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
	75A000	A. BUILDING: _____ B. WING _____	C 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINDSAY PLACE	39 SUPAWNA ROAD PENNSVILLE, NJ 08070

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A 000	Initial Comments Initial Comments: Type of Survey: Complaint Complaint #s: NJ 00190419, NJ 00190632 Census: 39 (5/19 & 5/20/26) Sample Size: 4 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) Administrator's Responsibilities (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 07/15/26

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This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00190419

Based on interview and record review, it was determined that the Executive Director (ED) failed to implement the policy titled, "Investigation Standard", "Documentation Guidelines" and "Call Light Response" by failing to complete an investigation following [redacted] failing to re-evaluate resident following a NJ Exec Order 26.4b1 and failing to respond to call light for 4 of 4 residents reviewed, Resident #1, #2, #3 and Resident #4. This deficient practice was evidenced by the following:

1. On 5/19/26 at 12:00 p.m., the surveyor reviewed Resident #3's medical record (MR), which revealed that Resident #3 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of NJ Ex Order 26.4(b)(1).

Continued surveyor review of Resident #3's progress note (PN) written by a Certified Medication Aide (CMA) dated [redacted] at 1:22 p.m., revealed, " ... [Resident #3] sent out [to local [redacted] for NJ Ex Order 26.4(b)(1) ..."

On 5/20/26 at 10:14 a.m., the surveyor requested a copy of the investigation summary from the ED. The ED stated that all investigation documents were internal documents and could not be provided to the surveyor. However, the ED was not able to provide the surveyor documented evidence that an investigation was completed following Resident #3's [redacted] on [redacted].

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A 310	Continued From page 2 2. On 5/19/26 at 11:21 a.m., the surveyor reviewed Resident #1's MR, which revealed that Resident #1 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of NJ Ex Order 26.4(b)(1) The surveyor reviewed Resident #1's PN written by a Licensed Practical Nurse (LPN) dated NJ Ex Order 26.4 at 10:16 p.m., which revealed, " ... [Resident #1] returned to the facility from the NJ Exec Order 26.4b1 On 5/20/26 at 1:10 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about the DHW's re-evaluation of Resident #1 following Resident #1's NJ Exec Order 26.4b [redacted] on NJ Ex Order 26. The DHW stated that she completed a re-evaluation on Monday, NJ Ex Order 26.4(b) but did not document the evaluation. The DHW failed to provide the surveyor documented evidence to show that Resident #1 was re-evaluated upon re-admission to the facility on NJ Ex Order 26.4(b) 3. On 5/19/26 at 11:20 a.m., the surveyor reviewed Resident #2's medical record (MR), which revealed that Resident #2 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of a NJ Ex Order 26.4(b)(1) At 9:55 a.m., the surveyor interviewed Resident #2 and inquired about call bell response. Resident #2 stated that past NJ Exec Order 26.4b1 he/she activated his/her NJ Exec Order 26.4b1 "around 10:00 p.m. and waited "a long time" for assistance to NJ Ex Order 26.4(b)(1). Resident #2 stated that he/she eventually NJ Ex Order 26.4(b)(1) without staff assistance. At 1:00 p.m., the surveyor reviewed the pendant log document dated NJ Ex Order 26.4(b)(1)" provided by the Executive Director (ED) which revealed	A 310		

