

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82471	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2025
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NAME OF PROVIDER OR SUPPLIER ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756
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A 000	<p>Initial Comments</p> <p>Initial Comments: Type of Survey:</p> <p>Complaint #: NJ00188390, NJ00188400</p> <p>Census:80</p> <p>Sample Size: 3</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administrator's Responsibilities</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

12/30/25

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188390, NJ00188400</p> <p>Based on observation, interview and review of other pertinent facility documents, it was determined that the Executive Director (ED) failed to implement and enforce the facility policy titled "AS05 - Service Plans and Managed Risk Agreements" related to the development of Health Service Plans (HSP) and updated Service Plans (SP) for 3 of 3 residents reviewed: Resident #'s 1, 2, and 3. This deficient practice was evidenced by the following:</p> <p>1. On 8/11/25, the surveyor reviewed the Medical Record (MR) of Resident #1 that revealed a NJ Ex Order 26, 4B1 [REDACTED]. Surveyor review of Resident #1's Progress Notes (PNs) revealed the resident had received NJ Ex Order 26, 4B1. There was no HSP developed or SP updated for Resident #1 to ensure goals, interventions and effects of treatment were evaluated and reassessed for effectiveness.</p> <p>2. The surveyor reviewed the MR of Resident #2 that revealed a NJ Ex Order 26, 4B1 [REDACTED]. Surveyor review of Resident #2's PNs revealed Resident #2 was participating in NJ Ex Order 26, 4B1 [REDACTED] and NJ Ex Order 26, 4B1 [REDACTED]. There was no HSP developed or SP updated for Resident #2 to ensure goals, interventions and effects of treatment were</p>	A 310		
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New Jersey Department of Health

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A 310	<p>Continued From page 2</p> <p>evaluated and reassessed for effectiveness.</p> <p>3.The surveyor reviewed the MR of Resident #3 that revealed a NJ Ex Order 26, 4B1</p> <p>Surveyor review of Resident #3's PNsa revealed Resident #3 was participating in NJ Ex Order 26, 4B1 (NJ Exec O and NJ Ex Order 26, 4B1 (NJ Exec O There was no HSP developed or SP updated for Resident #3 to ensure goals, interventions and effects of treatment were evaluated and reassessed for effectiveness.</p> <p>At 2:12 p.m., the surveyor interviewed the Director of Health and Wellness (DOHW) regarding Resident #'s 1, 2, and 3's HSPs not being developed and SP not being updated to reflect the residents' NJ Exec Order 26.4b1. The DOHW stated that there was no HSP developed and no SP updated for the above residents. She stated that she had only been at the facility for the last NJ Ex Order 26, 4B1, was still in training, and had been told that the HSP and the SP were the same, and was not familiar with the facility's policy for HSP or SP.</p> <p>At 4:35 p.m., when the surveyor asked about Resident #'s 1, 2, and 3's HSP not being developed and SP not being updated with interventions for the residents' NJ Exec Order 26.4b1, the ED explained that she was not aware that the HSP had not been developed and SP had not been updated for the above-mentioned residents and that she was not familiar with all the nursing policies and the DOHW was new and still training.</p> <p>Surveyor review of a facility policy dated 06/07/2024, titled, " AS05 - Service Plans and Managed Risk Agreements," revealed , "... Procedure:...3. Service Plans are</p>	A 310		

New Jersey Department of Health

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A 310	Continued From page 3 created/updated:...ii. Health Service Plans are developed within 30 days prior to admission (4)...d. Whenever there is significant change in resident status ...b. Health Care Service Plans must include but are not limited to: (6) ...i. Orders for treatment or services ...6... a. The Service Plan should address any outside services received by the resident, including ...Physical Therapy ...,etc."	A 310		
A 517	8:36-5.6(b)(1-7) Staffing 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; and 7. The care of residents with Alzheimer's and	A 517		

