New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 65A111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Standard and Complaint Complaint #: NJ 00166985 Census: 55 Sample Size: 13 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to develop a policy and procedure to track staff attendance at monthly fire drills to ensure annual attendance of each staff. This deficient practice was evidenced by the following: On 9/30/2024 at 10:03 a.m., the surveyor reviewed the facility monthly fire drill records from 6/2023 through, and including 9/2024, which revealed the number of staff that attended the monthly fire drills. However, the fire drill report did not include the names and titles of the staff that attended the fire drills. On 10/1/2024 at 9:23 a.m., the surveyor interviewed the Executive Director (ED) regarding the system used to track and record employee attendance at annual fire drills. The ED stated that he was new to the facility and that he was in the process of instituting a new employee fire drill attendance tracking system. The ED was unable to provide the surveyor with documented evidence to show the names of staff that participated in the annual fire drills. Additionally, the ED was unable to provide the surveyor with the facility policy and procedure for fire drills and tracking of staff attendance. Reference: A1041 8:36-14.3(a)	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ___ B. WING ___	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	**52 MADISON AVENUE LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	Continued From page 2	A 517		
A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19.	A 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined the facility failed to ensure that 5 of 10 staff members, whose personnel records were reviewed, received the required annual staff education. This deficient practice was evidenced by the following: On 10/01/2024, the Executive Director (ED), and the Business Office Director (BOD), provided the surveyor with the employee files for the 10 employees included in the employee sample. The review of the in-service training logs revealed that 5 of 10 employees had no documentation for some of the required in-services. The findings were as follows: 1. An employee with NJ Ex Order 26. 4B1 [redacted] had no documentation for the in-services on Infection Control and Emergency Training for NJ Ex Order 26. 4B1. 2. An employee with NJ Ex Order 26. 4B1 had no documentation for the in-services on Alzheimer Dementia and Pain Management since DOH. 3. An employee with NJ Ex Order 26. 4B1 had no documentation for the in-services on Alzheimer Dementia and Pain Management since DOH. 4. An employee with NJ Ex Order 26. 4B1 had no documentation for the in-services on Assisted	A 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ___ B. WING ___	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	Continued From page 4 Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Emergency Training, Alzheimer Dementia, and Pain Management for NJ Ex Order 26. 4B1. 5. An employee with NJ Ex Order 26. 4B1 had no documentation for the in-services on Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Emergency Training, Alzheimer Dementia, and Pain Management for NJ Ex Order 26. 4B1. The employees' hire dates were obtained from the employee list provided by the facility. The surveyor observed that the newly hired employees had an orientation post-test which documented that the review of some of the mandatory staff education. There were no questions observed on the post-test that reviewed Alzheimer Dementia or Pain Management. For the employees that were hired within the last calendar year, there were no additional in-services recorded in their files. During interview on 10/01/24 at 11:52 a.m., the ED and BOD confirmed that the in-services in the employee files were the most updated record, as of NJ Ex Order 26. 4B1. On 9/30/24 at 12:39 p.m., the facility provided the survey team with an undated facility policy titled, "IN-SERVICE TRAINING. Surveyor review of the policy revealed the following: ..."1. Records of all training classes are maintained in the Executive Director's office. 2. The Director of Wellness, or their designee, will be responsible for assuring that appropriate records are completed by the instructor...4. ...This record will be filed in the employee's personnel record. 5. Records of in-service training programs are maintained for a	A 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	Continued From page 5 period of three (3) years from the date of the training program."	A 517		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to comply with the provision of Chapter 24, N.J.A.C. 8:24. "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines": N.J.A.C. 8:24 - 3.3 (c)(1)(vi.), 8:24-6.7(j)(1-3), 8:24-6.7(i), 8:24-4.5(a), 8:24-3.6, 8:24-6.7(l) and 8:24-4.6(c), which placed the highly susceptible population/residents' health and safety at risk for foodborne illness, for which an Imminent Danger (ID) was identified. This deficient practice was evidenced by the following: 1. 8:24-3.3 (c)(1)(vi.) Food shall be protected from cross contamination by: Storing damaged, spoiled, or recalled food from being held in the retail food establishment as specified under	A 891		

(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) COMPLETE DATE
A 891	Continued From page 6 N.J.A.C. 8:24-4.6 On 9/30/2024 at 11:17 a.m., the surveyor observed three bottles of ketchup in the facility's walk-in refrigerator that had black substances which adhered to the ketchup bottles. At that time, the surveyor interviewed the facility's Food Service Director (FSD), who stated that the black spotted substance that adhered to the ketchup bottles was mold, and that he would discard the three bottles. 2. 8:24-6.7(j)(1-3) Each handwashing sink, or group of adjacent sinks, shall be provided with the following 1. Individual, disposable towels; 2. Continuous towel system that supplies the user with a clean towel; or 3. A heated-air hand-drying device. 8:24-6.7(i) Each handwashing sink or group of two adjacent sinks shall be provided with a supply of hand cleaning liquid, powder, or bar soap. 8:24-6.7(l) A handwashing sink or group of adjacent skinks that is provided with disposable towels shall be provided with a waste receptacle. On 9/30/2024 at 11:03 a.m., during the tour of the facility's kitchen, in the presence of the facility's FSD, the surveyor observed that one of the kitchen handwashing stations, located near refrigerator #4, did not contain paper towels, and soap. At that time, the surveyor interviewed the facility's FSD who stated that the handwashing station should've had paper towels and soap. 3. 8:24-4.5(a) Equipment and equipment components shall be maintained in a state of repair and condition that meets the requirements specified under N.J.A.C 8:24-4.1 and 4.2.	A 891		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 65A111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 7	A 891		

Continued From page 7

A. On 9/30/2024 at 11:09 a.m., during the tour of the kitchen with the facility's FSD, the surveyor requested that the FSD run the dishwasher, dishwasher #2, located in the dairy section of the kitchen, to observe the dishwasher's wash and rinse temperature, to ensure that the dishwasher's temperatures were within an acceptable range to effectively clean the facility's kitchenware. At that time the FSD stated that the surveyor would not be able to see the dishwasher's wash and rinse temperature due to the lights in the temperature display not working.

