

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>90108</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/20/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MAURICE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1719 WEST MAIN STREET MILLVILLE, NJ 08332</b>
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A 000	<p>Initial Comments</p> <p>Initial Comments: CENSUS: 35 SAMPLE SIZE: 5</p> <p>TYPE OF SURVEY: Standard Survey of 47 residential units</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.</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> <p>A Life Safety Code Survey was conducted by the State Agency on 11/19/2025 - 11/20/2025. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</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

12/24/25

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, document review, and facility policy review, the facility failed to implement their policy to ensure quarterly competency training for 2 Certified Medication Aides [CMA] #1 and CMA #2 ) of 2 CMAs employed by the facility. This deficient practice had the potential to affect all 35 residents who currently resided in the facility.</p> <p>Findings included:</p> <p>An undated facility policy titled, "Medication Assistance Skills Checklist Policy," revealed, "Purpose: The purpose is to validate competency of Medication Associates. Procedure: 1. The Director of Wellness [DOW] assesses the skills and competency of Medication Associates. 2. Medication Associates are assessed prior to independent medication assistance to residents, weekly for one month and quarterly thereafter."</p> <p>CMA #1's "Medication Assistant Competency Checklist" revealed CMA #1 completed medication administration competency training with the DOW on 01/07/2025, 04/15/2025, and 07/15/2025. There was no evidence to indicate competency training after 07/15/2025.</p> <p>CMA #2's "Medication Assistant Competency</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>Checklist" revealed CMA #2 completed medication administration competency training with the DOW on 01/04/2025, 04/05/2025, and 07/10/2025. There was no evidence to indicate competency training after 07/10/2025.</p> <p>During an interview on 11/14/2025 at 11:32 AM, the DOW stated medication competency training was completed with the facility's two CMAs once every quarter. The DOW reviewed the Medication Assistant Competency Checklist for CMA #1 and CMA #2 and stated competency training should have been completed quarterly. The DOW stated she did not have any more recent CMA competency training for CMA #1 or CMA #2.</p> <p>During an interview on 11/14/2025 at 4:45 PM, the Executive Director stated she would expect CMA competency training to be conducted in accordance with the facility policy.</p>	A 310		
A 547	<p>8:36-5.7(a)(6) General Requirements</p> <p>(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:</p> <p>6. Policies and procedures for the maintenance of personnel records for each employee, including at least his or her name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification</p>	A 547		

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A 547	<p>Continued From page 3</p> <p>(if applicable), verification of credentials, records of physical examinations, job description, records of orientation and inservice education, and evaluation of job performance;</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, document review, and facility policy review, the facility failed to maintain personnel records in accordance with the facility policy for 5 (Certified Medication Aide [CMA] #1, CMA #2, Licensed Practical Nurse [LPN] #4, LPN #5, and Home Health Aide [HHA] #3) of 5 personnel files reviewed.</p> <p>Findings included:</p> <p>A facility policy titled, "Personnel File Maintenance Policy," effective 02/01/2024, revealed, "1. Purpose The purpose of this policy is to ensure that personnel records / employee files are created, maintained, accessed, retained, and disposed of in a manner that: * Complies with applicable federal laws and New Jersey state laws; * Protects the confidentiality and integrity of employee information; * Promotes accuracy, consistency and accessibility of employment records; * Minimizes legal and administrative risk." The policy specified, "Documents to include in the personnel file may include (but are not limited to): employment application/resume, offer letter, acknowledgments of handbook receipt, job description/changes, performance evaluations, promotion/transfer records, disciplinary notices, termination/separation documents." Per the policy, "Files may be maintained in paper or electronic format (or a hybrid). If electronic they</p>	A 547		

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A 547	<p>Continued From page 4</p> <p>must be accessible, secure, and retrievable in a format that allows production if required."</p> <p>CMA #1's personnel file revealed no application, education, or work history, no reference checks, no cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED) certification, no <b>NJ Exec Order 26.4b1</b>, no orientation materials, and no proof of participation in an emergency drill.</p> <p>CMA #2's personnel file revealed no application, education, or work history, no reference checks, no job description, no CPR/AED certification, no physical examinations, no <b>NJ Exec Order 26.4b1</b>, no orientation materials, and no proof of participation in an emergency drill.</p> <p>HHA #3's personnel file revealed no application, education, or work history, no reference checks, no job description, no physical examinations, no <b>NJ Exec Order 26.4b1</b>, no orientation materials, no proof of participation in an emergency drill, and no emergency training.</p> <p>LPN #4's personnel file revealed no application, education, or work history, no reference checks, no job description, no CPR/AED certification, no <b>NJ Exec Order 26.4b1</b>, no orientation materials, no proof of participation in an emergency drill, and no documentation of education related to assisted living concepts, resident rights, infection control, abuse and neglect, emergency training, Alzheimer's and dementia, or pain management.</p> <p>LPN #5's personnel file revealed no application, education, or work history, no reference checks, no job description, no physical examinations, no <b>NJ Exec Order 26.4b1</b>, no orientation materials, no</p>	A 547		