New Jersey Department of Health

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A 517	<p>Continued From page 4</p> <p>related dementia conditions and in accordance with N.J.A.C. 8:36-19.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188390, NJ00188400</p> <p>Based on interview and record review, it was determined that the facility failed to ensure completion of the required (mandatory) annual staff education for Resident Rights and/or <small>NJ Exec Order 26</small> and <small>NJ Exec Order 26</small> for 6 of 6 employees, Employee #'s 1, 2, 3, 4, 5 and 6. This deficient practice was evidenced by the following:</p> <p>On 8/11/25 at 1:40 p.m., the Executive Director (ED) of the Assisted Living Program (ALP) provided the surveyor with the 6 personnel files.</p> <p>The surveyor reviewed the 6 personnel files which revealed that there was no documented evidence of the required, annual staff education. The findings were as follows:</p>	A 517		
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A 517	<p>Continued From page 5</p> <ol style="list-style-type: none"> Employee #1 NJ Ex Order 26, 4B1 did not have documented evidence of the mandatory annual staff education for Resident Rights and NJ Exec Order 26.4b and NJ Exec Order 26.4b. Employee #2 NJ Ex Order 26, 4B1 did not have documented evidence of the mandatory annual staff education for Resident Rights and NJ Exec Order 26.4b and NJ Exec Order 26.4b. Employee #3 NJ Ex Order 26, 4B1 did not have documented evidence of the mandatory annual staff education for Resident Rights. Employee #4 NJ Ex Order 26, 4B1 did not have documented evidence of the mandatory annual staff education for Resident Rights and NJ Exec Order 26.4b and NJ Exec Order 26.4b. Employee #5 NJ Ex Order 26, 4B1 did not have documented evidence of the mandatory annual staff education for Resident Rights and NJ Exec Order 26.4b and NJ Exec Order 26.4b. Employee #6 NJ Ex Order 26, 4B1 did not have documented evidence of the mandatory annual staff education for Resident Rights. <p>At 1:58 p.m., the surveyor interviewed the ED and asked about the missing staff education regarding Residents Rights and NJ Exec Order 26.4b and NJ Exec Order 26.4b. The ED stated that the annual staff education for Resident Rights and NJ Exec Order 26.4b and NJ Exec Order 26.4b was not in the employee files and that they were completed using online training system and she then printed and submitted the record of training for all staff members to the surveyor for review.</p>	A 517		

New Jersey Department of Health

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A 517	<p>Continued From page 6</p> <p>The surveyor reviewed the online training record which revealed that 6 of the 6 employees reviewed did not complete annual staff education for Residents Rights, and 4 of the 6 staff members sampled did not complete annual staff education for NJ Exec Order 26.44 and NJ Exec Order 26.44.</p> <p>At 4:35 p.m., the surveyor interviewed the ED and asked if she had any other annual staff education documents available as the online training log did not indicate that the annual staff education was completed. The ED stated that she has only been at the facility for NJ Ex Order 26, 4B1 and that she was told that all annual staff education was completed on the online training system. During the same interview the ED stated that if the training was not listed in the online report, then it was not completed.</p> <p>Surveyor review of a facility policy dated 6/7/24, titled, "GP03 - Abuse, Neglect, and Exploitation", revealed, Procedure:1. All Care Managers will receive in-service training on elder abuse incidence, signs and symptoms of abuse, and reporting requirements during initial orientation. This training will be repeated per state regulations."</p>	A 517		
A 735	<p>8:36-7.2(e)(1-5) Health Care Assmnt. and Health Service Plan</p> <p>(e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following:</p> <p>1. Orders for treatment or services, medications, and diet, if needed;</p>	A 735		