During continued surveyor interview the FSD stated that he was utilizing a handheld heat thermometer to read the wash and rinse temperature of the washer. The FSD stated that the dishwasher display light stopped working about a month prior to the date of the survey and that the last time the temperature of the dishwasher was read was on 9/25/2024, due to the FSD leaving the handheld heat thermometer at home. The FSD stated that there was no work order for the dishwasher, and that the dishwasher was still in use at the time of the interview.

On 10/1/2024 at 10:18 a.m., the surveyor observed a facility kitchen staff member utilizing the dishwasher to clean the facility's soiled kitchenware.

B. On 9/30/2024 at 11:05 a.m., during the tour of the kitchen with the facility's FSD, the surveyor observed a freezer in the facility's dairy section of the kitchen; at that time the FSD informed the surveyor that the freezer did not work due to the freezer not being able to drop below temperature of 20 degrees. The surveyor observed a box of individual styrofoam cups of chocolate ice cream

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ____ B. WING ____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 8	A 891		

in the freezer. During continued surveyor interview, the FSD stated that the ice cream was for the facility's residents, and the ice cream should have in the facility's basement freezer.

4. 8:24-3.6(c)(1)(2) Bulk food that is available for consumer self-dispensing shall be prominently labeled with the following information in plain view of the consumer: 1. The manufacturer's or processor's label that was provided with the food; or 2. A card, sign, or other method of notification that includes the following: i. The common name of the food or, absent a common name, an adequately descriptive identity statement; ii. If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservative, if contained in the food;

On 9/30/2024 at 10:36 a.m., during the tour of the facility kitchen, in the presence of the facility's FSD, the surveyor observed the following opened items stored under the facility's food preparation area that were not labeled with open date or expiration date:

- 1 bottle of honey
- 1 gallon of gravy booster
- 1 gallon of vanilla flavoring
- 1 gallon of soy sauce

In addition, at that time, the surveyor also observed two bags of sugar open to air with no date. The above-mentioned items also contained a gray furry substance which adhered to the bottles. The bottle of honey had also leaked onto the other bottles.

At that time the surveyor interviewed the FSD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 9	A 891		

who stated that the facility didn't usually date the food items as long as they were not expired. At that time the surveyor also observed the FSD throwing the above-mentioned items in the trash.

At 10:41 a.m., the surveyor observed the following open items that were not dated and/or labeled:
- 2 bags of breadcrumbs (1 bag of breadcrumbs was open to air)
- 1 bag of unbleached flour
- 1 bundle of saran wrapped lasagna pasta (not labeled)
- 1 bag of egg noodles (not labeled)
- 1 bag of spaghetti noodles (not labeled)
- 1 bag of penne noodles (not labeled)
- 1 bag of fine egg noodles (not labeled)
- 2 tubs of peanut butter
-

At 10:57 a.m., the surveyor observed the following open items that were not labeled or dated:
- 1 bag of macaroni noodles
- 1 bag of ziti noodles
- 1 bag of lasagna noodles
-

At that time the surveyor interviewed the facility's FSD who stated that the above-mentioned items should've been labeled and dated.

At 10:59 a.m., the surveyor observed the following opened items in the food prep area in the dairy side of the facility's kitchen:
- 1 bottle of gravy master that was expired on 3/9/2024.
- 1 bottle of Worcestershire sauce (not dated - gray furry substance adhered to the bottle)
- 1 gallon of soy sauce (not dated)
- 1 bottle of brandy alcohol (not dated)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ________ B. WING ________	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 10	A 891		

At 11:18 a.m., the surveyor observed a large pan of marinara sauce with out a date in the facility's walk-in refrigerator. At that time the surveyor interviewed the facility's FSD who stated that the marinara sauce was from 9/27/2024 and should have been dated.

At 11:19 the surveyor observed the following opened items in the facility's lower-level pantry area:

- 1 foiled wrapped pudding (not dated, not labeled)
- 1 foil ziplock bag of stuffing (not dated)
- 1 bag of stuffing, mixed chicken garlic flavor (not dated)

At 11:21 a.m., the surveyor observed a large saucepan of chicken stock that was open to air, absence of label and date. At that time, the FSD stated the chicken stock was form 9/25/2024 and should've been labeled and dated.

5. 8:24-4.6(c) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris

At 10:33 a.m., during tour the facility's kitchen, in the presence of the facility's FSD, the surveyor observed a stove and conventional oven that had a thick black substance and small brown and black particles. At that time the surveyor interviewed the facility's FSD who stated that stove and conventional needed to be cleaned.

At 10:55 a.m., the surveyor observed the facility's ice maker and ice scoop/holder. The surveyor noted black substances that adhered to the inside of the ice maker and along the side of the opening. The surveyor used a white disposable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 65A111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 11	A 891		

paper towel and wiped the inside rim of the ice machine, which revealed a black substance on the paper towel. The surveyor observed that the ice scoop holder, with the ice scoop inside, had small multi-colored dark particles on the ice scoop and the holder. At that time the FSD stated that he would clean the ice machine and holder.

