the U. S. FOIA (b) (2) confirmed the record review. The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference at 3:14 PM. N.J.A.C. 8:39-31.6	E0022		01/05/2026
E0024 SS = F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of	E0024	A. How the facility identified the issue The deficient practice was identified on 12/9/25 during record review and interview in the presence of the U. S. FOIA (b) (2) and U. S. FOIA (b) (2)). Record review of the Emergency Plan revealed there were no EP policies and procedures for the use of volunteers or other emergency staffing strategies, including the process and role for integration of state and federally designated health care professionals during surge needs. The U. S. FOIA (b) (2) and U. S. FO confirmed the record review. The finding was reviewed with facility leadership during the Life Safety Code exit conference at 3:14 PM. B. How the facility will correct the issue The facility developed and implemented Emergency Preparedness policies and procedures addressing the use of volunteers and emergency staffing strategies, including the process and role for integrating state and federally designated health care professionals to address surge needs during an emergency. The Regional Director of Operations conducted education on the following facility policies: Emergency Management Plan, Emergency Management Policy, Shelter in Place Policy, Planning for Additional Staffing Needs, Formalized Agreements Contingencies, Informal Relationships, Coordinating Local Emergency Responders, Coordination with Community Resources, and Coordination with EMAs. This education was conducted with the Administrator and Maintenance Director. All new hires will receive this education upon hire. C. How the facility will prevent recurrence The Administrator will ensure the volunteer/staffing strategy procedures are incorporated into annual Emergency Preparedness program review activities and are included in emergency preparedness training and/or drill planning content to ensure	01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHABILITATION AND NURSING CENTER	151 NINTH AVENUE , LITTLE EGG HARBOR TW, New Jersey, 08087

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E0024 SS = F	Continued from page 8 State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 12/9/25 in the presence of the U. S. FOIA (b) (2) , it was determined the facility failed to ensure there were Emergency Preparedness (EP) policies and procedures for volunteers or other emergency staffing strategies in accordance with CRF 483.73(b)(6). This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facility's Emergency Plan revealed there were no EP policies and procedures for volunteers or other emergency staffing strategies, including the process and role for integration of state and federally designated health care professionals to address surge needs during an emergency provided. In an interview at the time, the U. S. FOIA (b) (2) confirmed the record review. The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference at 3:14 PM. N.J.A.C. 8:39-31.6	E0024	Continued from page 8 implementation readiness. D. How the facility will monitor ongoing compliance The Administrator or designee will complete weekly audits for 90 days to verify volunteer/emergency staffing strategy policies and procedures remain present and current within the Emergency Preparedness program. Findings will be documented and corrected promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026
E0026 SS = F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the	E0026	A. How the facility identified the issue The deficient practice was identified on 12/9/25 during record review and interview in the presence of the U. S. FOIA (b) (2) and U. S. FOIA (b) (2) Record review of the Emergency Plan revealed there were no EP policies and procedures for the facility's role under a waiver declared by the U. S. FOIA (b) (2) in accordance with section 1135 of the Act. The U. S. FOIA (b) (2) and U. S. FO confirmed the record review. The finding was reviewed with facility leadership during the Life Safety Code exit conference at 3:14 PM. B. How the facility will correct the issue The facility developed and implemented Emergency Preparedness policies and procedures that define the facility's role under a waiver declared by the Secretary (1135 waiver), including coordination with	01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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E0026 SS = F	Continued from page 9 following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the [redacted] in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 12/9/25 in the presence of the [redacted], it was determined the facility failed to ensure the development of emergency preparedness (EP) policies and procedures for the facility's role under a waiver declared by the [redacted] in accordance with CRF 483.73(b)(8). This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facility's Emergency Plan revealed there were no EP policies and procedures for the facility's role under a waiver declared by the [redacted] provided. In an interview at the time, the [redacted] confirmed the record review. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 3:14 PM. N.J.A.C. 8:39-31.6	E0026	Continued from page 9 emergency management officials and processes for providing care and treatment at an alternate care site as identified by emergency management officials. The Regional Director of Operations conducted education on the facility's Policy: Planning for Continuity of Operations (COOP). This education was conducted with the Administrator and Maintenance Director. All new hires will receive this education upon hire. C. How the facility will prevent recurrence The Administrator will ensure the 1135 waiver/alternate care site role is included in the annual Emergency Preparedness program review process to confirm the required content remains present and current. The content will be incorporated into Emergency Preparedness program education to ensure leadership awareness and readiness. D. How the facility will monitor ongoing compliance The Administrator or designee will conduct weekly audits for 90 days to verify EP policies and procedures include the facility's role under an 1135 waiver and remain readily accessible. Findings will be documented and corrected promptly. Results will be reviewed monthly at the QAPI meeting.	01/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - BUILDING** B. WING	(X3) DATE SURVEY COMPLETED **03/17/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYSTIC MEADOWS REHABILITATION AND NURSING CENTER	**151 NINTH AVENUE , LITTLE EGG HARBOR TW, New Jersey, 08087**

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K0000 Bldg. 02	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 3/17/2026 in relation to the 12/10/2025 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		12/26/2025

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: 315456	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 3/17/2026 in relation to the 12/10/2025 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		12/26/2025

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