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A 735	<p>Continued From page 7</p> <p>2. The resident's needs and preferences for himself or herself;</p> <p>3. The specific goals of treatment or services, if appropriate;</p> <p>4. The time intervals at which the resident's response to treatment will be reviewed; and</p> <p>5. The measures to be used to assess the effects of treatment.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188390, NJ00188400</p> <p>Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to develop a Health Service Plan (HSP) and update the Service Plan (SP) for participation in ^{NJ Ex Order 26, 4B1} and ^{NJ Ex Order 26, 4B1} ^{NJ Ex Order 26, 4B1} and ^{NJ Ex Order 26, 4B1} for 3 of 3 residents reiveid, Resident #'s 1, 2, and 3. This deficient practice was evidenced by the following:</p> <p>1. On 8/11/25, the surveyor reviewed the Medical Record (MR), that revealed Resident #1 had a ^{NJ Ex Order 26, 4B1}. Surveyor review of Resident #1's provider Progress Notes (PNs) revealed the resident had received ^{NJ Ex Order 26, 4B1}. There was no HSP developed or SP updated for Resident #1 to ensure goals,</p>	A 735		
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A 735	<p>Continued From page 8</p> <p>interventions and effects of treatment were evaluated and reassessed for effectiveness.</p> <p>2.The surveyor reviewed the MR, that revealed Resident #2 had a NJ Ex Order 26, 4B1 [REDACTED]. Surveyor review of Resident #2's provider PNs revealed the Resident #2 was participating in NJ Ex Order 26, 4B1 (NJ Exec [REDACTED]) and NJ Ex Order 26, 4B1 (NJ Exec [REDACTED]). There was no HSP developed or SP updated for Resident #2 to ensure goals, interventions and effects of treatment were evaluated and reassessed for effectiveness.</p> <p>3.The surveyor reviewed the MR, that revealed Resident # 3 had a NJ Ex Order 26, 4B1 [REDACTED]. Surveyor review of Resident #3's provider PNs revealed the Resident #3 was participating in NJ Ex Order 26, 4B1 (NJ Exec [REDACTED]) and NJ Ex Order 26, 4B1 (NJ Exec [REDACTED]). There was no HSP developed or SP updated for Resident #3 to ensure goals, interventions and effects of treatment were evaluated and reassessed for effectiveness.</p> <p>At 2:12 p.m., the surveyor interviewed the Director of Health and Wellness (DOHW) regarding Resident #'s 1, 2, and 3's HSPs not being developed and SPs not being updated to reflect the residents' NJ Exec Order 26.4b1. The DOHW stated that there was no HSP developed and no SP updated for the above residents. She stated that she had only been at the facility for the last NJ Ex Order 26, 4B1, was still in training, and had been told that the HSP and the SP were the same, and was not familiar with the facility's policy for HSP or SP.</p>	A 735		

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A 735	<p>Continued From page 9</p> <p>At 4:35 p.m., the surveyor interviewed the ED asked about Resident #'s 1, 2, and 3's HSPs not being developed and SPs not being updated with interventions for the residents' NJ Exec Order 26.4b1. The ED explained that she was not aware that HSP had not been developed and SP had not been updated for the above-mentioned residents and that she was not familiar with all the nursing policies and the DOHW was new and still training.</p> <p>Lastly, the surveyor reviewed a policy dated 06/07/2024, titled AS05 - Service Plans and Managed Risk Agreements, which stated in part: "...ii. Health Service Plans are developed ...d. Whenever there is significant change in resident status ...b. Health Care Service Plans must include ...i. Orders for treatment or services ...6. The Service Plan should address any outside services received by the resident, including ...Physical Therapy ...," etc.</p>	A 735		
A 763	<p>8:36-7.4(b) Health Care Services</p> <p>(b) A registered professional nurse shall be responsible for developing nursing practice policies and procedures and the coordination of all health care services required in the resident's health service plan.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188390, NJ00188400</p> <p>Based on interview, record review and review of</p>	A 763		