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A 310	Continued From page 3 that Resident #2 activated his/her [NJ Exec Order 26.4] at the following times: [NJ Ex Order 26.4(] at 3:41 a.m. and remained unanswered for 40 minutes and 37 seconds. [NJ Ex Order 26.4(] at 6:36 a.m. and remained unanswered for 32 minutes and 43 seconds. [NJ Ex Order 26.4(] at 7:09 a.m. and remained unanswered for 33 minutes and 48 seconds. [NJ Ex Order 26.4(] at 9:26 a.m. and remained unanswered for 8 hours and 15 minutes. [NJ Ex Order 26.4(b)(1)] at 4:05 p.m. and remained unanswered for 11 hours and 9 minutes. On 5/19/26 at 1:10 p.m., the surveyor reviewed Resident #4's MR, which revealed that Resident #4 was admitted to the facility in [NJ Ex Order 26.4(b)(1)], with a diagnosis of [NJ Ex Orde] At 10:00 a.m., the surveyor interviewed Resident #4 and inquired about call bell response at the facility. Resident #4 stated that there have been times when he/she activated his/her [NJ Exec Order 26.4b1] and waited "hours" for assistance. On 5/20/26 at 9:00 a.m., the surveyor reviewed the [NJ Exec Order 26.4] log document titled, "Past Calls" dated [NJ Ex Order 26.4(b)(1)] provided by the ED which revealed that Resident #4 activated his/her [NJ Exec Order 26.4] on [NJ Ex Order 26] at 1:02 a.m., and remained unanswered for 4 hours and 11 minutes. Continued surveyor review of the pendant log dated [NJ Ex Order 26.4(b)(1)] revealed that Resident #4 activated his/her pendant on [NJ Ex Order 26.4(] at 10:03 p.m., and remained unanswered for 23 minutes and 32 seconds.	A 310		

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A 310	Continued From page 4 On 5/20/26 at 1:10 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about pendant response time. The DHW stated that the policy doesn't give a specific time of when [NJ Exec Order 26.4] calls should be answered; However, staff are expected to answer [NJ Exec Order 26.4] calls within 10 minutes of pendant activation. During continued interview with the DHW, the surveyor inquired about the monitoring of the [NJ Exec Order 26.4] call system. The DHW stated that the [NJ Exec Order 26.4] calls were monitored by the DHW or the ED every morning, however the monitoring was not documented. Additionally, the surveyor inquired about the above call times that were not answered by staff. The DHW acknowledged that the [NJ Exec Order 26.4] calls were not answered by staff. At 2:56 p.m., the surveyor interviewed the ED and inquired about the [NJ Exec Order 26.4] call response times and monitoring system. The ED stated that the policy did not have a specific time of when [NJ Exec Order 26.4] calls were answered. The ED explained that it was expected that pendant calls were answered as soon as possible. The ED explained that the [NJ Exec Order 26.4] system was monitored daily but was not documented. The surveyor reviewed the facility policy titled, "Investigation Standard", with a last review date of 3/28/24, which revealed "... Procedure: ... Company shall cooperate with any government investigation, audits or inspections ... Responsibility: Company will initiate an appropriate investigation into possible violations of ... Company policy or standard of which company is aware ..."	A 310		

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A 310	Continued From page 5 The surveyor reviewed the facility policy titled, "Documentation Guideline", with a last review date of 3/28/25, which revealed, "... Alert Charting: Alert charting is defined as a minimum of once daily documentation for 72 hours following a significant event or change of condition. 1. After 72 hours the Health and Wellness Director ... should reevaluate if continued routine charting is necessary..." The policy titled, "Call Light Response" which was last reviewed on 5/19/26, revealed, "Policy: It is the policy of the community to respond to resident's request and needs, including responding to residents use of the call light system ... Procedure: ... 7. Staff will answer the resident's call light as soon as possible..."	A 310		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider shall 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	A 389		

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A 389	Continued From page 6 by: Complaint #: NJ 00190419 Based on interview and record review, it was determined that the facility failed to ensure a resident was [redacted] from [redacted] for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 5/19/26 at 12:00 p.m., the surveyor reviewed Resident #3's medical record (MR), which revealed that Resident #3 was admitted to the facility in [redacted] with a diagnosis of [redacted] Continued surveyor review of Resident #3's progress note (PN) written by a Certified Medication Aide (CMA) dated [redacted] at 1:22 p.m., revealed, " ... [Resident #3] sent out to [local [redacted] for [redacted] On 5/20/26 at 11:17 a.m., the surveyor interviewed CMA #1 and inquired about Resident #3's [redacted]. The CMA stated that she was notified by a Certified Home Health Aide (CHHA) that Resident #3 was [redacted] in Resident #3's apartment. CMA #1 further stated that when she went to the apartment to evaluate Resident #3 with CMA #2, Resident #3 stated that he/she was [redacted]. CMA #1 further stated that Resident #3 stated that he/she pressed the [redacted] button at approximately 12:00 a.m. on [redacted] and staff did not respond. At 11:42 a.m., the surveyor interviewed a Certified Nursing Aide (CNA) who was assigned to Resident #3 on the night of [redacted] During the interview, the surveyor inquired about	A 389		