At 11:08 a.m., on the dairy side of the kitchen, the surveyor observed a tabletop can opener that had multiple substances which adhered to the can opener, and the can opener attached to the table. At that time, the FSD stated that the can opener needed to be cleaned.

At 11:19 a.m., in the facility's lower-level kitchen storage area, the surveyor observed a tabletop can opener which had multiple substances in different variations of colors that adhered to the can opener, and the can opener holder attached to the table. At that time, the FSD stated that the can opener needed to be cleaned.

At 11:23 a.m., the surveyor observed the facility's uncovered mixer which had a coating of white particles. At that time, the FSD stated that the mixer was not cleaned and that it should've been cleaned.

The ID was reported to the Licensed Assisted Living Administrator on 9/30/2024 at 3:00 p.m. The Administrator was presented with the ID template, which included information about the concerns listed above.

On 10/1/2024, the surveyor verified that the Removal Plan was implemented, and it included education on the Policy for Cooling and Reheating Food to the Proper Temperatures to Assure Food Safety, and training on temping and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ____ B. WING ____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	**52 MADISON AVENUE LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 12 cooling during meal times by the dietary manager.	A 891		
A 901	8:36-10.5(c)(4) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 4. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus shall be posted in a conspicuous place in residents' area, and/or a copy of the menu shall be provided to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with changes or substitutes, shall be kept on file in the facility for at least 30 days; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post menus with portion sizes in the kitchen preparation area when plating the facility residents' meals. In addition, the facility failed to post menus in a manner so that they were clearly visible to the residents, and/or provide a copy of the menu to each resident. This deficient practice was evidenced by the following: 1. On 9/30/2024 at 11:40 a.m., during a tour of the facility's kitchen, the surveyor did not observe a menu with portion sizes at the facility's preparation area of the facility's kitchen. At that	A 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ___ B. WING ___	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 13 time, the surveyor interviewed the facility's Food Service Director (FSD) who stated that the facility did not utilized menus with portion sizes to plate residents' food. Additionally, the facility's FSD presented the surveyor with two-four ounce serving spoons and stated that the facility served residents four ounces of each item on the menu. At 12:29 p.m., while lunch was being served, the surveyor observed a facility Server, Server #2, plating a facility's resident's meal without the use of a menu with portion sizes. At 12:30 p.m., the surveyor observed a different facility Server, Server #1, plating a facility's resident's meal utilizing four-ounce spoons without the use of a menu with portion sizes. During interview Server #1 stated that the facility did not utilize menus with portion sizes and that she was instructed to use four-ounce serving spoons, which she presented to the surveyor. At 12:30 p.m., after the surveyor interviewed the facility's FSD who again stated that the facility's staff did not utilize menus with portion sizes and that he was the only facility member that had a certification in food handling. On 10/1/2024 at 12:04 p.m., the surveyor observed the facility's Dietary Aide as she plated a facility resident's plate without the use of the menu with portion sizes. At that time the Dietary Aide stated that she utilizes scoops to plate the food; the Dietary Aide presented the surveyor with four-ounce spoons. 2. On 9/30/2024 at 10:17 a.m., during a tour of the facility, the surveyor, in the presence of the facility's Director of Nursing, and did not observe a monthly menu posted in the residents' areas.	A 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 14 The surveyor observed daily menus which listed the breakfast, lunch, and dinner for that day only. At 12:52 p.m., the surveyor interviewed the facility's FSD who stated that the facility did not post a monthly menu or provide a monthly menu to the facility residents. During continued surveyor interview, the facility's FSD stated that only a menu is posted daily.	A 901		
A 907	8:36-10.5(c)(7) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 7. Between-meal snacks and beverages shall be available at all times for each resident, unless medically contraindicated as documented by a physician in the resident's health care plan; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that snacks were available for residents at all times. This deficient practice was evidenced by the following: On 9/30/2024 at 10:17 a.m., the survey team toured the facility with the facility's Director of Nursing (DON), during the tour, the survey team did not observe snacks available to the facility's residents. At 12:32 p.m., the surveyor interviewed the facility's Food Service Director (FSD) who stated	A 907		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 907	Continued From page 15 that snacks are not always available to the facility's residents, only during the holidays. At 12:45 p.m., the surveyor interviewed Resident #4 who stated that the facility does not leave snacks out that he/she could grab independently but that he/she can ask for it and receive it.	A 907		
A 913	8:36-10.5(c)(10) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 10. All meals shall be served at the proper temperature and shall be attractive when served to residents. Place settings and condiments shall be appropriate to the meal; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and in accordance with the New Jersey Administrative Code (N.J.A.C.) 8:24, "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines" it was determined that the dietary staff failed to monitor and record food temperatures in order to ensure meals were served at the proper temperatures, to prevent the risk of residents contracting food borne illnesses. This deficient practice was evidenced by the following: On 9/30/2024 at 11:00 a.m., the surveyor interviewed the facility's Food Service Director (FSD) and requested the facility's meal temperature logs, which documented monitoring	A 913		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 913	Continued From page 16 of the temperatures of food being served to the facility residents, for 2 weeks prior to the survey. At 12:35 p.m., the surveyor observed the lunch meal as it was served to the facility residents. The surveyor did not observe staff taking the temperature of the food. At 12:42 p.m., the surveyor requested the facility's server, who also plates food, to check the temperature of a plate being served to a resident. The temperature of the baked cheese blintzes was 100 degrees, and the piece of fish was temped at 95 degrees. At 12:53 p.m., the surveyor interviewed the facility's FSD who stated that the facility's kitchen staff does not check food temps. At that time, the FSD provided the surveyor with the requested documentation. At 1:00 p.m., the surveyor reviewed the requested documentation from the FSD and observed that it did not include the past two weeks of temperature readings for food that was served to the facility residents. The baked cheese blintzes and fish temperatures should have been at 135 degrees or above. The facility failed to confirm that food was at proper temperatures before serving to the facility residents. Due to not checking the temperature of the baked cheese blintzes and fish, the FSD was not aware of the improper temperatures. The ID was reported to the Executive Director (ED) on 9/30/24 at 3:00 p.m. The ED was presented with the ID template, which included information about the concerns listed above.	