

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70a002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2025
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NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (WAYNE)	STREET ADDRESS, CITY, STATE, ZIP CODE 800 HAMBURG TURNPIKE WAYNE, NJ 07470
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00189015 and NJ00188581 CENSUS: 35 SAMPLE SIZE: 3 SURVEY DATE: 11/04/2025 - 11/06/2025</p> <p>The facility is not in substantial compliance with all 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, based on this Complaint Survey.</p> <p>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.</p>	A 000		
A 389	<p>8:36-4.1(a)(16) Resident Rights</p> <p>(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:</p> <p>16. The right to be free from physical and mental abuse and/or neglect;</p> <p>This REQUIREMENT is not met as evidenced</p>	A 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/24/25

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A 389	<p>Continued From page 1</p> <p>by: Based on interview, record review, and facility document and policy review, the facility failed to maintain a resident's safety when staff did not ensure the resident wore [redacted] while walking to prevent a [redacted] and failed to complete [redacted] evaluations after a [redacted] for 1 (Resident #1) of 3 sampled residents reviewed for [redacted].</p> <p>Findings included:</p> <p>A facility policy titled, "Falls Prevention," dated May 2025, indicated, "Purpose: Identify residents at risk or predisposed to falls. Evaluate the health, safety and welfare of our residents and implement measures to attempt to prevent falls and minimize the risk that serious injury will result. Process: Falls Prevention Guidelines guide staff through a structured process to screen and identify residents for predisposing risk factors or a history of falls. Whenever possible, the staff implements precautionary measures to reduce the risk of falls by individualizing resident needs. Nursing, be observant of new residents - new surroundings may increase confusion and risk for falls. Resident checks: Is the resident incontinent: are glasses/hearing aides on and clean; and are shoes appropriate, fit properly and in good repair?"</p> <p>A facility document titled, "Falls Prevention Table," dated May 2025, indicated, "Type of Fall: Anticipated Physiological: fall evaluations are often predictive of a fall occurring; loss of balance, impaired gait or mobility, impaired cognition/confusion, impaired vision. Possible Interventions: properly fitting, non-skid shoes (no slip-ons)."</p> <p>A facility document titled, [redacted]</p>	A 389		