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A 547	Continued From page 5  proof of participation in an emergency drill, and no emergency training.  During an interview on 11/14/2025 at 3:46 PM, the Executive Director (ED) stated the staff's personnel files were in the process of being scanned into an electronic human resources system, but a majority of the personnel files had not been scanned and were being stored in two different offices. The ED reviewed the personnel files for CMA #1, CMA #2, HHA #3, LPN #4, and LPN #5 and verified the missing information in each of the personnel files. The ED stated the missing information should be in each of the personnel files.	A 547		
A 751	8:36-7.3(b) Resident Assessments and Care Plans  (b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to update the service plan quarterly for 1 (Resident #2) of 5 sampled residents.  Findings included:  An undated facility policy titled, "Service Plan," revealed, "Purpose: To assist residents in maintaining independence, individuality, dignity,	A 751		

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A 751	<p>Continued From page 6</p> <p>and privacy through a written plan of care. Procedure: 1. The Service Plan is completed by the Director of Wellness or Wellness Nurse" and "4. The Resident Service Plan will be updated with significant change of condition."</p> <p>The "Resident Information" indicated the facility admitted Resident #2 on [redacted NJ Exec Order 26.4b1]. According to the Resident Information, the resident had a medical history that included diagnoses of [redacted NJ Exec Order 26.4b1] and [redacted NJ Exec Order 26.4b1].</p> <p>Resident #2's "Resident Health Record" dated [redacted NJ Exec Order 26.4b1], revealed the resident was on a [redacted NJ Exec Order 26.4b1].</p> <p>Resident #2's "Service Plan Report" with an admission date of [redacted NJ Exec Order 26.4b1] and print date of [redacted NJ Exec Order 26.4b1], revealed no evidence to indicate the resident was on a [redacted NJ Exec Order 26.4b1]. Per the Service Plan Report, "Last Service Plan Review Completed: [redacted NJ Exec Order 26.4b1]."</p> <p>During an interview on 11/14/2025 at 2:50 PM, the Director of Wellness (DOW) stated she was responsible for reviewing the service plans and service plans should be reviewed quarterly. The DOW confirmed she could not find a more recent service plan for Resident #2 other than one that was last reviewed on [redacted NJ Exec Order 26.4b1].</p>	A 751		
A 891	<p>8:36-10.5(a) Dining Services</p> <p>(a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.</p>	A 891		

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A 891	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure opened food items were dated and labeled, expired food items were discarded, and the temperature of the dish machine was at the required temperature per the manufacturer. These deficient practices had the potential to affect all 35 residents who currently resided in the facility</p> <p>Findings included:</p> <p>An undated facility policy titled, "Dishwashing, Log," revealed, "2. The high temperature machine should be 150 - 160 degrees F [Fahrenheit], or as specified by the manufacturer."</p> <p>An undated facility policy titled "Labeling and Dating of Food" revealed, "Procedure: 1. All food removed from original package must have product name, receive date and use by date."</p> <p>During an observation of the kitchen on 11/14/2025 at 7:53 AM, the surveyor noted three unlabeled and undated food items wrapped in plastic wrap. Dietary Aide (DA) #6 stated the food item was ground beef and the manager took it out of the freezer on yesterday as it was planned to be served on 11/16/2025. The surveyor observed an unlabeled and undated storage container of</p>	A 891		

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A 891	<p>Continued From page 8</p> <p>vegetable soup, cucumber salad, and ham. There was an opened five pound container of peeled garlic with a use-by-date of 10/20/2025. There were six peeled eggs in storage container that was not labeled or dated, a plastic bag of shredded cheese with no date, and an unlabeled and undated plastic bag of meat.</p> <p>During an interview on 11/14/2025 at 9:10 AM, DA #7 stated she started the dish machine four to five times before the surveyor entered the kitchen on 11/14/2025. DA #7 stated the sticker attached to the dish machine indicated the temperature for wash should be 160 degrees F; however, the temperature was observed at 148 degrees F. DA #7 stated the staff had been having trouble getting the wash temperature to 160 degrees F. According to DA #7, it had been about one month since the dish machine registered a wash temperature of 160 degrees F.</p> <p>During an interview on 11/14/2025 at 4:36 PM, the Director of Wellness (DOW) stated opened food should be labeled and dated and there should not be any expired food in the kitchen. Per the DOW, the temperature of the dish machine should be what was listed on the sticker on the machine.</p> <p>During an interview on 11/14/2025 at 4:46 PM, DA #6 stated the cooks were responsible for dating and labeling foods and any opened food item should be dated and labeled.</p> <p>During an interview on 11/14/2025 at 4:53 PM, the Executive Director stated opened food items should be properly labeled and the wash temperature of the dish machine should reach the temperature listed on the sticker on the dish machine.</p>	A 891		

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A1051	<p>8:36-15.2 Resident Records</p> <p>The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure a resident's history and physical was maintained in the medical record for 2 (Resident #1 and Resident #4) of 5 sampled residents.</p> <p>Findings included:</p> <p>An undated facility policy titled, "Medical Records Policy," revealed, "3. Policy Statement: The facility maintains complete, accurate, confidential, and up-to-date medical records for each resident."</p> <p>The "Resident Information" revealed the facility admitted Resident #1 on [redacted] NJ Exec Order 26.4b1. Resident #1's record revealed no evidence of a [redacted] NJ Exec Order 26.4b1 and [redacted] completed for the resident.</p> <p>The "Resident Information" revealed the facility admitted Resident #4 on [redacted] NJ Exec Order 26.4b1. Resident #4's record revealed no evidence of a [redacted] NJ Exec Order 26.4b1 and [redacted] completed for the resident.</p> <p>During an interview on 11/14/2025 at 3:13 PM, the Director of Wellness (DOW) stated she could not find the [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1 for Resident #1. The DOW stated she knew Resident #1 had it done, but she could not find the documentation.</p>	A1051		

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A1051	<p>Continued From page 10</p> <p>The DOW stated a resident's history and physical should be in the medical record.</p> <p>During a follow-up interview on 11/14/2025 at 3:35 PM, the DOW stated Resident #4 saw the physician about two weeks prior, but she could not find the documentation for the resident's history and physical. Per the DOW, the resident's history and physical should be in the resident's medical record.</p>	A1051		

POC#3 received 1/9/20  
Accepted 1/9/20



## PLAN OF CORRECTION

**Facility:** Maurice House

**License Type:** Assisted Living Residence

**Census:** 35

**Survey Type:** Standard Survey (47 Residential Units)

**Survey Dates:** 11/14/2025 & Life Safety Code Survey 11/19/2025–11/20/2025

The facility submits the following Plan of Correction in response to the Statement of Deficiencies. The facility understands that this Plan of Correction constitutes an allegation of compliance and that continued compliance will be monitored by the facility.

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### A 310 – N.J.A.C. 8:36-3.4(a)(1)

#### Administration – Policy Implementation (Medication Competency)

##### Deficiency Summary

The facility failed to implement its policy requiring **quarterly medication competency evaluations** for 2 of 2 Certified Medication Aides (CMAs)

##### 1. Immediate Correction for Affected Individuals

- The Director of Wellness (DOW) immediately completed **medication assistance competency evaluations** for CMA #1 and CMA #2.
- Completed competency checklists were placed in each CMA's personnel file.
- No residents were harmed, and medication assistance continued under supervision until competency validation was completed.

##### 2. Systemic Changes to Prevent Recurrence

- The Medication Assistance Skills Checklist Policy was reviewed with the DOW and Executive Director (ED).
  - A **Quarterly CMA Competency Tracking Log** was implemented.
  - Quarterly competency dates are now pre-scheduled on the facility clinical calendar.
-



- The ED will receive written quarterly confirmation of completed competencies.

### 3. Monitoring

- Monthly audits of CMA files by DOW
- Quarterly review by the DOW and ED
- Findings reviewed during QAPI meetings

### 4. Responsible Party

- Director of Wellness
- Oversight: Executive Director

### 5. Date of Compliance

Date of Compliance: \_\_\_\_\_ 11/21/2025 \_\_\_\_\_

*KJ approved  
1/9/20*

## A 547 – N.J.A.C. 8:36-5.7(a)(6)

### Personnel Records

### Deficiency Summary

The facility failed to maintain complete personnel records for 5 of 5 staff files reviewed.

#### 1. Immediate Correction for Affected Individuals

- The ED and DOW conducted a **full audit** of the personnel files for CMA #1, CMA #2, HHA #3, LPN #4, and LPN #5.
- Staff were required to submit missing documentation, including:
  - Applications/resumes
  - Job descriptions
  - CPR/AED certifications
  - Physical exams and PPD testing
  - Orientation and emergency training
  - Education and licensure documentation
- Missing orientation, emergency, and in-service education was provided and documented.



## 2. Systemic Changes to Prevent Recurrence

- The Personnel File Maintenance Policy was re-educated to administrative staff.
- A **standardized Personnel File Checklist** was implemented.
- Personnel records were centralized into **one secure HR system**.
- No employee may work independently without a completed personnel file.

## 3. Monitoring

- Quarterly personnel file audits by the ED.
- Clinical training verification by the DOW.
- Results reviewed in QAPI.

## 4. Responsible Party

- Executive Director
- Clinical Oversight: Director of Wellness

## 5. Date of Compliance

Date of Compliance: \_\_\_\_\_ 1/31/2026 \_\_\_\_\_

*KA approved 1/19/26*

## A 751 – N.J.A.C. 8:36-7.3(b)

### Resident Assessments and Service Plans

### Deficiency Summary

The facility failed to update the quarterly service plan for 1 of 5 residents reviewed.

#### 1. Immediate Correction

- Resident #2's service plan was immediately updated to reflect the **NJ Exec Order 26.4b1**
- The updated service plan was reviewed with care staff.

#### 2. Systemic Changes



- A **Quarterly Service Plan Review Log** was implemented.
- Service plan due dates are now tracked electronically.
- Policy review completed with the DOW.

### 3. Monitoring

- Monthly chart audits by the DOW.
- Quarterly ED review.
- Findings reviewed in QAPI.

### 4. Responsible Party

- Director of Wellness

### 5. Date of Compliance

Date of Compliance: \_\_\_\_\_ 11/28/2025 \_\_\_\_\_

*KZ approved  
1/9/26*

## A 891 – N.J.A.C. 8:36-10.5(a)

### Dining Services / Food Safety

#### Deficiency Summary

The facility failed to ensure food was labeled/dated, expired food discarded, and dish machine temperatures met manufacturer requirements.

#### 1. Immediate Correction

- All unlabeled, undated, and expired food items were discarded immediately.
- Dish machine use was suspended until temperatures were corrected.
- Dietary staff were re-educated on labeling, dating, and temperature requirements.

#### 2. Systemic Changes

- Food labeling and dishwashing policies were re-educated.
- **Daily food labeling checks** implemented.



- Dish machine temperature logs reviewed each shift.
- Maintenance service scheduled for dish machine.

### 3. Monitoring

- Daily kitchen inspections by Dietary Supervisor.
- Monthly ED audits
- Results reviewed in QAPI.

### 4. Responsible Party

- Dietary Supervisor
- Executive Director

### 5. Date of Compliance

Date of Compliance: \_\_\_\_\_ 11/21/2025 \_\_\_\_\_

*Approved  
11/19/20*

## A 1051 – N.J.A.C. 8:36-15.2

### Resident Medical Records

#### Deficiency Summary

The facility failed to maintain a **NJ Exec Order 26.4b1** for 2 of 5 residents reviewed.

#### 1. Immediate Correction

- **NJ Exec Order 26.4b1** for Resident #1 and Resident #4 were obtained and placed in the medical records.
- Records were verified for completeness.

#### 2. Systemic Changes

- Admission checklist revised to require H&P prior to admission completion.
- Quarterly medical records audits implemented.
- Policy re-education completed.



### 3. Monitoring

- Quarterly joint DOW and ED review.
- Findings reviewed in QAPI.

### 4. Responsible Party

- Director of Wellness
- Executive Director

### 5. Date of Compliance

Date of Compliance: \_\_\_\_\_1/31/2026\_\_\_\_\_

*KZ approved  
1/9/26*

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 90108	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 1/9/2026	Y3
NAME OF FACILITY MAURICE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 WEST MAIN STREET MILLVILLE, NJ 08332		

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 A0547	Correction	ID Prefix A0751	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.7(a)(6)	Completed	Reg. # 8:36-7.3(b)	Completed
LSC	11/21/2025	LSC	01/31/2026	LSC	11/28/2025
ID Prefix A0891	Correction	ID Prefix A1051	Correction	ID Prefix	Correction
Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-15.2	Completed	Reg. #	Completed
LSC	11/21/2025	LSC	01/31/2026	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 11/20/2025		<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		