A 913		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	**52 MADISON AVENUE LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 913	Continued From page 17 Surveyor review of the facility's policy titled, "COOLING AND REHEATING" which revealed, "POLICY TO PROPERLY COOL AND HEAT FOOD TO PROPER TEMPERATURES TO ASSURE ALL FOOD IS SAFE TO CONSUME FOR OUR RESIDENTS. PURPOSE ALL FOOD IS SERVED IN A SAFE AND SANITARY MANOR. PATHOGENS GROW WELL IN THE TDZ [Temperature Danger Zone] (41-135). HOWEVER, THEY GROW FASTER AT TEMPERATURES BETWEEN 125-70. FOOD MUST PASS THROUGH THIS TEMPERATURE RANGE QUICKLY TO REDUCE THIS GROWTH. RESPONSIBILITY FOOD SERVICE DIRECTOR ... REHEAT COMMERCIALLY PROCESSED AND PACKAGED READY TO EAT FOOD TO AN INTERNAL TEMPERATURE OF AT LEAST 135 DEGREES F. THIS INCLUDES ITEMS SUCH AS CHEESE STICKS AND DEEP FRIED VEGETABLES ..." On 10/1/24, the surveyor verified that the Removal Plan was implemented that included education on the Policy for Cooling and Reheating Food to the Proper Temperatures to Assure Food Safety and training on temping and cooling during meal times by the dietary manager.	A 913		
A 975	8:36-11.7(a)(1) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart.	A 975		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 975	Continued From page 18 1. The storage area shall be kept locked when not in use. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure the medication refrigerators were locked for 2 of 2 medication refrigerators, Refrigerator #1 and Refrigerator #2. This deficient practice was evidenced by the following: On 9/30/2024 at 10:28 a.m., the surveyor observed that there was no lock on Refrigerator #1 which contained resident medication. The surveyor also observed that the refrigerator did not contain a medication lock box. At 10:30 a.m., the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that there was no lock for the medication refrigerator nor a refrigerator narcotic lock box. At 10:51 a.m., the surveyor observed there was no lock on the second-floor medication refrigerator, Refrigerator #2. In addition, the surveyor observed that Refrigerator #2 also did not contain a medication lock box. At 10:59 a.m., the surveyor interviewed LPN #2 who also stated that there was no lock for the medication refrigerator, nor a narcotic medication lock box.	A 975		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ____ B. WING ____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 975	Continued From page 19 At 12:05 p.m., the surveyor interviewed the Director of Nursing (DON) who stated that there were no locks or lock boxes for the refrigerated medications. In addition, the DON stated that there were no narcotics at the facility that required refrigeration on the day of survey. The surveyor reviewed the facility policy and procedure titled, "Medication Storage" which indicated "...2. The storage area shall be kept locked at all times when not in use. ..."	A 975		
A1041	8:36-14.3(a) Emergency Services and Procedures (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 9/30/24 and 10/1/24, it was determined that the facility	A1041		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1041	Continued From page 20 failed to develop and maintain documentation of employee participation and attendance for one fire drill annually. This deficient practice was evidenced by the following: On 9/30/2024 at 10:03 a.m., the surveyor reviewed the facility monthly fire drill records dated from 6/2023 through and including 9/2024 which revealed the number of staff that attended the monthly fire drills. However, the fire drill report did not include the names and titles of the staff that attended the drill. On 9/30/2024 at 2:05 p.m., the surveyor interviewed the Certified Nursing Aide (CNA) regarding training and fire drills at the facility. The CNA stated that she received in person training and that the facility had monthly fire drills. On 9/30/2024 at 2:11 p.m., the surveyor interviewed the Housekeeper (HK) regarding participation in facility fire drills. The HK stated that she participated in the facility fire drills but was unsure of the date. On 10/1/2024 at 9:23 a.m., the surveyor interviewed the Executive Director (ED) regarding the system used to track and record employee attendance at annual fire drills. The ED stated that he was NJ Exec Order 26.4b1 and that he was in the process of instituting a new employee fire drill attendance tracking system. The ED also stated that he was unable to provide documented evidence to show the names of staff who participated in annual fire drills. In addition, the ED was unable to provide the surveyor with the facility policy and procedure for fire drills and tracking of staff attendance.	A1041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1169	Continued From page 21	A1169		
A1169	8:36-16.15(a) Physical Plant (a) Fire extinguishers shall comply with National Fire Protection Association (NFPA) 10, Standards For Portable Fire Extinguishers, 2002 edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 9/30/2024 in the presence of facility management, it was determined that the facility failed to: Perform a monthly examination for 27 of 27 portable fire extinguishers observed and inspected as required by National Fire Protection Association (NFPA) 10, 2010 Edition, Sections - 4.3 and N.J.A.C. 5:70. This deficient practice was evidenced by the following: References: NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any	A1169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 65A111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1169	Continued From page 22 conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. On 9/30/2024 during the survey entrance at approximately 9:35 a.m., with the facility Administrator, and Regional Maintenance Director (MD), the surveyor requested a copy of the facility lay-out which identifies the various rooms. Surveyor review of the facility provided lay-out identified the facility is a three-story (3) building with a basement. Beginning at 10:35 a.m., in the presence of the facility's MD, the surveyor toured the building and observed and inspected Thirty (30) fire extinguishers in various locations that were last annually inspected July 2024. There was no evidence of a monthly visual examination being performed and documented for August 2024 on the tags attached to the following fire extinguishers, 1. On the 3rd. floor Facility Identification (FI) numbers, FI-24, FI-25, FI-28, FI-27, FI-26, FI-23 and FI-22. 2. On the 2nd. floor, FI-16, FI-15, FI-17, FI-18, FI-20 and FI-21. 3. On the basement level, there was (1) one ABC extinguisher next to elevator #3, (1) one BC type fire extinguisher inside the elevator mechanical	A1169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ___ B. WING ___	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1169	Continued From page 23	A1169		