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A 389	<p>Continued From page 2</p> <p>Evaluation Flow Sheet," dated [redacted] indicated, "Directions: Complete [redacted] evaluation with vital signs initially, then every 30 minutes x [times] 4, then every hour x 4, then every 8 hours x 9 (72 hours). More frequent evaluations may be necessary. Complete episodic charting for at least 72 hours including any pertinent evaluation findings related to the [redacted] evaluation. Review the most recent evaluation on the medical record and notify the physician of any changes from the previous evaluation. File completed flow sheets in the center specified area of the resident record."</p> <p>Resident #1's "Face Sheet" indicated the resident moved into the facility on [redacted] for [redacted]. According to the Face Sheet, the resident had a medical history that included diagnoses of [redacted].</p> <p>Resident #1's "Clinical Evaluation" dated [redacted] revealed Resident #1 had active diagnoses that included [redacted] with other [redacted]. The Clinical Evaluation revealed Resident #1's level of [redacted] was [redacted] and [redacted]. The Clinical Evaluation revealed Resident #1 had [redacted] and [redacted], was [redacted] and [redacted], had [redacted], and was [redacted] with [redacted] and [redacted].</p> <p>An "Incident Report - Patient Involved," dated [redacted] and completed by Licensed Practical Nurse (LPN) #3, revealed Resident #1 had an [redacted] or [redacted] at 10:45 AM that resulted in a [redacted] to the [redacted].</p>	A 389		
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A 389	<p>Continued From page 3</p> <p>and [redacted] to the NJ Exec Order 26.4b1.</p> <p>A second "Incident Report - Patient Involved," dated [redacted] and completed by LPN #6, revealed Resident #1 [redacted] on [redacted] at 7:00 PM in the hallway. The report revealed that Resident #1 was taken to the hospital on [redacted] at 8:30 PM for further evaluation of [redacted] on the [redacted] of the [redacted]. A "Witness Statement" by Caregiver (CG) #7 revealed that Resident #1 was observed to [redacted] towards the kitchen on a unit that was [redacted] the unit the resident [redacted] on. The statement revealed CG #7 [redacted] the resident back to their unit, and while returning to their unit the resident started NJ Exec Order 26.4b1.</p> <p>The statement revealed that Resident #1 was wearing [redacted] and [redacted].</p> <p>A "Nursing 24 hour Report" dated [redacted] revealed that on [redacted] Resident #1 [redacted] at 10:45 AM and 7:00 PM.</p> <p>A [redacted] Evaluation Flow Sheet" dated [redacted] for Resident #1 revealed the results of [redacted] checks were recorded at 11:00 AM, 11:30 AM, 12:00 PM, 12:30 PM, and 4:30 PM. The [redacted] Evaluation Flow Sheet did not have documentation of hourly checks from 1:30 PM to 3:30 PM as per the instructions.</p> <p>An interview on 11/04/2025 at 1:12 PM with LPN #3 revealed that on [redacted] around 10:45 AM, LPN #3 was notified that Resident #1 [redacted] on another unit. LPN #3 stated that when he arrived at the other unit, he [redacted] Resident #1 NJ Exec Order 26.4b1, and the resident had a NJ Exec Order 26.4b1 above the [redacted]. LPN #3 stated that he assessed the resident and indicated that the resident was</p>	A 389		
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A 389	<p>Continued From page 4</p> <p>NJ Exec Order 26.4b1 . LPN #3 stated that vital signs were taken, and NJ Exec Order checks were initiated. LPN #3 stated that the results of the NJ Exec Order checks reflected that the level of NJ Exec Order 26.4b1) for Resident #1 was within NJ Exec Order 26.4b1 .</p> <p>During a follow-up interview on 11/06/2025 at 10:00 AM, LPN #3 reviewed Resident #1's NJ Exec Order 26.4b1 Evaluation Flow Sheet and stated he completed the document. LPN #3 stated that he did not remember if he told the oncoming nurse (LPN #6) about the document, and if he did not, LPN #6 would not have known to complete it. LPN #3 stated he worked longer than the 7:00 AM to 3:00 PM shift that day, but that he did not complete the hourly NJ Exec Order checks for Resident #1 from 1:30 PM to 3:30 PM. LPN #3 also stated that he may have forgotten to tell LPN #6 to complete the NJ Exec Order checks. LPN #3 stated that it was the facility's practice to complete NJ Exec Order checks as an intervention if a resident had an NJ Exec Order 26.4b1 that resulted in a NJ Exec Order 26.4b1 . LPN #3 stated he should have completed the NJ Exec Order checks for Resident #1 per the directions on the NJ Exec Order 26.4b1 Evaluation Flow Sheet, but he made a mistake when he completed the document, and he did not complete the NJ Exec Order 26.4b1 . He further stated that he miscalculated the frequency of when to complete the NJ Exec Order checks per the instructions on the form.</p> <p>An interview on 11/04/2025 at 3:43 PM with LPN #6 revealed he was the nurse for Resident #1 on NJ Exec Order 26.4b1 for the 3:00 PM to 11:00 PM shift. LPN #6 stated that when he came to work on NJ Exec Order 26.4b1 he was informed that Resident #1 NJ Exec around 10:45 AM that morning, and he observed Resident #1 with a NJ Exec Order 26.4b1 from the prior NJ Exec that happened earlier in the day. LPN #6 stated</p>	A 389		