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A 389	Continued From page 7 Resident #3's [NJ Ex Order 26.4(b)(1)] and the last time that the CNA checked on Resident #3. The CNA confirmed that she had Resident #3 on her assignment on [NJ Ex Order 26.4(b)(1)] and stated that she could not remember anything from the night of [NJ Ex Order 26.4(b)(1)] or when she checked on the resident. At 11:56 a.m., the surveyor interviewed CMA #2 who responded to Resident #3's [NJ Ex Order 26.4(b)(1)] CMA #2 stated that she checked the [NJ Exec Order 26.4(b)] monitor at the reception desk at approximately 6:30 a.m., on [NJ Ex Order 26.4(b)(1)] and observed Resident #3's pendant was on for several hours and was not answered. CMA #2 stated that she instructed the CHHA to go check on Resident #3. CMA #2 stated that the CHHA returned to notify them [CMA #1 and CMA #2] that Resident #3 was [NJ Ex] the apartment. During continued interview, CMA #2 stated that when she went to Resident #3's apartment, she observed Resident #3 was [NJ Ex Order 26.4(b)(1)]. CMA #2 stated that when she asked Resident #3 if Resident #3 used his/her [NJ Exec Order 26.4(b)] for help. CMA #2 stated that Resident #3 informed her that he/she used the [NJ Exec Order 26.4(b)] after Resident #3 [NJ Ex Or] but nobody responded. At 12:34 p.m., the surveyor interviewed the CHHA and inquired about Resident #3's [NJ Ex Order 26.4(b)(1)] The CHHA stated that she was assigned to Resident #3 on [NJ Ex Order 26.4(b)(1)] on the day shift. The CHHA further stated that during rounds with the previous shift CNA, that the CNA told her that she did not have to check Resident #3 because she just saw Resident #3. During continued surveyor interview, the CHHA stated that she was instructed by CMA #2 to check on Resident #3 because Resident #3 used	A 389		

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his/her pendant monitor several hours ago. The CHHA stated that when she went to Resident #3's apartment, she observed Resident #3 on the floor. The CHHA stated that Resident #3 stated that "he/she used his [NJ Exec Order 26.4] sometime around midnight and nobody came to help him/her."

The surveyor reviewed the [NJ Exec Order 26.4] call log titled, "Past Calls" provided by the Executive Director (ED) on 5/19/26, which revealed that Resident #3 used his/her [NJ Exec Order 26.4] at 11:43 p.m., on [NJ Ex Order 26.4] and remained unanswered for 8 hours and 20 minutes.

At 12:38 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about Resident #3's [NJ Ex Order 26.4(b)(1)] The DHW stated that she was made aware of [NJ Ex Order 26.4] by staff after Resident #3 was transferred to the [NJ Exec Order 26.4] for evaluation. The DHW stated that she called the hospital on [NJ Ex Order 26.4(b)] for an update and was notified that Resident #3 NJ Ex Order 26.4(b)(1) [redacted]p and would require [NJ Ex Order 26.4(b)(1)]

During continued interview with the DHW, the surveyor inquired about the [NJ Exec Order 26.4] call log provided by the Executive Director on 5/19/26 which revealed that Resident #3 used his/her [NJ Exec Order 26.4] on [NJ Ex Order 26.4] at 11:43 p.m. and remained unanswered for 8 hours and 20 min. The DHW confirmed that Resident #3's [NJ Exec Order 26.4] call went unanswered for 8 hours and 20 min.

The surveyor reviewed the policy titled, "Resident Rights" last reviewed 2/5/26, which revealed, "... Freedom from Abuse ... To be free from ... neglect..."

The policy titled, "Call Light Response" last reviewed on 5/19/26, revealed, "Policy: It is the

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A 389	Continued From page 9 policy of the community to respond to resident's request and needs, including responding to residents use of the call light system ..."	A 389		
A 537	8:36-5.7(a)(1) Policy and Procedure Manual (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and resident care services of the facility or program; This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete the annual review of the facility's Policy and Procedure (P&P) manual. This deficient practice was evidenced by the following: On 5/19/26 at 9:46 a.m., the surveyor inquired of the Executive Director (ED) if the facility P&P	A 537		

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A 537	Continued From page 10 were electronic or paper. The ED stated that the facility used an electronic policy and procedure manual. The surveyor requested a printout of the index from the electronic P&P manual for review. At 10:45 a.m., the Operation Specialists (OS) stated that the index could not be printed, however all of the most current policies needed by the surveyor could be printed. The surveyor reviewed the facility policy titled, "Investigation Standard" provided by the OS, revised on 3/28/24. There was no documented evidence that the policy was reviewed or updated at least annually. The surveyor reviewed the facility policy titled, "Policies, Standards and Guidelines Standard" provided by the OS, revised on 6/13/24. There was no documented evidence that the policy was reviewed or updated at least annually. The surveyor reviewed the facility policy titled, "Documentation Guideline" provided by the OS, revised 3/28/25. There was no documented evidence that the policy was reviewed or updated at least annually. On 5/20/26 at 1:34 p.m., the surveyor interviewed the ED and inquired about the annual review of the facility PP. The ED stated that corporate office updated all P&Ps. The policy titled, "Policies, Standards and Guidelines Standard" which was last reviewed on 6/13/24, revealed, "... Procedures: ... 4. Instructional documents are reviewed annually by discipline to verify the instructional documented...."	A 537		

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A1073	Continued From page 11	A1073		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00190632 Based on interview and record review, it was determined that the facility failed to maintain and provide the surveyor with complete medical record (MR) for 1 of 4 residents, Residents #1. This deficient practice was evidenced by the following: On 5/19/26 at 9:28 a.m., the surveyor interviewed the Executive Director (ED) and requested access to Resident #1's MR. The ED informed the surveyor that Resident #1's records were both electronic and paper. At 11:21 a.m., the surveyor reviewed Resident #1's MR, which revealed that Resident #1 was admitted to the facility in NJ Ex Order 26.4(b)(1), with	A1073		

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A1073	Continued From page 12 a diagnosis of NJ Ex Order 26.4(b)(1). Surveyor review of Resident #1's discharge summary dated NJ Ex Order 26.4(b) revealed the following medication changes: New order NJ Ex Order 26.4(b)(1) 1 tablet by mouth two times a day. "Stop taking" NJ Ex Order 26.4(b)(1)) 1 tablet by mouth every day. "Stop taking" NJ Ex Order 26.4(b)(1)) 1 tablet by mouth every day. "Stop taking" NJ Ex Order 26.4(b)(1) 1 tablet by mouth every day. Further surveyor review of Resident #1's Medication Administration Record (MAR) dated NJ Ex Order 26.4(b)(1) revealed the following: NJ Ex Order 26.4(b)(1) 1 tablet by mouth every day with a start date of NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) 1 tablet by mouth every day with a start date of NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) 1 tablet by mouth every day with a start date of NJ Ex Order 26.4(b)(1) On 5/20/26 at 10:56 a.m., the surveyor requested from the Director of Health and Wellness (DHW) copies of the Nurse Practitioner (NP) progress notes (PN)s from NJ Ex Order 26.4(b)(1) though the date of survey, NJ Ex Order 26.4(b). At 12:18 a.m., the DHW stated that the NP did not leave PNs in Resident #1's MR. The DHW	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75A000	A. BUILDING: _____ B. WING _____	C 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINDSAY PLACE	39 SUPAWNA ROAD PENNSVILLE, NJ 08070

(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
A1073	Continued From page 13 stated that she would reach out to the NP for the requested PNs. At 1:10 p.m., the surveyor interviewed the DHW and inquired about the medication changes for Resident #1's NJ Ex Order 26.4(b)(1) The DHW stated that NJ Ex Order 26.4(b)(1) were all discontinued when Resident #1 was discharged from the [redacted] on [redacted] The DHW explained that the [redacted] was reordered by the NP on [redacted] and the NJ Ex Order 26.4(b)(1) were reordered by the NP on [redacted] The surveyor then requested the physician order for the NJ Ex Order 26.4(b)(1) . The DHW later informed the surveyor that she was not able to locate the physician order for the above medications. The surveyor reviewed the facility policy titled, "Documentation Guideline", with a last review date of 3/28/25, which revealed " ... Routine Documentation ... 2. Physician visit dates and new orders received ..."	A1073		
H 000	Initials Comments Type of Survey: Complaint Complaint #s: NJ 00190419, NJ 00190632 Census: 39 (5/19 & 5/20/26) Sample Size: 4 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for	H 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75A000	A. BUILDING: _____ B. WING _____	C 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINDSAY PLACE	39 SUPAWNA ROAD PENNSVILLE, NJ 08070

(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
H 000	Continued From page 14 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.	H 000		
H5790	8:43E-13.4(d) Mandatory use of Universal Transfer Form (d) A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00190419 and NJ 00190632 Based on interview and record review, it was determined that the facility failed to maintain a copy of the Universal Transfer Form a, form that communicates pertinent patient care information at the time of a transfer between health care facilities/programs for 2 of 4 residents reviewed,	H5790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75A000	A. BUILDING: _____ B. WING _____	C 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINDSAY PLACE	39 SUPAWNA ROAD PENNSVILLE, NJ 08070

(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
H5790	Continued From page 15 Resident #1 and Resident #3. This deficient practice was evidenced by the following: On 5/19/26 at 11:21 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of NJ Ex Order 26.4(b)(1). Continued surveyor review of Resident #1's Progress Note (PN), in the MR, written by a Licensed Practical Nurse (LPN) dated NJ Ex Order 26.4(b) at 10:09 p.m., which revealed, " ... [Resident #1] sent out [to local hospital] for evaluation ..." Further surveyor review of Resident #1's PN, written by a Certified Medication Aide (CMA) dated NJ Ex Order 26 at 1:51 p.m., which revealed, " ... [Resident #1] sent out to [local hospital] for NJ Ex Order 26.4(b)(1) ..." At 12:00 p.m., the surveyor reviewed Resident #3's MR, which revealed that Resident #3 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of NJ Ex Order 26.4(b)(1). Continued surveyor review of Resident #3's PN written by a CMA dated NJ Ex Order 26 at 1:22 p.m., revealed, " ... [Resident #3] sent out [to local hospital] for NJ Ex Order 26.4(b)(1) ..." On 5/19/26 at 12:38 p.m., the surveyor requested the Health and Wellness Director (HWD) to provide the surveyor with the Universal Transfer Form (UTF) for the Resident #1's NJ Exec Order 26.4 to the NJ Exec Order 26.4 on NJ Ex Order 26.4(b) and NJ Ex Order 26.4, and Resident #3's transfer to the hospital on NJ Ex Order 26.4 At 1:38 a.m., the HWD provided the surveyor with Resident #1 and Resident #3's paper MR and	H5790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75A000	A. BUILDING: _____ B. WING _____	C 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINDSAY PLACE	39 SUPAWNA ROAD PENNSVILLE, NJ 08070

(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
H5790	Continued From page 16 stated if there was a UTF, it would be in the paper MR. The surveyor was not provided with the UTFs for Resident #1 and Resident #3's hospital transfers on [NJ Ex Order 26.4(b)], [NJ Ex Order 26] and [NJ Ex Order 26.4] The surveyor reviewed a facility policy, titled, "New Jersey- Community Emergency Procedures Standard" revealed, "... d) The community shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record ..."	H5790		

POC #2 Recvd 7/15/26
Acceptable letter sent
7/16/26

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The Addison at Lindsay Place
39 Supawna Road, Pennsville, NJ 08070
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The Addison of Linday Place POC -- Survey 5/19/26 + 5/20/26

NJ Ex Order 26.4(

Accepted 7/16/26

A310 8:36-3.4(a)(1) Administrators Responsibilities; Implementation of policies and procedures

1 **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice;**
Resident #1, Resident #2, Resident #4 are still residing in the community (Addison at Lindsay Place). Resident #3 no longer resides in the community after NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) Resident #3 had an investigation completed post NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) the facility cannot retroactively address the identified issue. This investigation wasn't provided per investigation standard policy. The Health and Wellness Director in-serviced all LPN's, CMA's and HHA/CNA's on the call light policy. The ED met with Resident #1, Resident #2 and Resident #4 to discuss call light wait time improvements. The Health and Wellness Director was in-serviced on re-assessment parameters for residents.

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 this deficient practice.

3 **What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur;**
On 7/1/2026 the Health and Wellness Director and Executive Director provided LPN's, CMA's, HHA/CNA's in-services on the call light policy. All in-service records are maintained in an in-service binder in the Executive Director's office.
Executive Director and/or designee will review previous days' call bell logs each morning at stand up. This will be reviewed daily for one months' time, then weekly for two months' time or until compliance is established. Call bell logs will be initialed to confirm review. All reviewed call bell logs will be kept in a binder in Executive Directors office.
Executive Director and Director of Plant Operations have completed a pendant audit to verify all residents have working pendants, completed 6/30/2026.

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Health and Wellness Director or designee to monitor re-admissions from hospital 5 days weekly to capture all reassessments upon resident return from the hospital, completed 6/30/22026.
Executive Director and/or designee will monitor readmissions and verify re-assessment weekly for a months' time, and monthly for two months' time or until compliance is established.
Executive Director and/or designee will prepare redacted investigation reports when investigations are completed in order to provide proof that investigation was completed.

4 **How the facility will monitor the corrective actions to ensure the deficient practice is being correct and will not reoccur;**
The pendant system audit and resident re-assessments upon readmission to facility will be discussed by the Executive Director with Directors in attendance at the next quarterly Quality Assurance review 7/15/2026
Date of Completion: 9/30/2026

A389 8:36-4.1(a)(16) Resident Rights

[redacted] Accepted 7/16/26

1 **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice;**
Resident #3 no longer resides at this community (Addison of Linday Place).
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 this deficient practice.
3 **What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur;**
On 7/1/2026 the Health and Wellness Director and Executive Director provided LPN's, CMA's, HHA/CNA's in-services on the call light policy, Resident Rights Policy, with emphasis on neglect, Resident Bill of Rights (NJ), and expectation of Resident Checks.
Executive Director distributed copies of resident rights to all resident rooms 6/30/2026.
Resident rights are prominently displayed in common area and included in move-in packet.
Executive Director and/or designee will review previous days' call bell logs each morning at stand up. This will be reviewed daily for one months' time, then weekly for two months' time or until compliance is established. Call bell logs will be initialed to confirm review. All reviewed call bell logs will be kept in a binder in Executive Directors office.

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Executive Director and Director of Plant Operations have completed a pendant audit to verify all residents have working pendants, completed 6/30/2026.

4. **How the facility will monitor the corrective actions to ensure the deficient practice is being correct and will not reoccur;**
   The pendant system audit will be discussed and reviewed by the Executive Director and/or designee, each quarter, with Directors in attendance, the next quarterly Quality Assurance review occurring on 7/15/2026.
   Executive Director and/or designee to verify and monitor in-service compliance on Resident Bill of Rights (NJ) every week for one months' time, and thereafter as needed. Resident satisfaction surveys and resident council feedback will be used as monitoring tools.
   Date of Completion: 9/30/2026

[redacted] Accepted 7/16/26

A537 8:36-5.7(a)(1) Policy and Procedure Manual

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice;**
   Residents # 1-4 were potentially affected by this 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 this deficient practice.
3. **What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur;**
   Executive Director printed policy and procedure manual on 07/01/2026 and individually reviewed policies and procedures, dating them with review date.
4. **How the facility will monitor the corrective actions to ensure the deficient practice is being correct and will not reoccur;**
   The policies and procedures will be confirmed quarterly by the Executive Director and/or designee to ensure no changes have been distributed, and Executive Director and/ or Designee will review all policies annually with Directors in attendance, during the Quality Assurance Meeting. All policies and procedures verified 07/01/2026, next review will be 4/15/2027 during quarterly Quality Assurance Meeting.
   Date of Completion: 07/01/2026

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NJ Ex Order 26.4(b) [redacted] Accepted 7/16/26

A1073 8:36-15.6(b) Resident Records

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice;**
   Resident #1 is still residing at the community (Addison at Lindsay Place). Resident #1's progress notes were obtained after conclusion of the survey. Resident #1's progress notes reflected all medication changes noted on statement of deficiencies.
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 of systemic changes made to ensure that the deficient practice will not recur;**
   On 7/1/2026 Executive Director and Health and Wellness Director provided LPN's, CMA's, HHA/CNA's in-services on the documentation guideline and expectation of retention of orders, discharges and other applicable information in Resident Records. All in-service records are maintained in an in-service binder in the Executive Director's office.
   Health and Wellness Director and/or designee will audit the retention of documentation on a weekly basis for a period by maintaining a log of all outside providers and visit dates for one months' time, and biweekly for one months' time, or until compliance is established. This audit will be documented in a log. The Executive Director will initial log to verify review. This log will be maintained in a binder in the Executive Director's office.
4. **How the facility will monitor the corrective actions to ensure the deficient practice is being correct and will not reoccur;**
   The chart audit and documentation guideline will be discussed and reviewed by the Executive Director and/or designee, each quarter, with Directors in attendance, the next quarterly Quality Assurance review occurring on 7/15/2026.
   Date of Completion: 8/31/2026

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The Addison at Lindsay Place
39 Supawna Road, Pennsville, NJ 08070
856-339-0100

[redacted] Accepted 7/16/26

H5790 8:43E-13.4(d) Mandatory Use of Universal Transfer Form

1 **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice;**
Resident #1 is still residing at the community (Addison at Lindsay Place). Resident #3 is no longer residing at the community. Community cannot retroactively create a universal transfer form for Resident #1 and Resident #3. Copy of the Universal Transfer Form was sent with the resident.

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 this deficient practice.

3 **What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur;**
On 7/1/2026 Executive Director and Health and Wellness Director provided LPN's, CMA's, HHA/CNA's in-services on the utilization and retention of the Universal Transfer Form. Health and Wellness Director and/or designee will maintain a log and review all transfers and verify universal transfer form is filed correctly every week for one months' time, and bi-weekly for one months' time or until compliance is established.

4 **How the facility will monitor the corrective actions to ensure the deficient practice is being correct and will not reoccur;**
The universal transfer form audit will be discussed and reviewed by the Executive Director and/or designee, each quarter, with Directors in attendance, the next quarterly Quality Assurance review occurring on 7/15/2026.
Date of Completion: 8/31/2026

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
75A000 Y1	A. Building B. Wing Y2	7/16/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINDSAY PLACE	39 SUPAWNA ROAD PENNSVILLE, NJ 08070

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	Correction	ID Prefix A0389	Correction	ID Prefix A0537	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.7(a)(1)	Completed
LSC	09/30/2026	LSC	09/30/2026	LSC	07/01/2026
ID Prefix A1073	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-15.6(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/31/2026	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/20/2026

☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
75A000		7/16/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINDSAY PLACE	39 SUPAWNA ROAD PENNSVILLE, NJ 08070

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 H5790 Reg. # 8:43E-13.4(d) LSC	Correction Completed 08/31/2026	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 5/20/2026	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: 3MVN12