New Jersey Department of Health

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A 763	<p>Continued From page 10</p> <p>other pertinent facility documents, it was determined that a Registered Nurse failed to coordinate health care services for 3 of 3 residents reviewed: Resident #'s 1, 2, and 3. This deficient practice was evidenced by the following:</p> <p>1. On 8/11/25 the surveyor reviewed the Medical Record (MR) of Resident #1 that revealed a ^{NJ Ex Order 2} [REDACTED]. Surveyor review of Resident #1's provider Progress Notes (PNs) revealed the resident had received NJ Ex Order 26, 4B1 and no documentation of the services were available in the MR. Review of Resident # 1's MR revealed no documentation or nursing PNs reflecting coordination of care services.</p> <p>2. The surveyor reviewed the MR of Resident #2 that a NJ Ex Order 26, 4B1 [REDACTED]. Surveyor review of Resident #2's provider PNs revealed the Resident #2 was participating in NJ Ex Order 26, 4B1 (NJ Exec [REDACTED]) and NJ Ex Order 26, 4B1 (NJ Exec [REDACTED]). Further review of the MR revealed no documentation or nursing PNs reflecting coordination of care services.</p> <p>3. Surveyor review of Resident #3's MR, revealed a NJ Ex Order 26, 4B1 [REDACTED]. Surveyor review of Resident #3's provider PNs revealed the Resident #3 was participating in NJ Ex Order 26, 4B1 (NJ Exec [REDACTED]) and NJ Ex Order 26, 4B1 (NJ Exec [REDACTED]). Further review of the MR revealed no documentation or nursing PN reflecting coordination of care services.</p> <p>At 2:12 p.m., the surveyor interviewed the Director of Health and Wellness (DOHW) to inquire about the location of PNs from other</p>	A 763		
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A 763	<p>Continued From page 11</p> <p>disciplines and nursing PN for Resident #'s 1, 2, and 3. The DOHW stated that she did not know why the notes from other disciplines were not in the medical records, but she would print copies for surveyor review. The surveyor asked if she was aware of the services provided for Resident #'s 1,2 and 3, the DOHW stated that she would have to review the Medical Record (MR), as she had been at the facility only [redacted], was still in training and unfamiliar with the residents' service needs.</p> <p>At 2:32 p.m., the DOHW gave the surveyor documents for review regarding Resident #'s 1, 2, and 3's interdisciplinary PNs. The documents reviewed revealed the following:</p> <p>1. Surveyor review of a document for Resident #1, dated 6/30/2025 titled, "Monthly Evaluation," signed by the physician of Resident #1 revealed that the resident had been seen on [redacted] by [redacted]; however, no progress note was documented and that the physician received a [redacted] note that afternoon [redacted] from a [redacted] visit that had occurred on [redacted]. Review of Resident # 1's MR revealed no documentation or PNs reflecting coordination of care services.</p> <p>2. Surveyor review of a document for Resident #2, dated 05/05/25 titled, "[redacted] Evaluation," revealed that Resident #2 reported [redacted]. It included a treatment plan for [redacted] times per week for [redacted] weeks.</p> <p>Surveyor review of a document dated [redacted]</p>	A 763		
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A 763	<p>Continued From page 12</p> <p>titled, "NJ Ex Order 26, 4B1 Evaluation," revealed that Resident #2 would continue NJ Ex Order times per week for NJ Ex Order weeks.</p> <p>3. Surveyor review of a document for Resident #3 dated NJ Exec Order 26.4b1, titled, "NJ Ex Order 26, 4B1 Evaluation," indicated that Resident #3 had been evaluated for NJ Ex Order 26, 4B1 and had attended NJ Ex treatment sessions, with a plan for NJ Ex NJ Ex Order times per week for NJ Ex weeks.</p> <p>Surveyor review of a document dated NJ Exec Order 26.4b1 titled, "NJ Ex Order 26, 4B1 Evaluation," indicated that Resident #3 had been evaluated for NJ Ex Order 26, 4B1 and would continue to be seen NJ Ex Order per week.</p> <p>Surveyor review of a document dated NJ Exec Order 26 titled, "NJ Ex Order 26, 4B1 Evaluation," revealed that Resident #3 had attended NJ Ex treatment sessions following referral for treatment of NJ Ex Order 26, 4B1 and had been NJ Ex Order 26, 4B1 for achieving NJ Exec Order 26.4b1 level.</p>	A 763		
A1231	<p>8:36-17.5(a)(1) Heating and Air Conditioning</p> <p>((a) The heating and air conditioning system shall be adequate to maintain the required temperature in all areas used by residents. Residents may have individually controlled thermostats in residential units in order to maintain temperatures at their own comfort level.</p> <p>1. During the heating season, the temperature in the facility shall be kept at a minimum of 72 degrees Fahrenheit (22 degrees Celsius) during the day ("day" means the time between sunrise</p>	A1231		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82471	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2025
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NAME OF PROVIDER OR SUPPLIER ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756
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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
A1231	<p>Continued From page 13</p> <p>and sunset) and 68 degrees Fahrenheit (20 degrees Celsius) at night, when residents are in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain temperature logs of the resident rooms for 80 of 80 residents. This deficient practice was as evidenced by the following:</p> <p>On 8/8/25 at 9:50 a.m., during document review, the surveyor observed temperature logs for 8/6/25 and 8/7/25 only.</p> <p>At 9:55 a.m., the surveyor interviewed the Administrator, who stated that they do not keep temperature logs for ambient (surrounding) air. The Administrator stated that they were told by the New Jersey Department of Health to start taking air temperature logs starting 8/6/25.</p> <p>At 12:46 p.m. the surveyor interviewed the Maintenance Director (MD). The MD stated that the facility checks ambient air temperatures on a weekly basis, but could not provide a running log to confirm the temperature range.</p> <p>At the time of survey, the facility did not provide a policy on Temperatures.</p>	A1231		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82471	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2025
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NAME OF PROVIDER OR SUPPLIER ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756
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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
A1235 A1235	Continued From page 14 8:36-17.5(a)(3)(i-ii) Heating and Air Conditioning (a) The heating and air conditioning system shall be adequate to maintain the required temperature in all areas used by residents. Residents may have individually controlled thermostats in residential units in order to maintain temperatures at their own comfort level. 3. During warm weather conditions, the temperature within the facility shall not exceed 82 degrees Fahrenheit. i. The facility shall provide for and operate adequate ventilation in all areas used by residents. ii. All areas of the facility used by residents shall be equipped with air conditioning and the air conditioning shall be operated so that the temperature in these areas does not exceed 82 degrees Fahrenheit. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to equip all areas used by residents with air conditioning, affecting 80 of 80 residents. This deficient practice was evidenced by the following: On 8/8/25 at 12:46 p.m., the surveyor interviewed the Maintenance Director (MD) about the temperature, the MD stated that the temperature	A1235 A1235		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82471	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2025
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NAME OF PROVIDER OR SUPPLIER ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756
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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
A1235	<p>Continued From page 15</p> <p>was checked on a weekly basis. The MD continued to say that 89 air conditioning units were installed in resident rooms during February and March.</p> <p>In the same interview, the MD stated that the building does not have any air conditioning systems in hallways and some common areas due to the age of the building. The MD stated that with limited funds, it had been hard to find an air conditioning system to help regulate ambient air temperature. The MD stated that, the facility, runs the air conditioning units in vacant rooms and left the doors open to help regulate air temperatures in hallways.</p> <p>At the time of survey, the facility did not provide a policy on Air Conditioning Systems.</p>	A1235		



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A310

1. To Correct:
 - a. Health Service Plans (HSPs) were developed, and General Service Plans (GSPs) were updated by the Director of Health and Wellness (DHW) for residents # 1 (current resident), #2 (current resident) and #3 (current resident) to reflect the services received, the coordination of care and to ensure goals, interventions and effects of treatment were evaluated and reassessed for effectiveness. These were completed on 11/5/25.
2. To Identify Other Affected:
 - a. All residents have the potential to be affected so to identify if any were affected, an audit was initiated by the DHW on 10/21/25 of current resident medical records to ensure compliance with this regulation.
 - b. HSPs were developed and/or updated by the DHW for current residents affected on 11/5/25.
 - c. GSPs (General Service Plan) were developed and/or updated by the DHW for current residents on 11/5/25.
3. To Prevent Reoccurrence:
 - a. The Executive Director or Designee educated current nursing staff by 11/15/25 on the requirements of this regulation.
 - b. A tracking system and standardized notification form was developed and implemented by the DHW on 11/15/25 to ensure the DHW is notified immediately when a resident begins outside services.
4. To Monitor Continued Effectiveness:
 - a. Interdisciplinary team meetings will be held bimonthly by the DHW and will include review of all new or ongoing outside services beginning on 11/11/25 to confirm appropriate HSP and GSP documentation.
 - b. The Executive Director or Designee will conduct weekly audits x 8 weeks on 10% of residents receiving outside services to confirm that HSPs and GSPs are complete and accurate beginning on 12/10/25.
 - c. Then, the ED will complete monthly audits x 4 months beginning on 2/4/26. Results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee by the ED.
 - d. After six months, beginning on 5/6/26, quarterly audits will be conducted by the ED or designee as part of the facility's ongoing QAPI program. Any discrepancies in HSP or SP, resulting from this audit, will be corrected within 48 hours and staff will receive re-education by the Executive Director or Designee. If no errors are identified, re-education will not be required.
5. Completion Date: 12/31/2026