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A 389	<p>Continued From page 5</p> <p>that sometime that evening he received a call from CG #7 on another unit, who said he NJ Exec Order 26.4b1 for Resident #1 in the hallway. LPN #6 said that CG #7 reported to him that Resident #1 NJ Exec Order 26.4b1. LPN #6 stated that when he arrived at the other unit, Resident #1 NJ Exec Order 26.4b1 from the NJ Exec at 10:45 AM that morning, and the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. LPN #3 further stated that he was not certain if Resident #1 wore NJ Exec Order at the time of that NJ Exec</p> <p>During a follow-up interview on 11/05/2025 at 3:45 PM, LPN #6 reviewed Resident #1's NJ Exec Order 26.4b1 Evaluation Flow Sheet. LPN #6 stated that he did not recall seeing the form on NJ Exec Order 26.4b1 or being informed by LPN #3 to complete the form. LPN #6 stated that (after the NJ Exec on NJ Exec Order 26.4b1 at 7:00 PM) he assessed the resident's NJ Exec Order to be NJ Exec Order 26.4b1, and he continued to NJ Exec Order 26.4b1 the resident until NJ Exec Order 26.4b1 arrived at 8:30 PM and transferred the resident to the emergency room (ER). LPN #6 stated that during monitoring, Resident #1 remained at NJ Exec Order 26.4b1 and talked about their usual conversation.</p> <p>During an interview on 11/05/2025 at 3:34 PM, CG #7 revealed that he was notified when he came to work for the 3:00 PM to 11:00 PM shift on NJ Exec Order 26.4b1 that Resident #1 NJ Exec earlier that morning. CG #7 stated he saw Resident #1 during the shift NJ Exec Order 26.4b1 on another unit with NJ Exec Order 26.4b1, and the resident had a NJ Exec Order 26.4b1. CG #7 then stated that later in the shift, around 7:00 PM, he saw Resident #1 NJ Exec Order onto another unit and saw the resident at the end of hall. CG #7 stated that Resident #1 NJ Exec Order 26.4b1 towards him then started NJ Exec Order 26.4b1 towards the kitchen on the unit.</p>	A 389		
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A 389	<p>Continued From page 6</p> <p>CG #7 stated that at that time, he did not notice that the resident was NJ Exec Order 26.4b1. CG #7 stated he went to the resident and NJ Exec Order 26.4b1 them back to their unit. CG #7 further stated that while the resident NJ Exec Order 26.4b1 toward their unit, he noticed the resident was NJ Exec Order 26.4b1, only NJ Exec Order 26.4b1. CG #7 stated the resident then started NJ Exec Order 26.4b1 and before he could get to the resident, the resident NJ Exec Order 26.4b1 on the same side of their face as the NJ Exec Order 26.4b1. CG #7 stated he immediately notified LPN #6 of the NJ Exec Order 26.4b1. CG #7 further stated that he noticed Resident #1 did not have NJ Exec Order 26.4b1 on when he told the resident to return to their unit, but then the resident started NJ Exec Order 26.4b1 again and he could not get to the resident in time before the resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. CG #7 stated that he should have looked at the resident to make sure they were NJ Exec Order 26.4b1 before NJ Exec Order 26.4b1 the resident back to their unit.</p> <p>An interview on 11/05/2025 at 9:50 AM with the Resident Services Coordinator (RSC) revealed she was notified that Resident #1 NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 at 7:00 PM. The RSC stated she was notified because it was the NJ Exec Order 26.4b1 that occurred for the resident in the same day. The RSC stated that the resident NJ Exec Order 26.4b1 a NJ Exec Order 26.4b1 above the NJ Exec Order 26.4b1 from the NJ Exec Order 26.4b1 that occurred that morning, then the NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1 that evening, so Resident #1 was transferred to the ER for further evaluation of the NJ Exec Order 26.4b1. During the interview, the RSC reviewed the NJ Exec Order 26.4b1 Evaluation Flow Sheet for Resident #1 and stated the document was incomplete and should have been completed. The RSC stated that she expected NJ Exec Order 26.4b1 checks to be completed and documented whenever a resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 a NJ Exec Order 26.4b1. The RSC stated that an NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1.</p>	A 389		
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A 389	<p>Continued From page 7</p> <p>of the [redacted] was not considered a significant event but would require [redacted] checks to be completed as per the instructions on the form.</p> <p>A follow-up interview on 11/06/2025 at 3:25 PM with the RSC revealed she expected CG #7 to have [redacted] the resident to [redacted] until [redacted] could be placed on the resident rather than instructing the resident to return to their unit [redacted].</p> <p>An interview on 11/05/2025 at 9:28 AM with the Executive Director (ED) revealed the facility did not have a policy on [redacted] checks, but she expected [redacted] checks to be completed and documented with any [redacted] that resulted in a [redacted]. The ED stated that she expected the nurse who completed the [redacted] Evaluation Flow Sheet to follow the instructions on the form.</p> <p>A follow-up interview on 11/06/2025 at 3:28 PM with the ED revealed that she expected CG #7 not to send a resident down the hallway without [redacted] in place. The ED stated that CG #7 should have made sure Resident #1 had on the [redacted] before [redacted] the resident to return to their unit in [redacted] without [redacted].</p>	A 389		
A 565	<p>8:36-5.10(a)(3) General Requirements</p> <p>(a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following:</p> <p>3. Any suspected cases of resident abuse or exploitation which have been reported to the</p>	A 565		

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A 565	<p>Continued From page 8</p> <p>State Long-Term Care Ombudsman.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility document and policy review, the facility failed to immediately report to the state agency an NJ Exec Order 26.4b1 for 1 (Resident #2) of 1 sampled resident reviewed for NJ Exec Order 26.4b1.</p> <p>Findings included:</p> <p>The facility policy titled, "Resident Protection," dated May 2025, revealed, "Note: For the purpose of this policy, abuse includes all types of abuse, neglect, exploitation, mistreatment and misappropriation of resident's property." The policy revealed the section titled, "Procedure:" included, "3. The community provides employees orientation and ongoing education about the prohibition of abuse, such as:" "- How to immediately report suspicions or allegations of abuse (including injuries of unknown origin), neglect, exploitation, mistreatment, misappropriation or resident property or a crime against a resident." The section further revealed, "4. Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment, misappropriation, or crime against a resident." Further review revealed, "6. The Executive Director is responsible for investigating,</p>	A 565		
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A 565	<p>Continued From page 9</p> <p>reporting and coordination of the investigation process of any alleged or suspected abuse regardless of the source of the concern." The policy revealed, "11. Communities can best support the detection and prevention of abuse by implementing a process that supports immediate reporting of suspected abuse." The policy revealed, "14. The community creates and maintains a proactive approach by identifying events that may constitute or contribute to abuse. When investigating whether abuse has occurred the community identifies and considers events such as behavioral changes, bruising of a resident, suspicious resident patterns, unexplained injuries, communication or social interaction changes, and other trends that may signify abuse."</p> <p>Resident #2's "Face Sheet" indicated the resident moved into the facility on [redacted] According to the Face Sheet, the resident had a medical history that included a diagnosis of [redacted]</p> <p>Resident #2's "Clinical Evaluation" dated [redacted] indicated a "Move in/Re-entry" date of [redacted]. The Clinical Evaluation revealed Resident #2 was [redacted]. The Clinical Evaluation revealed the resident displayed [redacted] and [redacted] care, and required staff to provide [redacted] activities of daily living care, except Resident #2 [redacted]</p> <p>A "Nursing 24 hour Report" dated [redacted] revealed that on [redacted] on the 7:00 AM - 3:00 PM shift, Resident #2 was noted with a "[redacted]" on their [redacted].</p> <p>An electronic mail (email) dated [redacted] at</p>	A 565		
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A 565	<p>Continued From page 10</p> <p>7:08 PM from the Executive Director (ED) to the Department of Health revealed that an initial report for a reportable event was made. The email indicated the subject as NJ Exec Order 26.4b1 " for Resident #2.</p> <p>The "Reportable Event Record/Report" dated NJ Exec Order 26.4b1 and completed by the ED, revealed that on the morning of NJ Exec Order 26.4b1, Resident #2's NJ Exec Order 26.4b1 of their NJ Exec Order 26.4b1 was observed NJ Exec Ord by a caregiver who reported it to a nurse.</p> <p>A phone interview on 11/06/2025 at 9:04 AM with Caregiver (CG) #4 revealed she was the caregiver for Resident #2 on NJ Exec Order 26.4b1 for the 7:00 AM to 3:00 PM shift. CG #4 stated that when she took Resident #2 to the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 during morning care, she saw a NJ Exec Order 26.4b1 on the resident's NJ Exec CG #4 stated she asked Resident #2 what happened, but the resident NJ Exec Order 26.4b1 #4 stated she immediately notified Licensed Practical Nurse (LPN) #5 of the NJ Exec Order 26.4b1 because Resident #2 did not have the NJ Exec Order on NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 on the 7:00 AM to 3:00 PM shift when she was also the assigned caregiver for the resident.</p> <p>An interview on 11/05/2025 at 1:15 PM with LPN #5 revealed that on NJ Exec Order 26.4b1 during the morning of the 7:00 AM to 3:00 PM shift, CG #4 reported to LPN #5 that Resident #2 had a NJ Exec Order on the NJ Exec LPN #5 stated she observed Resident #2 with a NJ Exec Ord and NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1. LPN #5 stated she asked the nurse, who was the nurse on the 7:00 AM to 3:00 PM shift on NJ Exec Order 26.4b1, and the caregiver who also worked the day before on 3:00 PM to 11:00 PM shift on NJ Exec Order 26.4b1 about the</p>	A 565		