room, and (1) one ABC type fire extinguisher in the Salon and FI- 32.

4. On the first floor, there was (1) one ABC type fire extinguisher in the dining room, FI- 5, FI- 10, FI- 13, FI- 14, FI- 12, FI- 11, FI- 9 and two (2) "Class- K Wet Chemical" fire extinguishers in the kitchen.

During surveyor interview with the MD at the time of the observations, he confirmed the findings at the time of observations.

NFPA 10
NJAC 8:36 -16.15 (a).

A1179 | 8:36-17.1(a) Housekeeping-Sanitation-Safety-Maintenance | A1179

(a) The facility shall provide and maintain a sanitary and safe environment for residents.

This REQUIREMENT is not met as evidenced by:
Based on interview and review of facility documents, it was determined that the facility failed to ensure that the kitchen was maintained in sanitary conditions. This deficient practice was evidenced by the following:

On 9/30/2024 and 10/1/2024 the Department of Health (DOH) conducted a standard survey at the facility. During a tour of the kitchen the surveyor observed that the facility kitchen was not in compliance with sanitary regulations according to N.J.A.C. 8:24, "Sanitation in Retail Food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1179	Continued From page 24 Establishments, ..." On 10/1/2024 at 9:14 a.m., the surveyor interviewed the Executive Director (ED) regarding the last sanitary Local Health Department (LHD) inspection. The ED stated that the last inspection was in the year 2017. The surveyor then requested a copy of the sanitary report with comment sheet for review. At 9:45 a.m., the ED provided the surveyor with a copy of the facility "County Health Department Sanitary Inspection Report" but was unable to provide the surveyor with a copy of the comment sheet. The surveyor then reviewed the inspection report which revealed that the facility was last inspected on 3/22/17 and findings at that time were "Satisfactory." During surveyor interview with the ED, he acknowledged that the facility was not inspected for sanitation in seven years. Further, the ED stated that he called the LHD and the facility would receive a sanitation inspection on 10/8/24. Reference: A0891, 8:36 - 10.5(a), A0913, 10.5(c)(10)	A1179		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ____ B. WING ____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1249	Continued From page 25	A1249		

Continued From page 25

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined that the facility failed to maintain 8 of 25 battery back-up illuminated exit signs in proper working condition, and failed to ensure a window screen was maintained for 1 of 13 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 9/30/2024 during the survey entrance conference, at approximately 9:35 a.m., with the facility Administrator, and Regional Maintenance Director (MD), the surveyor requested a copy of the facility lay-out which identifies the various rooms and smoke compartments. The surveyor also asked the MD if the facility had an Emergency Generator. The MD stated that they had a generator and battery back up systems for emergency lights and illuminated exit signs.

Surveyor review of the facility provided lay-out identified the facility is a three-story (3) building with a basement.

The surveyor began the tour of the facility at 10:35 a.m., in the presence of the facility's MD. Along the building tour the surveyor observed and tested 25 battery back-up illuminated exit signs with the following exit signs that did not function properly in the following locations:

1. On the third floor at 10:39 a.m., one (1) battery

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1249	Continued From page 26 back up illuminate exit sign above the double smoke doors next to resident apartment #[NJ Exec O] when tested did not function properly. . 2. At 10:41 a.m., one (1) battery back up illuminated exit sign next to stairwell #3 when tested did not function properly. 3. At 10:43 a.m., two (2) battery back up illuminated exit signs above the double smoke doors (one on each side) near the residents laundry room when tested did not function properly. 4. At 10:48 a.m., two (2) battery back up illuminated exit signs above the double smoke doors (one on each side) near the South wing when tested did not function properly. 5. At 10:51 a.m., one (1) battery back up illuminated exit sign across from elevator #1 when tested did not function properly. 6. At 10:57 a.m., one (1) battery back up illuminated exit sign next to stairwell #6 when tested did not function properly. Complaint#: NJ00166985 7. On 9/30/24 at 9:40 a.m., the surveyor interviewed the MD and asked what the process was for repairs if needed in a resident's room. The MD stated that there is a maintenance binder (MB) and it is kept at the receptionist's desk. The MD further stated that residents, staff, or a family member could notify the Concierge and it gets documented in the MB as a work order. The surveyor interviewed the Concierge on 9/30/24 at 10:42 a.m., who stated that once she enters work orders into the MB the maintenance	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	**52 MADISON AVENUE LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1249	Continued From page 27 staff review it and sign off on the work order once the repairs are completed. At 11:10 a.m., the surveyor reviewed the MB from August 2023 and there were no repairs requested for Resident #2's window or screen. At 11:38 a.m., the surveyor interviewed Resident #2, who stated that the window was fixed during the summer, however; at that same time the surveyor observed on the bottom of the double window, the right side in the resident's room, the screen was torn. At 12:05 p.m., the surveyor requested a "Maintenance" policy and the Administrator stated that there was no Maintenance policy.	A1249		
A1275	8:36-18.2(a)(1) Infection Prevention and Control Services (a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications and OSHA standards, incorporated herein by reference, as amended and supplemented: 1. Guidelines for Hand Hygiene in Health Care Settings, MMWR/51 (RR-16), October 25, 2002; This REQUIREMENT is not met as evidenced	A1275		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1275	Continued From page 28	A1275		

by:
Based on observation and interview, it was determined that the facility's staff failed to perform proper hand hygiene technique in accordance with the Centers for Disease Control (CDC) recommendations and the facility's policy titled, "HANDWASHING" for 2 of 2 staff members observed for handwashing: Food Service Director (FSD) and Server. This deficient practice was evidenced by the following:

On 9/30/2024 at 11:36 a.m., the surveyor observed the facility's FSD washing his hands at a handwashing sink located in the facility's kitchen. The FSD turned on the faucet, wet his hands, lathered the soap in his hands for 9 seconds, rinsed his hands, then dried his hands with a paper towel. At that time, the surveyor interviewed the FSD who stated that he was educated on proper handwashing.

At 11:39 a.m., the surveyor observed the facility's Server, Server #1 washing her hands at a handwashing sink located in the facility's kitchen. Server #1 turned on the faucet, wet her hands, later the soap in her hands for 10 seconds, touched the faucet with her bare hands, rinsed her hands, then dried her hands with a paper towel. Immediately after the handwashing observation, the surveyor interviewed the facility's Server who stated that she was educated on proper handwashing.

Surveyor review of the facility's policy titled, "HANDWASHING" revealed, "POLICY... 6. Lather well making sure the lather extends at least one inch past your wrist. Continue for at least 20 seconds."

As per CDC guidelines, handwashing should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A111	A. BUILDING: ______ B. WING ______	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1275	Continued From page 29 consist of scrubbing one's hand for 20 seconds. Reference: https://www.cdc.gov/clean-hands/about/index.html	A1275		

POC #3
Rcd 3/13/25
accepted
3/18/25

The Lakewood Courtyard
52 Madison Avenue
Lakewood, NJ 08701

A310 8:36-3.4(a)(1) Administration

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

No residents were found to be affected by the deficient practice.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents have the potential to be affected by the deficient practice in an emergency situation.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

A spreadsheet was created on February 20th, 2025, to track team member attendance at fire drills and annual required trainings. All staff necessary, department managers & ED (Executive Director/CALA) were in-serviced on the spreadsheet by February 28th.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The CALA or their designee will review the spreadsheet for compliance every month to ensure all team members have received the proper training.

Completion Date: February 28th , 2025

A517 8:36-5.6(b)(1-7) General Requirements

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

No residents were found to be affected by the deficient practice.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents have the potential to be affected by the deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur:

A training spreadsheet will be created and implemented by the Executive Director for all mandatory training. This spreadsheet was created on February 20th, 2025. The following In-services will be completed with all staff, including those identified in the deficiency, by March 15th , 2025: Provision of services and assistance in accordance with the concepts of Assisted Living and including care of residents with physical impairments, Emergency plans & procedures, infection prevention and control program, resident rights, abuse and neglect, pain management, the care of resident with Alzheimer's and related dementia conditions and in accordance with NJAC 8.36-19.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The CALA or their designee will review the spreadsheet for compliance every month to ensure all team members have received the proper training.

Completion Date: March 15th , 2025

A891 8:36-10.5(a) Dining Services

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

All residents were affected by these deficient practices. Systemic changes in practice and oversight are needed to correct these deficient practices.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents had the potential to be affected by these deficient practices.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Dietary Director will ensure all food items will be labeled and dated, and the refrigerator will be checked daily for expired or unsafe food items. The ketchup and all other non-dated items were disposed of during the survey.

The handwashing sink was immediately stocked with proper supplies. The dietary director will add handwashing sink checks to the assignments for the servers for each shift.

The dishwasher thermostat was initially put out of service during the survey due to the display lights not working. It was repaired on October 7th, 2024, and the temperatures were within the required ranges. The staff is now taking temperatures and logging them as required three times per day.

The freezer in question was immediately emptied, the food disposed of, and it was marked as out of service. It remains out of service currently, and it is unplugged and sealed shut so no one can use it.

Our Regional Director of Dietary Services was brought in, and he inspected the kitchen and disposed of every open food item in the kitchen since dates were unknown and some were stored improperly. All dietary staff will be in-serviced on proper labeling and storage. This will be checked daily by the Dietary Director or their designee.

Cleaning logs will be created for the kitchen and equipment. All dietary staff will have assignments for cleaning for each shift to maintain a clean kitchen.

The CALA or his designee will make weekly spot checks to ensure that the kitchen and equipment is clean, organized and all food labeled and dated. The handwashing sinks are fully stocked, and the dishwasher temperature logs are completed, and temperatures are within range. That all dietary equipment is functioning, and all open food items are labeled, dated, and stored properly

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The Dietary Director will be responsible for checking the above corrections daily during his morning walk through. He will address any concerns with the staff, and he will correct any issues. When the Dietary Director is not there, his designee will be responsible for ensuring that the corrections are in place.

The dietician will include these items in her quarterly inspection and provide that documentation to the CALA.

For the next 6 months, there will be a monthly unannounced inspection for the kitchen conducted by our Regional Dietary Director. A report will be provided to the community Dietary Director, CALA, and the Corporate Team. Disciplinary will be taken and documented if necessary.