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A517

1. To Correct:
 - a. All 6 employees reviewed during the survey completed the required mandatory education on Resident Rights and/or Abuse and Neglect via online training system on 11/5/2025.
2. To Identify Other Affected:
 - a. All team members may be affected; to identify those affected, all employee personnel files will be audited by the BOD (Business Office Director) on or before 12/5/25 to identify team members who have not completed the required training and education as outlined in regulation NJAC 8:36-5.6 (b) (1-7).
 - b. All team members will be provided re-education on the topics of Resident Rights and Abuse and Neglect by the ED (Executive Director) or Designee by December 15, 2025. This training will be conducted one time to ensure that all team members are in compliance with the requirement for 2025.
3. To Prevent Reoccurrence:
 - a. A New Hire Checklist was created by the BOD (Business Office Director) on 11/15/25 to include all required education per regulations. The New Hire Checklist will be implemented into the monthly onboarding and orientation process beginning on 12/17/25 by the BOD.
 - b. All new hires will attend mandatory orientation facilitated by the BOD at time of hire, during which time they will receive the required education and training per regulation. New hire orientation will be held monthly beginning on 12/17/25.
 - c. Effective 12/17/25, the ED (Executive Director) or Designee, will review the New Hire Checklist to ensure completion of required training and sign off within 30 days of the team members hire date.
 - d. Effective 12/17/25, the ED or Designee, will facilitate mandatory annual educational training for all current employees to attend during their anniversary month of their original date of hire, training will include the required trainings outlined in regulation NJ 8:36-5.6 (b) (1-7).
 - e. Effective 11/15/25, the Business Office Director will run a monthly online training system report and review with the ED to ensure all team members remain in compliance with assigned training.
4. To Monitor Continued Effectiveness:
 - a. Effective 1/5/26, New Hire Checklists and online training system reports will be reviewed monthly x3, then quarterly in March, June, September and December of 2026 by the ED (Executive Director) or Designee to ensure continued compliance.
5. Overall Completion Date: 12/31/2026



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A735

1. To Correct:

a. Health Service Plans (HSPs) were developed and General Service Plans (GSPs) were updated by the Director of Health and Wellness (DHW) for residents # 1 (current resident), #2 (current resident) and #3 (current resident) to reflect the services received, the coordination of care and to ensure goals, interventions and effects of treatment were evaluated and reassessed for effectiveness. These were completed on 11/5/25.

2. To Identify Other Affected:

- a. All residents have the potential to be affected so to identify if any were affected, an audit was initiated by the DHW on 10/21/25 of current resident medical records to ensure compliance with this regulation.
- b. HSPs were developed and/or updated by the DHW for current residents affected by 11/5/25.
- c. GSPs (General Service Plan) were developed and/or updated by the DHW for current residents on 11/5/25.

3. To Prevent Reoccurrence:

- a. The Executive Director or Designee educated current nursing staff by 11/15/25 on the requirements of this regulation.
- b. A tracking system and standardized notification form was developed and implemented by the DHW on 11/15/25 to ensure the DHW is notified immediately when a resident begins outside services.

4. To Monitor Continued Effectiveness:

- a. Interdisciplinary team meetings will be held bimonthly by the DHW and will include review of all new or ongoing outside services beginning on 11/11/25 to confirm appropriate HSP and GSP documentation.
- b. The Executive Director or Designee will conduct weekly audits x 8 weeks on 10% of residents receiving outside services to confirm that HSPs and GSPs are complete and accurate beginning on 12/10/25.
- c. Then, the ED will complete monthly audits x 4 months beginning on 2/4/26, results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee.
- d. After six months, beginning on 5/6/26, quarterly audits will be conducted as part of the facility's ongoing QAPI program. Any discrepancies in HSP or SP, resulting from this audit, will be corrected within 48 hours and staff will receive re-education by the Executive Director or Designee. If no errors are identified, re-education will not be required.

5. Completion Date: 12/31/2026



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A763

1. To Correct:
 - a. Residents #1 (current resident record updated on [redacted] NJ Exec Order 26.4b), #2 (current resident record updated on [redacted] NJ Exec Order 26.4b), and #3 (current resident record updated on [redacted] NJ Exec Order 26.4b) medical records were reviewed by DHW (Director of Health and Wellness) and updated nursing notes showing coordination of care were added. DHW updated residents Health Service Plans (HSP) and Service Plans (SP) to include outside services, goals, and follow-up. These tasks were all completed by the DHW by 10/20/25.
2. To Identify Other Affected:
 - a. All residents have the potential to be affected so to identify if any were affected, an audit was initiated by the DHW on 10/21/25 of current resident medical records to identify residents receiving outside services.
 - b. Documentation and plans were updated as identified by the DHW on 11/21/25.
3. To Prevent Reoccurrence:
 - a. The Executive Director or Designee facilitated a one-time education for current nursing staff on 11/15/25 on documentation of coordination of care.
 - b. A log was created and implemented by the DHW on 10/20/25 to track all residents receiving outside services and will be reviewed weekly, indefinitely by the DHW during interdisciplinary team meeting.
4. To Monitor Continued Effectiveness:
 - a. Interdisciplinary team meetings will be held bimonthly by the DHW and will include review of all new or ongoing outside services beginning on 11/11/25
 - b. The DHW or Designee will conduct weekly audits x 8 weeks on documentation.
 - c. Then, the DHW will complete monthly audits x 4 months beginning on 2/4/26.
 - d. After six months, beginning on 5/6/26, quarterly audits will be conducted by the DHW or Designee. Any discrepancies will be corrected within 48 hours and staff will receive re-education by the DHW or Designee. If no errors are identified, re-education will not be required.
5. Completion Date: 12/31/2026

A1231

1. To Correct:
 - a. On 11/5/2025, ambient temperatures were taken and recorded for all occupied rooms and communal areas by the DFO (Director of Facility Operations). All areas were measured to within compliant temperature range.
 - b. The Temperature Policy was printed and placed in the Policy and Procedure binder by the ROS (Regional Operations Specialist) on 11/5/25.
 - c. On 11/5/25, the ROS, provided re-education to the DFO on temperature policy and reviewed regulatory temperature thresholds. This training will be conducted one time, or within 14 days



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of the hire of a new DFO.

2. To Identify Other Effected:
 - a. All residents may be affected, in order to identify others affected, on 11/5/25, ambient air temperatures and PTAC service audit was completed for all occupied rooms by the DFO.
 - b. On 11/5/25, portable AC units were offered to residents by the DFO. In the case of a resident refusal and temperatures were measured to be 82 degrees Fahrenheit or greater (or, during the heating season, less than 72 degrees during the day and 68 degrees Fahrenheit at night) , acceptance of the portable AC was encouraged by the DFO, and the refusal was documented. Effective 11/5/25, the DFO or Designee, will maintain a list of these residents and continue to monitor the ambient temperature of these rooms once per shift (AM, PM, Overnight), daily until portable unit is accepted or PTAC service maintains regulatory temperatures. A risk agreement will be completed the DHW (Director of Health and Wellness) if a resident refuses continuously for 3 consecutive days or more when recordings of temperatures are 5 degrees or more out of regulatory range.
3. To Prevent Reoccurrence: 11/30/2025
 - a. On 11/30/25, ambient air temperature logs were implemented by the DFO which include random 10% monitoring of residents' rooms on each floor and all common areas during various times of the day. DFO to notify ED as soon as possible for discrepancies. Any discrepancies found will trigger an additional 10% sample to be recorded until a sample entirely satisfies the temperature requirements. A portable AC/PTAC unit will be offered to an effected resident or placed in common areas by the DFO when needed to maintain compliance. In the case of a resident refusal and temperatures measured to be 82 degrees Fahrenheit or greater, acceptance of the portable AC will be encouraged by the DFO and the refusal will be documented. Effective 11/5/25, the DFO or Designee, will maintain a list of these residents and continue to monitor the ambient temperature of these rooms once per shift (AM, PM, overnight), daily until portable unit is accepted or PTAC service maintains regulatory temperatures. A risk agreement will be completed by the DHW if a resident refuses continuously for 3 consecutive days or more when recordings of temperature are 5 degrees or more out of regulatory range.
4. To Monitor Continued Effectiveness:
 - a. Effective 12/13/25, ambient air temperature logs to be reviewed by ED or designee weekly x4, then monthly x4 and during quarterly in March, June, September, and December 2026 during QA.
5. Completion Date: 12/31/2026

A1235

1. To Correct:
 - a. On 11/5/2025, ambient temperatures were taken and recorded for all occupied rooms and communal areas by the DFO (Director of Facility Operations). All areas were measured to within compliant temperature range.
 - b. The Temperature Policy was printed and placed in the Policy and Procedure binder by the ROS (Regional Operations Specialist) on 11/5/25.
 - c. On 11/5/25, the ROS, provided re-education to the DFO on temperature policy and reviewed regulatory temperature thresholds. This training will be conducted one time, or within 14 days



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- of the hire of a new DFO.
2. To Identify Other Effectuated:
 - a. All residents may be affected, in order to identify others affected, on 11/5/25, ambient air temperatures and PTAC service audit was completed for all occupied rooms by the DFO.
 - b. On 11/5/25, portable AC units were offered to residents by the DFO. In the case of a resident refusal and temperatures were measured to be 82 degrees Fahrenheit or greater (or, during the heating season, less than 72 degrees during the day and 68 degrees Fahrenheit at night), acceptance of the portable AC was encouraged by the DFO, and the refusal was documented. Effective 11/5/25, the DFO or Designee, will maintain a list of these residents and continue to monitor the ambient temperature of these rooms once per shift (AM, PM, Overnight), daily until portable unit is accepted or PTAC service maintains regulatory temperatures. A risk agreement will be completed the DHW (Director of Health and Wellness) if a resident refuses continuously for 3 consecutive days or more when recordings of temperatures are 5 degrees or more out of regulatory range.
 3. To Prevent Reoccurrence: 11/30/2025
 - a. On 11/30/25, ambient air temperature logs were implemented by the DFO which include random 10% monitoring of residents' rooms on each floor and all common areas during various times of the day. DFO to notify ED as soon as possible for discrepancies. Any discrepancies found will trigger an additional 10% sample to be recorded until a sample entirely satisfies the temperature requirements. A portable AC/PTAC unit will be offered to an effected resident or placed in common areas by the DFO when needed to maintain compliance. In the case of a resident refusal and temperatures measured to be 82 degrees Fahrenheit or greater, acceptance of the portable AC will be encouraged by the DFO and the refusal will be documented. Effective 11/5/25, the DFO or Designee, will maintain a list of these residents and continue to monitor the ambient temperature of these rooms once per shift (AM, PM, overnight), daily until portable unit is accepted or PTAC service maintains regulatory temperatures. A risk agreement will be completed by the DHW if a resident refuses continuously for 3 consecutive days or more when recordings of temperature are 5 degrees or more out of regulatory range.
 4. To Monitor Continued Effectiveness:
 - a. Effective 12/13/25, ambient air temperature logs to be reviewed by ED or designee weekly x4, then monthly x4 and during quarterly in March, June, September, and December 2026 during QA.
 5. Completion Date: 12/31/2026

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 82471 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/31/2025 Y3
NAME OF FACILITY ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756	

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 A0517	Correction	ID Prefix A0735	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-7.2(e)(1-5)	Completed
LSC	12/31/2026	LSC	12/31/2026	LSC	12/31/2026
ID Prefix A0763	Correction	ID Prefix A1231	Correction	ID Prefix	Correction
Reg. # 8:36-7.4(b)	Completed	Reg. # 8:36-17.5(a)(1)	Completed	Reg. #	Completed
LSC	12/31/2026	LSC	12/31/2026	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 8/11/2025		<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		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 82471 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/31/2025 Y3
NAME OF FACILITY ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756	

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 A0517	Correction	ID Prefix A0735	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-7.2(e)(1-5)	Completed
LSC	12/31/2026	LSC	12/31/2026	LSC	12/31/2026
ID Prefix A0763	Correction	ID Prefix A1231	Correction	ID Prefix A1235	Correction
Reg. # 8:36-7.4(b)	Completed	Reg. # 8:36-17.5(a)(1)	Completed	Reg. # 8:36-17.5(a)(3)(i-ii)	Completed
LSC	12/31/2026	LSC	12/31/2026	LSC	12/31/2026
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 8/11/2025		<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		