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NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (WAYNE)	STREET ADDRESS, CITY, STATE, ZIP CODE 800 HAMBURG TURNPIKE WAYNE, NJ 07470
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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A 565	<p>Continued From page 11</p> <p>resident's [redacted] but both stated that the resident did not have a [redacted] to their [redacted] on those shifts. LPN #5 stated she did not ask the caregiver on the 11:00 PM to 7:00 AM shift on [redacted] about the [redacted] and she did not know how the [redacted] occurred. LPN #5 stated she recorded the [redacted] on the 24-hour report and notified LPN #3. LPN #5 stated that she did not contact the Resident Services Coordinator (RSC) or the ED because even though the resident [redacted] staff during care, she did not think anyone did anything to the resident. LPN #5 stated she received [redacted] and [redacted] training, which included instructions for immediate reporting to the RSC or the ED for [redacted] and stated, "I will have to pay closer attention to my [redacted] training."</p> <p>An interview on 11/04/2025 at 1:49 PM with LPN #3 revealed he was notified of the [redacted] on the [redacted] of Resident #2 on [redacted], by LPN #5. He stated he was the nurse for Resident #2 on [redacted] on the 7:00 AM to 3:00 PM shift, and Resident #2 did not have a [redacted] on their [redacted]. LPN #3 stated he notified the RSC on [redacted] morning, [redacted], of the [redacted] to the [redacted] of Resident #2.</p> <p>An interview on 11/06/2025 at 3:25 PM with the RSC revealed she was notified on Monday morning, [redacted], by LPN #3 of the [redacted] to the [redacted] of Resident #2. The RSC stated she immediately notified the ED of the [redacted] on the [redacted] of Resident #2. The RSC stated that she expected immediate notification by LPN #5 of the [redacted] on the resident's [redacted] if staff did not know how the [redacted] occurred.</p> <p>During an interview on 11/05/2025 at 1:50 PM, the ED stated that LPN #5 should have notified the RSC or the ED immediately of the [redacted] on</p>	A 565		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70a002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2025
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NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (WAYNE)	STREET ADDRESS, CITY, STATE, ZIP CODE 800 HAMBURG TURNPIKE WAYNE, NJ 07470
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 565	<p>Continued From page 12</p> <p>the [REDACTED] of Resident #2 since staff did not know how the [REDACTED] occurred. The ED further stated immediate notification by LPN #5 would have allowed the ED to notify the state agency immediately.</p> <p>During a follow-up interview on 11/06/2025 at 3:28 PM, the ED stated she was aware of the requirement to immediately report to the state agency [REDACTED] of [REDACTED] which included NJ Exec Order 26.4b1 [REDACTED]. The ED stated she was made aware of the [REDACTED] to Resident #2's [REDACTED] on [REDACTED], and she did not have an explanation as to why she did not report the [REDACTED] of [REDACTED] to the state agency until [REDACTED].</p>	A 565		
A1049	<p>8:36-15.1 Resident Records</p> <p>A current, complete health record shall be maintained for each resident who is receiving health care services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility document and policy review, the facility failed to maintain a complete and accurate medical record when the documentation of a [REDACTED] was not recorded in the medical record for 1 (Resident #1) of 3 sampled residents reviewed.</p> <p>Findings included:</p> <p>The facility policy titled, "Documentation," dated May 2025, revealed the section titled, "Procedure:" included, "3. When an instance is</p>	A1049		

New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (WAYNE)	STREET ADDRESS, CITY, STATE, ZIP CODE 800 HAMBURG TURNPIKE WAYNE, NJ 07470
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A1049	<p>Continued From page 13</p> <p>documented on the 24-hour Report, follow-up, detailed documentation should occur in Resident's Health Record by DON [Director of Nursing]/HSD [Health Services Director]/RSC [Resident Services Coordinator] or licensed nurse. Caregivers and med techs [medication technicians] may also document information in the EHR [electronic health record] or individual service notes."</p> <p>Resident #1's "Face Sheet" indicated that the resident moved into the facility on [NJ Exec Order 26.4b1]. According to the Face Sheet, the resident had a medical history that included diagnoses of [NJ Exec Order 26.4b1].</p> <p>A "Nursing 24 Hour Report" dated [NJ Exec Order 26.4b1] revealed Resident #1 [NJ Exec Order 26.4b1] at 10:45 AM.</p> <p>An "Investigation Report" revealed that on [NJ Exec Order 26.4b1] at 10:45 AM, Caregiver (CG) #2 reported to a nurse that Resident #1 was [NJ Exec Order 26.4b1] on the [NJ Exec Order 26.4b1]. The Investigation Report indicated that the nurse observed Resident #1 on the [NJ Exec Order 26.4b1] with a [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4b1] area and the resident was [NJ Exec Order 26.4b1] from the [NJ Exec Order 26.4b1] on their [NJ Exec Order 26.4b1].</p> <p>Review of the progress notes in the electronic medical record for Resident #1 revealed there was no documentation of the [NJ Exec Order 26.4b1] or the details that resulted from the [NJ Exec Order 26.4b1] for Resident #1 that occurred on [NJ Exec Order 26.4b1] at 10:45 AM.</p> <p>An interview on 11/04/2025 at 1:12 PM with Licensed Practical Nurse (LPN) #3 revealed that on [NJ Exec Order 26.4b1] around 10:45 AM, he was notified by CG #2 that Resident #1 [NJ Exec Order 26.4b1] on the [NJ Exec Order 26.4b1] in the [NJ Exec Order 26.4b1] after a [NJ Exec Order 26.4b1] LPN #3 stated he wrote an</p>	A1049		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70a002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2025
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NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (WAYNE)	STREET ADDRESS, CITY, STATE, ZIP CODE 800 HAMBURG TURNPIKE WAYNE, NJ 07470
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A1049	<p>Continued From page 14</p> <p>incident report regarding the [redacted] but he forgot to record the [redacted] in the resident's medical record. LPN #3 further stated, "I should have written a progress note."</p> <p>An interview on 11/05/2025 at 9:50 AM with the Resident Services Coordinator (RSC) revealed she would expect documentation of a [redacted] recorded in the medical record. The RSC stated that she reviewed the medical record for Resident #1, and she did not find documentation of the [redacted] that occurred on [redacted] at 10:45 AM. The RSC further stated that the nurse completed an incident report regarding the [redacted] but the incident report was not part of the medical record. The RSC further stated that the [redacted] for Resident #1 that occurred on [redacted] at 10:45 AM was documented on the 24-hour report, which was nurse-to-nurse shift reporting, and that anything recorded on the 24-hour report should also be documented in the resident's medical record. The RSC stated that she checked the medical record for Resident #1, but she did not find any documentation from the nurse regarding the [redacted] or [redacted] at 10:45 AM.</p> <p>An interview on 11/06/2025 at 3:28 PM with the Executive Director (ED) revealed that she expected that a [redacted] would be documented in the resident's medical record by the nurse. The ED further stated that the nurse should have documented a progress note in the medical record regarding the [redacted] for Resident #1 that occurred on [redacted] at 10:45 AM. The ED stated that although the [redacted] on [redacted] at 10:45 AM was documented on the incident report, the report was not part of the medical record, and if a family member requested copies from the medical record, the incident report would not be included because it was not part of the medical</p>	A1049		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70a002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2025
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NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (WAYNE)	STREET ADDRESS, CITY, STATE, ZIP CODE 800 HAMBURG TURNPIKE WAYNE, NJ 07470
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1049	Continued From page 15 record.	A1049		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70a002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2025
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NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (WAYNE)	STREET ADDRESS, CITY STATE ZIP CODE 800 HAMBURG TURNPIKE WAYNE, NJ 07470
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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A 000 Initial Comments

A 000

Initial Comments:
TYPE OF SURVEY: Complaint
COMPLAINT #: NJ00189015 and NJ00188581
CENSUS: 35
SAMPLE SIZE: 3
SURVEY DATE: 11/04/2025 - 11/06/2025

The facility is not in substantial compliance with all 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, based on this Complaint Survey.

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 389 8:36-4.1(a)(16) Resident Rights

A 389

(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:

16. The right to be free from physical and mental abuse and/or neglect;



This REQUIREMENT is not met as evidenced

LABORATORY STATE FORM **NJ Exec Order 26.4b1**

TITLE *Executive Director*

(X6) DATE *12/27/2025*

Arden Courts Wayne
800 Hamburg Turnpike
Wayne, New Jersey 07470
973.942.5600
973.942.4485 fax

POC #2 received 1/2/26
Accepted 1/2/26

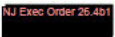



Arden Courts 
Memory Care Community

Plan of Correction

Arden Courts of Wayne

Survey Date: 11/6/2025

A 389

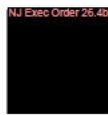
1. Resident #1 was affected by this deficient practice. All residents have the right to be free from  and  and/or  Resident #1 was a  resident and no longer resides at facility.

2. All residents have the potential to be affected by this deficient practice.
3. (A) Executive Director, Resident Services Coordinator (R.N.) and/or Resident Services Supervisor (L.P.N) will in-service all staff on Fall Prevention. Inservice completion date 12/31/2025. All staff will receive copy of the Fall Prevention Table-completion date 12/31/2025. All staff will continue to be educated on Resident Rights annually, which includes the right to be free from physical and mental abuse and/or neglect. All new hires will be educated on Resident's Rights during orientation.

(B) Failure to correctly complete neurological evaluation per direction. All Nurses received In-service on correctly completing neurological evaluations. Completion date 12/23/2025. Copy of the Neurological Evaluation Flow Sheet which includes directions were given to all nurses.
4. (A) Executive Director and/or Resident Services Coordinator (R.N.) will audit random staff on Fall Prevention guidelines starting 12/29/25, then weekly x4 weeks, then monthly for two months.

(B) Every resident that requires Neurocheck evaluation will be audited by Executive Director and/or Resident Services Coordinator (R.N). This practice will continue for next 2 months and randomly thereafter.

Completion Date 12/31/2025



approved
1/2/26

Plan of Correction

Arden Courts of Wayne

Survey Date 11/6/2025

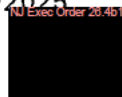
A 565

1. Resident #2 was affected by this deficient practice. Resident #2 currently resides at facility.
2. All residents have the potential to be affected by this deficient practice.
3. All staff will be educated on Resident Protection and to immediately report any injury of unknown origin as well as any suspected abuse & neglect to Executive Director to report to Dept of Health. Executive Director will report to state agency on timely basis per regulation. Description of In-service provided.

In-Service completion date 12/31/25. All staff will continue to be educated annually on immediate reporting of suspicions or allegations of abuse (including injuries of unknown origins), neglect, exploitations, mistreatment, misappropriation or resident property or a crime against a resident. All new hires will be educated on same during orientation

4. Register Nurse /Executive Director audit & sign all incident reports along with physician on timely basis. Executive Director and/or designee will randomly ask staff related to competency regarding Resident Protection Policy starting on 12/18/25, then weekly X4, then monthly for two months

Completion Date 12/31/2025



approved
1/2/26

Plan of Correction

Arden Courts of Wayne

A 1049

1. Resident #1 was affected by this efficient practice. Resident #1 was on NJ Exec Order 26.4b1 and no longer resides at facility.
2. All residents have the potential to be affected by this deficient practice.
3. All nurses were in-serviced by Resident Services Coordinator on documentation procedures and expectations. Documentation policy was given to all nurses. In-service completion date was 12/23/25.
4. Executive Director and/or Resident Services Coordinator will audit documentation after falls to be sure all is correctly completed, including adding information/note in electronic medical records. This practice will continue for next 2 months and randomly thereafter.

Completion Date 12/23/2025

NJ Exec Order 26.4b1

*approved
1/2/26*

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 70a002	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/2/2026
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NAME OF FACILITY ARDEN COURTS (WAYNE)	STREET ADDRESS, CITY, STATE, ZIP CODE 800 HAMBURG TURNPIKE WAYNE, NJ 07470
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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 A0389	Correction	ID Prefix A0565	Correction	ID Prefix A1049	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.10(a)(3)	Completed	Reg. # 8:36-15.1	Completed
LSC	12/31/2025	LSC	12/31/2025	LSC	12/23/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/6/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 70a002	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/2/2026
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NAME OF FACILITY ARDEN COURTS (WAYNE)	STREET ADDRESS, CITY, STATE, ZIP CODE 800 HAMBURG TURNPIKE WAYNE, NJ 07470
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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 A0389	Correction	ID Prefix A0565	Correction	ID Prefix A1049	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.10(a)(3)	Completed	Reg. # 8:36-15.1	Completed
LSC	12/31/2025	LSC	12/31/2025	LSC	12/23/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/6/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		