Completion Date: March 1st , 2025

<u>A901 8:36-10.5(c)(4) Dining Services</u>

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

All residents were affected by the deficient practice.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents have the potential to be affected by the deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

A menu will be created with the dietician and the resident's input that is within the Glatt Kosher Guidelines that meets the resident's needs. The dietician will create portion sizes for each food item and this menu will be printed and posted for those plating and serving to utilize. A weekly menu will be posted for the residents to reference. All kitchen and serving staff were inserviced on the new menus with the portion sizes and how to use them between the 28th and the 29th of January, 2025.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The Dietary Director will be responsible for ordering and providing the food necessary for the menu to be produced and ensuring that the Cooks are following the menu as written.

The CALA or his designee will make weekly spot checks to ensure that the kitchen is providing the meals as written on the menu.

The CALA or his designee will check weekly to ensure that week's menu is posted for the residents.

The CALA or his designee will observe one of each meal service weekly to ensure proper portions are being served for the first month and then spot check randomly.

Completion Date: January 29th , 2025

A907 8:36-10.5(c)(7) Dining Services

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

Snacks will be available 24 hours per day/7 days per week in the Bistro. There is a water cooler available in the lobby 24 hours per day/ 7 days per week. Additional beverages will be available by request.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents had the potential to be affected by the deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Snacks will be available 24 hours per day/7 days per week in the Bistro. There is a water cooler available in the lobby 24 hours per day/ 7 days per week. Additional beverages will be available by request.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The CALA will assign a designee who will ensure that there are snacks and beverages easily accessible to the residents at all times. We will in-service the staff so they know about snacks being available 24 hours per day and alert them to where they can refill snacks from if they run out during hours that the kitchen is closed.

Completion Date: March 15th , 2025

A913 8:36-10.5(c)(10) Dining Services

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

All residents were affected by the deficient practice. On October 1st, 2024, this correction was put into place before the surveyor left the community.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents were affected by the deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Removal Plan requested by the Department of Health was facilitated and all necessary dining staff were in-serviced on food temperatures and cooling. Temperature logs were put into place for all meals and all staff were in-serviced on how to use them.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

At this time, all temperature logs have been completed since this violation and inspected by the CALA and the Dietary Director. The Dietary Director or his designee will ensure the temperature logs are completed for each meal.

This will be reviewed monthly during the Regional Dietary Directors unannounced inspections. The CALA or their designee will continue to spot check during meal service to ensure these logs are completed.

Completion Date: October 1st, 2024

A975 8:36-11.7(a)(1) Pharmaceutical Services

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

We replaced the medication refrigerators in question on October 4th, 2024. The new refrigerators are both equipped with narcotic lock boxes and they both lock.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents had the potential to be affected by the deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Medication staff was in serviced on the requirement that these refrigerators remain locked when they are not utilizing them on October 4, 2024, by our Director of Nursing, Irene Yambao, RN.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The DON or her designee will spot check to ensure the refrigerators are locked at least once per week and will document her findings in a refrigerator log.

Completion Date: October 4th, 2024

A1041 8:36-14.3(a) Emergency Services and Procedures

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

No residents were found to be affected by the deficient practice.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents have the potential to be affected by the deficient practice in an emergency.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

A spreadsheet will be created to track team members' attendance at fire drills.

A training spreadsheet was created and implemented by the Executive Director to track team members' names and indicate their last attendance at a fire drill. This will ensure that we can identify all staff are participating in at least 1 drill per year. There will be a sign in sheet maintained for all fire drills. This spreadsheet was created on February 20th, 2025. The facility managers were educated on this spreadsheet and it is being maintained and updated by the Executive Director or their designee.

We are contracted with [redacted: NJ Exec Order 26] to provide 1 drill per month and 1 disaster drill per year. A trained member of our company may do additional drills as needed to ensure all team members meet this requirement.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The CALA or their designee will review and update the spreadsheet for compliance every month to ensure all team members have received the proper training.

Completion Date: March 24th, 2025

A1169 8:36-16.5(a) Physical Plant

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

No residents were found to be affected by the deficient practice.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents could be affected by the deficient practice in an emergency.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

All 27 fire extinguishers noted in the deficiency were inspected by October 14th, 2024. All Fire exit signs were repaired as of October 14th, 2024.

Direct Supply [redacted: NJ Exec Order 26] is a technology-based system for delivering life safety, asset management, maintenance, and repair services to building management professionals. [redacted: NJ Exec Order 26] allows our Maintenance and Administrative teams to track work orders, inspections and tasks. We started using [redacted: NJ Exec Order 26] on January 13th, 2025, to assist with plant operations upkeep and reminders. The Plant Operations Director will receive a notification now through [redacted: NJ Exec Order 26] to remind him of the monthly inspection obligation for fire extinguishers. The users of this system were inserviced on the new system during the week of January 7th, 2025.

We have started using a spreadsheet with all fire extinguishers listed and all Exit signs to ensure completion of all extinguishers and that none will be missed.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The CALA or their designee will review the spreadsheet for compliance every month to ensure all fire extinguishers were inspected and conduct spot checks of extinguishers tags while walking the community.

Completion Date: January 13th, 2025

A1179 8:36-17.1(a) Housekeeping – Sanitation – Safety - Maintenance

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

All residents were found to be affected by the deficient practice.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents have the potential to be affected by the deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Ocean County Health Department came out to inspect our kitchen on October 8th, 2024, and deemed it Satisfactory.

Direct Supply NJ Exec Order 26 is a technology-based system for delivering life safety, asset management, maintenance, and repair services to building management professionals. NJ Exec Order 26 allows our Maintenance and Administrative teams to track work orders, inspections and tasks. We started using NJ Exec Order 26 on January 13th, 2025, to assist with plant operations upkeep and reminders. The CALA will receive a notification now through NJ Exec Order 26 to remind him of the annual inspection and prompt him to call the Ocean County Health Department if they have not come out to inspect before the certificate expires.
The users of this system were inserviced on the new system during the week of January 7th, 2025.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The CALA or their designee will set the NJ Exec Order 26 notification 11 months after the last inspection of October 8th, 2024, to contact the Ocean County Health Department to make sure they have us scheduled for inspection.

Completion Date: January 13th, 2025

POC ACCEPTED 3/18/2025 NJ Ex Order 26. 4B1

A1249 8:36-17.7 Housekeeping- Sanitation-Safety-Maintenance

1) How the corrective action will be accomplished for those found to have been affec[ted] by the deficient practice:

Resident #2's screen was repaired on October 4th, 2024.
All 8 exit lights were repaired or replaced by October 14th, 2024.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents have the potential to be affected.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Direct Supply [NJ Exec Order]S is a technology-based system for delivering life safety, asset management, maintenance, and repair services to building management professionals. [NJ Exec Order]S allows our Maintenance and Administrative teams to track work orders, inspections and tasks. s. We started using [NJ Exec Order]S January 13th, 2025, to manage work orders and task delegation for our maintenance team. The front desk will enter all work orders and maintenance requests into [NJ Exec Order]S. The Plant Operations Director will receive a notification now through [NJ Exec Order]S with all open work orders and he can utilize it to assign that task or complete it himself.

The users of this system were inserviced on the new system during the week of January 7th, 2025 by the Plant Operations Director, who was trained virtually through an online webinar with the [NJ Exec Order]S trainer.

An audit of all resident rooms started on January 23rd and will be completed by March 15th to check for any maintenance concerns. The CALA or their designee will enter work orders into [NJ Exec Order]S for any concerns that were found on the room audits.

A visual inspection is done monthly for all Exit signs to ensure they are working. This is documented on a checklist and maintained in a binder by the Plant Operations Director.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The CALA or their designee will review open work orders in [NJ Exec Order]S weekly to ensure completion.

Completion Date: March 15th, 2025

<u>A1275 8:36-18.2(a)(1) Infection Prevention and Control Services</u>

1) How the corrective action will be accomplished for those found to have been affected by the deficient practice:

No residents were identified as having been affected by the deficient practice.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents have the potential to be affected by the deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Our Infection Control Nurse or her designee will conduct in-services with all departments on

proper handwashing procedure, including demonstration of proper technique and timeframe by March 17th, 2025.

The Dietary Department was in serviced on Handwashing procedure, including the Food Service Director and Server #1 who were listed in the deficiency during the survey.

Handwashing training will be conducted annually as per regulation and additionally as needed.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

The CALA or his designee will observe one of each meal service weekly to ensure proper handwashing technique is being utilized by all dining staff.

Completion Date: March 17th, 2025

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 65A111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED R-C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments Initial Comments: Type of Survey: Standard and Complaint Complaint #: NJ 00166985 Census: 55 Sample Size: 13 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	{A 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/20/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
65A111 (Y1)	A. Building B. Wing (Y2)	10/1/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 03/18/2025	ID Prefix A0517 Reg. # 8:36-5.6(b)(1-7) LSC	Correction Completed 03/18/2025	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 03/18/2025
ID Prefix A0901 Reg. # 8:36-10.5(c)(4) LSC	Correction Completed 03/18/2025	ID Prefix A0907 Reg. # 8:36-10.5(c)(7) LSC	Correction Completed 03/18/2025	ID Prefix A0913 Reg. # 8:36-10.5(c)(10) LSC	Correction Completed 03/18/2025
ID Prefix A0975 Reg. # 8:36-11.7(a)(1) LSC	Correction Completed 03/18/2025	ID Prefix A1041 Reg. # 8:36-14.3(a) LSC	Correction Completed 03/18/2025	ID Prefix A1179 Reg. # 8:36-17.1(a) LSC	Correction Completed 03/18/2025
ID Prefix A1249 Reg. # 8:36-17.7 LSC	Correction Completed 03/18/2025	ID Prefix A1275 Reg. # 8:36-18.2(a)(1) LSC	Correction Completed 03/18/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/1/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
65A111 (Y1)	A. Building B. Wing (Y2)	10/1/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD COURTYARD, THE	52 MADISON AVENUE LAKEWOOD, NJ 08701

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 03/18/2025	ID Prefix A0517 Reg. # 8:36-5.6(b)(1-7) LSC	Correction Completed 03/18/2025	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 03/18/2025
ID Prefix A0901 Reg. # 8:36-10.5(c)(4) LSC	Correction Completed 03/18/2025	ID Prefix A0907 Reg. # 8:36-10.5(c)(7) LSC	Correction Completed 03/18/2025	ID Prefix A0913 Reg. # 8:36-10.5(c)(10) LSC	Correction Completed 03/18/2025
ID Prefix A0975 Reg. # 8:36-11.7(a)(1) LSC	Correction Completed 03/18/2025	ID Prefix A1041 Reg. # 8:36-14.3(a) LSC	Correction Completed 03/18/2025	ID Prefix A1169 Reg. # 8:36-16.15(a) LSC	Correction Completed 03/18/2025
ID Prefix A1179 Reg. # 8:36-17.1(a) LSC	Correction Completed 03/18/2025	ID Prefix A1249 Reg. # 8:36-17.7 LSC	Correction Completed 03/18/2025	ID Prefix A1275 Reg. # 8:36-18.2(a)(1) LSC	Correction Completed 03/18/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/1/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO