STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Standard with Complaint #'s: NJ 00190468, NJ 00190654 Census: 73 Sample Size: 10 (Residents), 12 (Employees) 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 06/19/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined that the Administrator failed to ensure the development, implementation and enforcement of all policies and procedures pertaining to laundry services, in accordance with N.J.A.C. 8:36-17.8 (a)-(g). This deficient practice was evidenced by the following:

On 5/19/2026 at 10:55 a.m., the surveyor observed a large, wheeled, unlabeled bin that contained soiled linens in the 3rd floor laundry room of the [NJ Ex Order 26.4(b)(1)] unit. Additionally, uncovered residents personal clothing was spread out over one of the washing machines and an uncovered laundry basket containing residents personal clothing was on top the other washing washer.

During surveyor interview with the Maintenance Coordinator (MC) regarding the laundry room, the surveyor asked the MC where soiled linens were kept. The MC stated that soiled linens are usually collected in large, wheeled bins and immediately taken downstairs to the laundry room with the bigger washing machines. The MC further stated that he was unsure if the uncovered personal clothing on top of the washing machines was clean or dirty. The surveyor then requested the facility's policy and procedures for laundry services.

The surveyor reviewed the policies provided by the Senior Executive Director (SED) titled, "Dryer Fire Prevention Policy" and "Ergonomics in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 2 Laundry Room", which revealed that neither policy contained any information which included the protection of clean linens, the storage, transportation, collection and handling of clean and soiled personal clothing and/or linens. During surveyor interview with the SED, The SED stated that she was unable to locate a facility policy and procedure which included the storage, transportation, collection and handling of clean and soiled personal clothing and/or linens.	A 310		
A 473	8:36-5.1(g) Types of Services Provided to Residents (g) The assisted living residence, comprehensive personal care home, or assisted living program shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance (ITM) of the emergency generator was conducted in accordance with applicable Federal, State, and Local laws. This deficient practice was evidenced by the following: On 5/18/26, the surveyor reviewed the	A 473		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 473	Continued From page 3 emergency generator ITM documentation provided by the Maintenance Coordinator, which revealed the following: 1. Monthly load testing of the emergency generator was not being conducted for at least 30 minutes once every 30 days. 2. Battery powered emergency lighting was not provided at 3 of 3 emergency generator Automatic Transfer Switches (ATS). During surveyor interview with the Maintenance Coordinator (MC) regarding the above concerns, the MC confirmed that monthly testing was not being conducted for at least 30 minutes and stated that they would have the generator service company adjust the automatic run timer to ensure that the generator runs for at least 30 minutes. The MC further confirmed that battery powered emergency lighting was not provided at 3 of 3 ATS. At 12:27 p.m., the surveyor observed that the facility's emergency generator was not equipped with a remote emergency stop button. During surveyor interview with the MC, the MC confirmed that the emergency generator did not have a remote emergency stop button. On 5/19/2026 at 10:41 a.m., the surveyor observed that the emergency generator's remote annunciator panel was located in the MC's office and not in a continuously occupied or supervised area. During surveyor interview with the MC regarding the remote annunciator panel, the MC confirmed that the annunciator panel was not located in a	A 473		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 473	Continued From page 4 continuously occupied/ supervised area.	A 473		
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 related dementia conditions and in accordance with N.J.A.C. 8:36-19.	A 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	Continued From page 5	A 517		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined that the facility failed to provide documentation of pain management and/or Alzheimer's dementia care orientation for 9 of 10 employees reviewed, Employee #'s 2, 3, 4, 5, 6, 7, 8, 9 and 10. This deficient practice was evidenced by the following:

On 5/15/25 at 9:30 a.m., and 12:10 p.m., the surveyor reviewed ten (10) employee files and in-service training transcripts, which were provided by the Business Office Coordinator (BOC). The surveyor did not observe documentation which revealed that all 10 employees received the mandatory in-services. The findings were as follows:

1. Employee #2, the Activities and Volunteer Coordinator was hired on [redacted]. The surveyor did not observe documentation which reflected that Employee #2 received pain management education upon or after hire.

2. Employee #3, the Assisted Living Coordinator was hired on [redacted]. The surveyor did not observe documentation which reflected that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	Continued From page 6 Employee #3 received pain management education upon or after hire. 3. Employee #4, the Care Manager was hired on [NJ Ex Order 26.4(b)(1)]. The surveyor did not observe documentation which reflected that Employee #4 received pain management education upon or after hire. 4. Employee #5, the Life Enrichment Manager was hired on [NJ Ex Order 26.4(b)(1)] The surveyor did not observe documentation which reflected that Employee #5 received pain management education upon or after hire. 5. Employee #6, the Licensed Practical Nurse (LPN) Care Manager was hired on [NJ Ex Order 26.4(b)(1)]. The surveyor did not observe documentation which reflected that Employee #6 received pain management education upon or after hire. 6. Employee #7, the Dishwasher was hired on [NJ Ex Order 26.4(b)(1)] The surveyor did not observe documentation which reflected that Employee #7 received pain management education upon or after hire. 7. Employee #8, the Licensed Practical Nurse (LPN) Med Care Manager was hired [NJ Ex Order 26.4(b)(1)]. The surveyor did not observe documentation which reflected that Employee #8 received pain management and Alzheimer's dementia care education upon or after hire. 8. Employee #9, the Care Manager was hired [NJ Ex Order 26.4(b)(1)] The surveyor did not observe documentation which reflected that Employee #9 received pain management education upon or after hire.	A 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	Continued From page 7 9. Employee #10, the Wellness Nurse Registered Nurse (RN) was hired [NJ Ex Order 26.4(b)(1)]. The surveyor did not observe documentation which reflected that Employee #10 received pain management and Alzheimer's dementia care education upon or after hire. At 12:52 p.m., the surveyor interviewed the BOC and Senior Executive Director (SED) and inquired about orientation and the mandatory annual in-services. The SED stated that new-hire orientations should be documented in the employee files. Additionally, the SED stated that all in-services which were completed were documented on the in-service transcripts for each employee.	A 517		
A 753	8:36-7.3(c) General and Health Service Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced by: Complaint: #NJ00190654 Based on interviews and record review, it was determined that the facility failed to document the revision of the General Service Plan (GSP) regarding resident's [NJ Ex Ord] for 1 of 8 residents	A 753		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 753	Continued From page 8 reviewed, Resident #2. This deficient practice was evidenced by the following: On 5/11/26, the Department of Health (DOH) conducted a standard survey with multiple complaints, which revealed resident's care services and General Service plan (SP) which was not updated. On 5/15/25 at 1:04 p.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 diagnoses of NJ Ex Order 26.4(b)(1) . The surveyor reviewed Resident #2's GSP which revealed that there was no evidence of revision and updates documented on Resident #2's GSP after Resident #2 had NJ Ex Ord on NJ Ex Order 26 and on NJ Ex Order 26.4(b) Further review of Resident #2's MR revealed that Resident #2, had a NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(written by the RCD, which revealed that Resident #2 was a high risk for NJ Ex Orde At 2:18 p.m., the surveyor inquired with the Regional Operations Director (ROD) and asked who was responsible for updating and documenting revisions for the GSPs. The ROD stated that the RCD and the Registered Nurses (RNs) were responsible for documenting revisions and updated GSP and assessments. The surveyor asked why the GSP for Resident #2 was not updated. The ROD added that the RCD was no longer employed at the facility at the time of the survey. The ROD confirmed that Resident #2's GSP was not updated after the NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) incident.	A 753		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 753	Continued From page 9 The surveyor reviewed a facility policy titled, "Resident Needs Assessment/Service Plan [HW203-NJ]" dated 01/01/2021, which revealed " Procedure ... 8. Documentation of the review will be indicated in the residents' records and any documentation of any necessary revision of the resident service plan and//or health service plan ..."	A 753		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to label food, monitor the temperature of the refrigerator, freezer and the dish washing machine. Additionally, the facility failed to document results of the sanitization of pots and pans or provide covers for the garbage cans in	A 891		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 10 the kitchen, in accordance with the provisions of Chapter 24, N.J.A.C. 8:24. "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines." This deficient practice was evidenced by the following: 1. On 5/14/26 at 10:14 a.m., the surveyor began the tour the facility's kitchen with the Lead Cook (LC) and the surveyor observed that the following food items were open, however the food items were not labeled with a date: a. Crispy fried onions. b. Loaf of bread. c. 1 large plastic container of strawberry syrup, that was half full. d. Mango syrup, a quarter left in the container. e. A bottle of NJ Ex Order 26.4(b)(1) f. Cake baked in an aluminum pan covered with clear plastic wrap. g. Open bags of pasta wrapped in clear plastic. At 12:32 p.m., the surveyor returned to the kitchen with the chef, who stated that he supervised the food service for the facility. The surveyor identified food items in the dry closet that were open and not labeled. The Chef stated that the open food items should be labeled but he was new to the facility. On 5/15/26 at 10:14 a.m., the surveyor interviewed the Dining Service Coordinator (DSC) who stated that it was the dining staff's responsibility to wrap, label, and date the food	A 891		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 11 items when the food items were opened .The DSC further stated that it was important to label and date open food packages because all food had a shelf life, and all undated food should be discarded. 2. On 5/14/26 at 10:14 a.m., during continued tour with the Lead Cook (LC), the surveyor observed a posted document titled "Pot and Pan Test Strip Log" dated April of 2026 which was completed from day 1 to day 30. The surveyor requested the Pot and Pan Test Strip log from May of 2026. The LC stated that the May 2026 testing sheet was not posted, therefore the staff did not document the results for the month of May 2026. On 5/15/26 at 10:14 a.m., the surveyor interviewed the DSC. During the interview, the DSC stated that it is important for staff to test the sink containing the sanitizer solution to ensure the sanitizer was at the proper concentration and effective in reducing bacterial contamination. 3. On 5/14/26 at 10:14 a.m., during continued tour with the LC, the surveyor requested the dish machine temperature log for May 2026. The LC stated that she did not have a dishwashing machine log or documentation of dishwasher temperatures for the month of May. On 5/15/26 at 12:08 p.m., the surveyor interviewed the DSC who stated that the method of disinfection in the dishwashing machine is the heat. The DSC further stated that documenting the temperature ensured that the machine was working properly and able to "keep everyone safe from bacteria."	A 891		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 12 4. On 5/14/26 at 12:32 p.m., the surveyor requested temperature logs for the refrigerator and the freezer. The Chef provided the surveyor with the temperature log for April of 2026, however the Chef stated that the temperature log for May was not initiated yet. On 5/15/26 at 10:14 a.m., the surveyor interviewed the DSC who stated that the temperature logs for the refrigerator and freezer should be documented twice a day, during the day and at night. The DSC further stated that the food should be kept at the correct temperature, and that any food that was not kept at the correct temperature, should be discarded. 5. On 5/14/26 at 10:15 a.m., the surveyor observed 2 large gray garbage cans in the kitchen which did not have lids. At 12:37 p.m., the surveyor interviewed the Chef, who stated that the kitchen only had "one step trash can" that had a lid. The Chef further stated that he was aware that the other cans in the kitchen did not have any lid covers. The surveyor requested policies and procedures for monitoring temperatures of the refrigerator, the freezer, and the dish washing machine and additionally, sink sanitizing. The DSC and the Executive Director stated that there were no policies, and that the guidelines were clearly written on each log.	A 891		
A 913	8:36-10.5(c)(10) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following:	A 913		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 913	Continued From page 13 10. All meals shall be served at the proper temperature and shall be attractive when served to residents. Place settings and condiments shall be appropriate to the meal; This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to ensure that the food temperature for items prepared in the facility kitchen was obtained and documented in accordance with N.J.A.C. 8:24-3.4(a) and N.J.A.C. 8:36-10.5(a), which require food service operations to comply with the New Jersey Sanitation Code. This deficient practice was evidenced by the following: On 5/14/26 at 12:32 p.m., during the tour of the kitchen with the Chef, the surveyor reviewed a facility document titled, "Production Summary Worksheet with Temps" (PSWT), dated 4/25/26 with food temperatures documented. The surveyor requested the food temperature documentation from 4/26/26 through 4/30/26 and for the month of May 2026. The Chef was unable to provide the documentation to the surveyor. On 5/15/26 at 12:08 p.m., in the presence of the surveyor during the interview, the the Dining Service Coordinator (DSC) reviewed the PSWT. The DSC stated that the Chef was new and did not have access to print the daily PSWT form. The DSC further stated that he could not confirm that the temperatures of the food were taken due	A 913		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 913	Continued From page 14 to the lack of documentation. A review of the facility's undated policy titled, "Dining Services Policy Food Storage, Preparation and Service", documented the following, "...c. food temperatures are taken and recorded on the Production Summary Worksheet with Temperatures fifteen (15) minutes prior to service...d. Safe internal cooking and holding temperatures are defined by the FDA Food Code are met and recorded on the production sheets..."	A 913		
A 935	8:36-11.4(b) Administration of medications (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint: #NJ00190468 Based on interview and record review, it was determined that the Registered Nurse (RN) failed to contact the physician for clarification of a medication order after a hospital discharged for 1 of 8 residents reviewed, Resident #2. This	A 935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 935	Continued From page 15 deficient practice was evidenced by the following: On 5/15/25 at 1:04 p.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 diagnoses of NJ Ex Order 26.4(b)(1) . The surveyor reviewed Resident #2's discharged After Visit Summary Medications dated NJ Ex Order 26.4(b)(1), which revealed the following medications: -NJ Ex Order 26.4(b)(1) take 1 capsule by mouth daily NJ Ex Order 26.4(b)(1) take 2 capsule by mouth nightly NJ Ex Order 26.4(b)(1)) take 2 tablet by mouth daily -NJ Ex Order 26.4(b)(1) take 1 capsule by mouth every 12 hours The surveyor reviewed Resident #2's Medication Administration Record (MAR) which revealed that Resident #2, did not receive medication administration for NJ Ex Order 26.4(b)(1) capsule by mouth nightly, between NJ Ex Order 26.4(b) to NJ Ex Order 26.4(b)(1) post NJ Ex Order 26.4(b discharged. At 1:58 p.m., the surveyor interviewed the Regional Operations Director (ROD) and asked about Resident #2's medication that was not administered. The ROD explained that Resident #2 was at the hospital, scheduled for discharge on NJ Ex Order 26.4(b. The ROD stated that the hospital physician called in new orders for Resident #2, for NJ Ex Order 26.4(b)(1) capsule, to take 1 capsule by mouth daily. The ROD added that Resident #2 returned with an order for NJ Ex Order 26.4(b)(1)	A 935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 935	Continued From page 16 NJ Ex Order 26.4(b)(1) capsule, to take 1 capsule by mouth daily. The ROD confirmed that the Resident Care Coordinator (RCD) failed to call Resident #2's physician for clarification of medications with multiple orders. At 2:18 p.m., the surveyor asked the ROD who was responsible for verifying physician orders. The ROD explained that the RCD was responsible for verifying all medication orders. She added that the RCD was terminated for Resident #2's medication error. The surveyor reviewed a facility sheet titled, "Order Transcription" which revealed the following: "... Obtain ... WRITTEN & ELECTRONIC contact prescriber for clarification or accuracy as needed ..."	A 935		
A 937	8:36-11.5(a) Certified Medication Aide Program (a) The administration of medications is within the scope of practice and remains the responsibility of the registered professional nurse. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility's Registered Nurse (RN), failed to ensure the responsibility of	A 937		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 937	Continued From page 17 overseeing the quarterly medication administration observations for 3 of 3 Certified Medication Aides (CMA), Employee (s) #1, #11 and #12. This deficient practice was evidenced by the following: On 5/15/26 at 11:45 a.m., the surveyor reviewed a facility binder provided by the Regional Director of Resident Care (RDRC) which contained the medication observations for the facility's CMAs, titled, "Medication Skill Capability Evaluation Checklist/ Skill Validation" (MSCE). 1. The surveyor reviewed the MSCEs for Employee #1, a CMA who was hired on [redacted] which were completed on the dates, 11/20/23, 3/26/24, 8/27/24 and 1/24/25. There was no documentation which reflected that the RN had completed the medication administration observations quarterly for Employee #1. 2. The surveyor reviewed the MSCEs for Employee #11, a CMA who was hired on [redacted], which were completed on the dates, 11/27/25 and 2/21/26. There was no documentation provided which reflected that the RN had completed quarterly medication administration observations for Employee #11. 3. The surveyor observed the MSCEs for Employee #12, a CMA and Lead Care Manager, hired on [redacted], which were completed on the dates, 8/16/23, 3/27/25 and 12/16/25. There was no documentation observed which reflected that the RN had completed quarterly medication administration observations for Employee #12. At 1:00 p.m. the surveyor interviewed the RDRC regarding the quarterly MSCE for the CMAs. The RDRC stated that she was aware the former	A 937		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 937	Continued From page 18 Director of Health and Wellness was not completing the medication observations quarterly and that was part of the reason she was no longer employed at the facility. The surveyor reviewed a facility policy titled, Medication Administration/ Assistance: Training & Skill Capability Evaluation, dated 1/24/26, which revealed, "Policy Statement: In addition to the Medication Administration/Assistance: Training & Skill Capability Evaluation policy, the Communities in New Jersey must do the following ...2. It is the responsibility of the Resident Care Director (RCD) that all NJ Certified Medication Aide-CMAs ...shall be observed at least quarterly on going, and the results documented and maintained in the CMA's	A 937		
A1095	8:36-16.5(b) Automatic Fire Detection System (b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101.. This REQUIREMENT is not met as evidenced	A1095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(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
A1095	Continued From page 19 by: Based on interview and record review, it was determined that the facility failed to ensure that the Inspection Testing and Maintenance of the Fire Alarm System (FAS) was in accordance with the National Fire Protection Association NFPA 72, 1999 Edition. This deficient practice was evidenced by the following: On 5/18/2026, the surveyor reviewed the FAS inspection reports provided by the Maintenance Coordinator (MC), which revealed semi-annual load voltage testing of the FAS battery was not conducted. Additionally, annual testing of auxiliary functions which include door-releasing devices, door unlocking, elevator recall and elevator shunt -trip were not conducted. The surveyor interviewed the MC regarding FAS battery and auxiliary function testing and the MC confirmed that the semi-annual and annual inspections were not conducted.	A1095		
A1097	8:36-16.6 Fire Suppression Systems All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23.	A1097		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(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
A1097	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the fire suppression system was in accordance with the Uniform Construction Code, N.J.A.C 5:23. This deficient practice was evidenced by the following: On 5/18/2026 at 9:54 a.m. and 12:22 p.m., the surveyor observed that the gauges on the stairway enclosure standpipes were dated 2014, however sprinkler system gauges are required to be changed every 5 years. During surveyor interview with the Maintenance Coordinator (MC) regarding the standpipe gauges, the MC confirmed that they were dated 2014. The surveyor reviewed the annual fire door inspections provided by the MC, which revealed that annual fire door inspections in accordance with the National Fire Protection Association (NFPA) 80 were last conducted on 5/7/2025, over a year prior to this survey. Additionally, the annual fire door inspections did not include exit stairway enclosure fire doors. During surveyor interview with the MC regarding the annual fire door inspections, the MC confirmed that the inspections were last conducted over a year ago, and that the annual inspection was not conducted on the exit stairway fire doors.	A1097		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(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
A1123	Continued From page 21	A1123		
A1123	8:36-16.12(c) Laundry Equipment (c) When commercial type laundry equipment is utilized, it shall be installed in a separate laundry room. The remainder of the home shall be protected from the laundry room by fire separation assemblies of at least one-hour rated construction. Openings in all fire separation assemblies shall be protected in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that a fire separation assembly of at least one-hour rated construction was provided between the third-floor laundry room and the rest of the facility. This deficient practice was evidenced by the following: On 5/19/2026 at 10:30 a.m., the surveyor observed that the laundry room on the 3rd floor memory care unit contained two natural gas commercial stack dryers. The laundry room wall and door contained non-fire rated glass panels. Additionally, the door to the laundry room did not self-close and positively latch. During surveyor interview with the Maintenance Coordinator (MC) regarding the laundry room, the	A1123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	**404 KING GEORGE ROAD BASKING RIDGE, NJ 07920**

(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
A1123	Continued From page 22 MC confirmed that the pair of commercial stack dryers were natural gas fueled, the wall and door contained non-fire-rated glass and that the door did not self-close and positively latch.	A1123		

POC # 3 received
7/7/26 Accepted

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

Tag A310 8:36-3.4(a)(1) Administrator's Responsibilities

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

- On 06/16/26 the use of individual resident laundry bags was implemented.
- On 6/16/26 ED purchased new laundry bins with lids to be designated as "clean" and "soiled".
- Education by the Executive Director has begun on 6/16/26 for all community staff on the "Linen & Laundry" policy completed on 7/1/2026. Linen & Laundry policy was created 1/1/21 and includes collection, transport, storage and handling of soiled linens & clothing.

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

- All residents have the potential to be affected.

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

- On 06/16/26 the use of individual resident laundry bags was implemented.
- On 6/16/26 ED purchased new laundry bins with lids to be designated as "clean" and "soiled".
- Education by the Executive Director has begun on 6/16/26 for all community staff on the "Linen & Laundry" policy completed on 7/1/2026. Linen & Laundry policy was created 1/1/21 and includes collection, transport, storage and handling of soiled linens & clothing.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Executive Director or designee will audit compliance weekly for 4 weeks and monthly thereafter for 2 months. Audit results & responses will be presented during the quarterly QA/QI meetings.

5. Completion Date for this tag: 7/1/2026

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

Tag A473 8:36-5.1(g) Types of Services Provided to Residents

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

- Maintenance Director completed monthly load testing for full 30 minutes on 6/8/2026.
- Battery powered lanterns were placed at all three automatic transfer switches' (ATS) on 6/19/26.
- Proposal received by vendor and approved on 6/18/26 to relocate the annunciator panel and installation of the emergency stop button.
- Work will be completed by 8/15/26 as vendor has indicated lead time to completion from their inspection will be 2-3 weeks depending on the scope of work after their inspection on 7/8/26.

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

- All residents have the potential to be affected.

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

- Maintenance Director was educated on the requirement of monthly generator load testing completed for a full 30 minutes once every 30 days by the Regional Director of Facilities on 6/16/2026.

- Maintenance Director completed monthly load testing for full 30 minutes on 6/8/2026.
- Battery powered lanterns were placed at all three automatic transfer switches' (ATS) on 6/19/26.
- Proposal received by vendor and approved on 6/18/26 to relocate the annunciator panel and installation of the emergency stop button.
- Work will be completed by 8/15/26 as vendor has indicated lead time to completion from their inspection will be 2-3 weeks depending on the scope of work after their inspection on 7/8/26.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Executive Director or designee will audit compliance monthly for 3 months. Audit results & responses will be presented during the quarterly QA/QI meetings.

5. Completion Date for this tag: 8/15/26

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

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

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

- Employee #2 completed Pain Management training on 7/8/25.
- Employee #3 completed Pain Management training on 7/4/25.
- Employee #4 completed Pain Management training on 6/16/26.
- Employee #5 completed Pain Management training on 7/1/25.
- Employee #6 completed Pain Management training on 7/3/25.
- Employee #7 completed Pain Management training on 6/5/25.
- Employee #8 completed Pain Management training on 6/18/26.
- Employee #9 completed Pain Management training on 7/3/25.
- Employee #10 is no longer employed at the facility.

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

- All residents have the potential to be affected.

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

- Business Office Manager educated on Policy "Team Member Training" on 6/16 by the Executive Director.
- The Executive Director scheduled mandatory education sessions for all team members completed on 6/24/2026, 6/25/2026, 6/26/2026 to include all mandatory training requirements per N.J.A.C 8:36-5.6(b) (1-7).
- The community has coordinated with our training platform, Relias for the Executive Director to receive monthly training completion reports beginning July to monitor training for all community team members. The Executive Director will be responsible for reviewing the reports.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Executive Director or designee will audit compliance monthly for 3 months. Audit results & responses will be presented during the quarterly QA/QI meetings.

5. Completion Date for this tag: 7/1/2026

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

Tag A753 8:36-7.3(c) General & Health Service Plans

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

- Resident # 2's medical record was reviewed by the Regional Health & Wellness Director on 6/1/26. The general service plan was revised to accurately reflect the resident's [redacted], identified [redacted], interventions, and current care needs. The revised General Service Plan was reviewed with the interdisciplinary team and the resident's power of attorney.

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.
- A 100% audit of residents who experienced falls within the previous 90 days, a significant change in condition or hospitalization within the last 90 days was completed on 6/16/26 by the Regional Director of Health & Wellness to ensure corresponding revisions to the General Service Plan and assessments had been documented appropriately. Any identified omissions were corrected immediately.

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

- The Fall & Mobility Management Policy has been implemented by the community as of 6/1/26 and requires review of the GSP following: Any Fall, Hospital return, significant change in condition.
- The Resident Care Director (RCD), or designee will complete a post-fall evaluation which will initiate GSP revision requirements.
- The Resident Care Director (RCD) will verify completion during weekly clinical review.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The RCD or designee will audit 20% of resident falls monthly for 3 months beginning July 2026. Audits will include completed post fall assessment, GSP updated timely, and Resident-specific interventions documented.
- Audit results & responses will be presented during the quarterly QA/QI meetings.

5. Completion Date for this tag: 7/1/26

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26
Tag A891 8:36-10.5(a) Dining Services

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

- On 6/1/26 the Regional Director of Culinary completed an audit to ensure all food items were stored properly, labeled and dated, trash cans with lids, and temperature logs for the dish machine and refrigerators were implemented.
- In-service education completed by the Senior Dining Services Coordinator on 5/27 for the culinary staff which included "Kitchen Safety & Sanitation", "Diets", and "Food Storage, Preparation and Service".
- Contracted Dietician completed comprehensive audit of the community on 6/3/26.
- Education provided to all culinary staff by the Executive Chef on culinary policies "Manual Ware Washing", "Machine Washing- High Temperatures", "Storage", and "Record Keeping & Documentation", and maintenance & documentation of the sanitation testing for pots and pans, began 6/17/26 to be completed by 7/1/26.

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

- All residents have the potential to be affected.

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

- On 6/1/26 the Regional Director of Culinary completed an audit to ensure all food items were stored properly, labeled and dated, trash cans with lids, and temperature logs for the dish machine and refrigerators were implemented.
- In-service education completed by the Senior Dining Services Coordinator on 5/27 for the culinary staff which included "Kitchen Safety & Sanitation", "Diets", and "Food Storage, Preparation and Service".
- Contracted Dietician completed comprehensive audit of the community on 6/3/26.
- Education provided to all culinary staff by the Executive Chef on culinary policies "Manual Ware Washing", "Machine Washing- High Temperatures", "Storage", and "Record Keeping & Documentation", and maintenance & documentation of the sanitation testing for pots and pans, began 6/17/26 to be completed by 7/1/26.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Executive Director or designee will audit compliance weekly for 4 weeks and monthly for 2 months thereafter.
- Community has contracted with a Registered Dietician, to complete random & periodic audits of the community.
- Audit results & responses will be presented during the quarterly QA/QI meetings.

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

5. Completion Date for this tag: 7/1/26

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

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

- Community implemented culinary policies as of 6/1/26 including "Cooking Food", "Use of Thermometers", "Holding Food", "Service Temperatures", and "Record Keeping & Documentation" which include documentation of food temperatures.
- Contracted Dietician completed comprehensive audit of the community on 6/3/26.
- Executive Chef began in-service education on the policies above for all culinary staff on 6/16/26 to be completed by 7/1/2026.

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

- All residents have the potential to be affected.

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

- Community implemented culinary policies as of 6/1/26 including "Cooking Food", "Use of Thermometers", "Holding Food", "Service Temperatures", and "Record Keeping & Documentation" which include documentation of food temperatures.
- Contracted Dietician completed comprehensive audit of the community on 6/3/26.
- Executive Chef began in-service education on the policies above for all culinary staff on 6/16/26 to be completed by 7/1/2026.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Executive Director or designee will audit compliance weekly for 4 weeks then monthly for 2 months thereafter.
- Community has contracted with a Registered Dietician, to complete random & periodic audits of the community.
- Audit results & responses will be presented during the quarterly QA/QI meetings.

5. Completion Date for this tag: 7/1/26

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

Tag A935 8:36-11.4(b) Administration of Medications

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

    - The community implemented the "Readmission Evaluation" in the electronic health record per the policy "Readmission Evaluation".
    - The Resident Care Director (RCD), or designee, must verify completion of reconciliation within 24 hours of readmission and contact the resident's primary care physician; this will be documented in the electronic health record. Education completed for nursing staff including order transcription, medication reconciliation, physician clarification requirements, and readmission evaluation.
    - The pharmacy provider completed training and education on site on 6/16/26.
    - Pharmacy consultant will provide services moving forward. The community will transition Electronic Health Record systems on 7/1.

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.
    - A retrospective audit of all residents returning from hospitalizations within the prior 90 days was completed on 06/1/2026 by the Regional Health & Wellness Director to ensure hospital discharge summaries matched physician orders, medication reconciliation was completed, clarification of conflicting orders occurred, and medication administration records reflected current orders. Any discrepancies identified were corrected immediately.

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

    - The community implemented the "Readmission Evaluation" in the electronic health record per the Monarch policy "Readmission Evaluation".
    - The RCD, or designee, must verify completion of reconciliation within 24 hours of readmission and contact the resident's primary care physician; this will be documented in the electronic health record. Education completed for nursing staff including order transcription, medication reconciliation, physician clarification requirements, and readmission evaluation.
    - The pharmacy provider completed training and education on site on 6/16/26.
    - Pharmacy consultant will provide services moving forward. Community transitioned Electronic Health Record systems on 7/1/26.

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.**

    - The RCD or designee will audit 20% of readmissions monthly for 3 months beginning in July 2026. Audit criteria will include verified physician orders, MAR accuracy confirmed, clarification documented, and reconciliation timely.
    - Audit results & responses will be presented during the quarterly QA/QI meetings.

5. **Completion Date for this tag:** 7/1/26

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

Tag A937 8:36-11.5(a) Certified Medication Aide Program

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

- Employee # 1 is currently out on NJ Ex Order 26.4(b)(1). RN will complete med pass observation upon their return prior to passing medications.
- RN completed med pass observations for Employee #11 & Employee #12 on 5/28/26 using the Medication Skill Capability Evaluation Checklist.

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.
- A 100% audit of all Certified Medication Aides was completed by the Resident Care Director on 06/1/2026 to verify quarterly observations. Any missing observations were completed immediately.

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

- Medication Observation tracking log was adopted per the Policy "Delegation & Skills Competencies" on 6/1/26.
- The RCD will maintain a rolling quarterly schedule identifying due dates for all CMA observations.
- Education was provided to the Resident Care Director (RN) regarding the regulatory requirements for CMA oversight on 6/1/26 by the Regional RN, and Quarterly competency completion status will be reviewed during clinical leadership meetings.

5. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The RCD or designee will review the competency tracker monthly for 12 months to ensure compliance. Audits will include; Quarterly observations completed, Documentation Present, and competencies current.
- Audit results & responses will be presented during the quarterly QA/QI meetings.

5. Completion Date for this tag: 7/1/26

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

Tag A1095 8:36-16.5(b) Automatic Fire Detection System

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

Community initiated contact with Academy Fire Protection to schedule

- The semi-annual load voltage testing of the Fire Alarm System (FAS) battery and the annual testing of the auxiliary system to include the door releasing devices, door unlocking, elevator recall, and elevator shunt-trip was completed by the vendor on 7/1/26.

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

- All residents have the potential to be affected.

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

- The semi-annual load voltage testing of the Fire Alarm System (FAS) battery and the annual testing of the auxiliary system to include the door releasing devices, door unlocking, elevator recall, and elevator shunt-trip was completed by the vendor on 7/1/26.
- Maintenance Coordinator was educated by the Regional Facilities Director on 6/16/26 regarding the inspection testing and maintenance of the fire alarm system (FAS) in accordance with the National Fire Protection Association NFPA 72, 1999 Edition.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Executive Director will audit compliance by documentation review and use of facility's preventative maintenance program annually during QA/QI.

5. Completion Date for this tag: 7/1/26

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

Tag A1097 8:36-16.6 Fire Suppression Systems

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

- Gauge on the stairway enclosure pipe was replaced by Maintenance Director on 6/10/26. The gauge was inspected by the fire vendor on 7/1/26.
- The annual door inspection to which includes the exit stairway enclosure doors was completed by vendor on 7/1/26.

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

- All residents have the potential to be affected.

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

- Gauge on the stairway enclosure pipe was replaced by Maintenance Director on 6/10/26. The gauge was inspected by the fire vendor on 7/1/26.
- The annual door inspection, which includes the exit stairway enclosure doors was completed by vendor on 7/1/26.
- Maintenance Coordinator was educated by the Regional Facilities Director on 6/16/26 regarding requirement of the replacement of the gauges to be replaced every 5 years per the Uniform Construction Code, N.J.A.C 5:23.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Executive Director will audit compliance by documentation review and use of facility's preventative maintenance program annually during QA/QI.

5. Completion Date for this tag: 7/1/26

Monarch Basking Ridge
License #80A008
Plan of Correction 6/18/26

Tag A1123 8:36-16.12(c) Laundry Equipment

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

- The facility has ceased operation of the third-floor laundry room until the appropriate construction has been completed to meet the Uniform Construction Code, N.J.A.C 5:23.

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

- All residents have the potential to be affected.

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

- The laundry room will remain out of operation until it is repaired to meet the requirements of the Uniform Construction Code, N.J.A.C 5:23.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Regional Facilities Director will supervise construction to ensure repairs meet the requirements of Uniform Construction Code 5:23.

5. Completion Date for this tag: 6/18/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
80a008 Y1	A. Building B. Wing Y2	7/7/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

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 A0473	Correction	ID Prefix A0517	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.1(g)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed
LSC	07/01/2026	LSC	08/15/2026	LSC	07/01/2026
ID Prefix A0753	Correction	ID Prefix A0891	Correction	ID Prefix A0913	Correction
Reg. # 8:36-7.3(c)	Completed	Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-10.5(c)(10)	Completed
LSC	07/01/2026	LSC	07/01/2026	LSC	07/01/2026
ID Prefix A0935	Correction	ID Prefix A0937	Correction	ID Prefix A1095	Correction
Reg. # 8:36-11.4(b)	Completed	Reg. # 8:36-11.5(a)	Completed	Reg. # 8:36-16.5(b)	Completed
LSC	07/01/2026	LSC	07/01/2026	LSC	07/01/2026
ID Prefix A1097	Correction	ID Prefix A1123	Correction	ID Prefix	Correction
Reg. # 8:36-16.6	Completed	Reg. # 8:36-16.12(c)	Completed	Reg. #	Completed
LSC	07/01/2026	LSC	06/18/2026	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 5/18/2026

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO