STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	al0101	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT EGG HAR	6817 EBLACK HORSE PIKE EGG HARBOR TOWNSHIP, NJ 08234

(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 Complaint#'s: NJ 00174431, NJ 00183196, NJ 00181592, NJ 00180053, NJ 00174513, NJ 00175472, NJ 00181075 Census: 151 Sample Size: 21 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 Life Safety Code Survey was conducted by the State Agency from 02/26/2025 to 02/27/2025. 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.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following:	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/30/25

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A 310	Continued From page 1 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined that the facility's Executive Director (ED) failed to ensure the implementation, and enforcement of the following facility's polices and procedures: titled, 1.) "Best Practice Guideline: Infection Control Guidelines for Infectious Respiratory Disease Outbreak" when staff failed to provide signage upon entry to the facility, failed to place the correct signage on residents' doors regarding [redacted] for 1 of 4 residents reviewed for [redacted], Resident #3 and 3 unsampled residents, and failed to provide and to educate staff on the correct protective personal equipment (ppe) to wear upon entry and exit into residents' rooms and the ED also failed to ensure that staff members and visitors were monitored for signs and symptoms of NJ Ex Order 26.4(b)(1); 2.) titled, "Incidents/Accidents" and "Incident Reporting" when an unexpected event occurred for 1 of 21 residents, reviewed, Resident #1; 3.) titled "Regularly Scheduled Transportation", and "Transportation" for 3 of 21 residents reviewed, Resident #s 4, 6 and 9. It was also determined	A 310		

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that the Administrator failed to ensure the enforcement of the facility policy titled "Activity Committee"; 4.) titled, "Gratuities" and "Guidelines for Accepting/Rejecting Gratuities", for 1 of 21 residents reviewed, Resident #12; and 5.) titled, "Post Fall Evaluation" by failing to complete a [redacted] assessment after a resident [redacted] assessment for 10 out of 10 residents the Director of Nursing (DON) identified as being [redacted].

These deficient practices were evidenced by the following:

1. On 2/26/25 at 9:10 a.m.., while conducting a Standard with Complaints survey, upon entry into the facility, there was no signage on the door to alert visitors that there was [redacted] in the facility. Once inside the facility, the surveyors observed residents and staff with [redacted] When the surveyors signed in at the front desk, there was a sign that stated [redacted] for residents and guests, Management. The Director of Nursing (DON) greeted the surveyors with a box of [redacted]. The surveyors asked the DON if there was [redacted] in the building, he replied that yes, there were a total of [redacted].

At 9:28 a.m., when the surveyor asked about the placement of the residents with [redacted], the ED, in the presence of the DON stated that the residents had [redacted] signs on their doors and [redacted] their rooms.

At 1:45 p.m., during an interview on the first floor with the Lead Housekeeper (LH), the surveyor observed 2 different signs on 2 resident doors,

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A 310	Continued From page 3 one sign read 'NJ Ex Order 26.4(b)(1) [redacted] and the other sign read '[redacted] with a picture of NJ Ex Order 26.4(b)(1) on it for an unsampled resident, when the surveyor asked her about the difference, she stated that the nurses were responsible for the signs on the doors and the room with the [redacted], NJ Ex Order 26.4(b)(1) was a new [redacted] room. At 2:12 p.m., the surveyor interviewed a Certified Nursing Assistant (CNA) concerning the signage on the doors and she was confused. In the same interview, the surveyor asked her if she received training on the [redacted] protocol since the latest [redacted] on [redacted] and she replied that there was no education provided and housekeeping puts the signs on the doors. At 2:17 p.m., the surveyor interviewed about the signage on the doors, the Licensed Practice Nurse (LPN #1) stated that if a resident had [redacted], the nurses put the signs on the doors. In the same interview, when the surveyor showed her the 2 different signs on the doors, she stated that both residents had [redacted], but the signs were different due to the resident stated it was a HIPPA violation. At 2:32 p.m., the surveyor interviewed LPN #2 about the 2 different door signs and the ppe not available outside the residents' doors, she stated that she did not know how the '*NJ Ex Order 26. 4B1* [redacted] " sign was placed on the door, since both residents were on NJ Ex Order 26.4(b)(1) and she stated the ppe should be outside the residents' doors. Resident #3 had an admission date of [redacted], and diagnoses which *NJ Ex Order 26. 4B1* [redacted].	A 310		

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A 310	Continued From page 4 Review of the "Progress Notes (PNs)" dated NJ Ex Order 26.4(b) revealed Resident #3 had signs and symptoms of NJ Ex Order 26. 4B1, vitals signs done and on NJ Ex Order 26.4(b) the resident developed a NJ Ex Order NJ Ex Order 26. and NJ Ex Order 26. 4B1 and the Nurse Practitioner ordered treatment. At 2:49 p.m., the surveyor observed the 'NJ Ex Order 26. 4B1 " sign on an unsampled resident's door on the second floor. At 4:11 p.m., the DON confirmed that there were only NJ Ex Order 26. 4B1 in the facility, not NJ Ex. On 2/27/25 at 8:45 a.m., the surveyor interviewed the DON about the NJ Ex Order 26. 4B protocol and training staff, he replied that there was no training done and he stated that he absolutely should have done it. When asked about the signage, the DON stated that the precautions signage should have included a NJ Ex Order 26.4(b)(1) The DON continued to say that he was not aware of an NJ Ex Order 26.4(b)(1) Response Plan Policy. In the same interview, when the surveyor asked what staff puts the signage on the residents' doors, the DON stated that he printed them out and the nurses put them on the doors. Surveyor review of the March 4, 2020, facility's policy and procedure titled, "Best Practice Guideline: Infection Control Guidelines for Infectious Respiratory Disease Outbreak" revealed "Purpose: To promote a safe environment for staff, residents and visitors to work and visit during a severe outbreak of infectious respiratory disease...Guidelines: ...3. The Community will take proactive measures to prevent the introduction of respiratory germs into	A 310		

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the community: a. Signs will be posted at the main entrance(s) instructing visitors not to visit if they have symptoms of respiratory infection, including fever, cough and shortness of breath ...4. The Community will take proactive measure sot minimize the spread of respiratory germs within the community: a. Staff will be educated regarding infectious respiratory diseased, including COVID-19, upon hire and as neededd on nautre and type of infectious respiratory outbreak. Education to inlcude: Symptoms of acute respiratory infection; Monitoring/reporting requirements for residents, visitors and staff displaying symptoms of acute respiratory infection. Respiratory hygiene...Hand Hygiene in accordance with CDC (Centers for Disease Control) guidelines...Use of PPE, including donning (putting on) and doffing (taking off) PPE...c. Monitor...employees for fever or respiratory symptoms: Staff will utilize Standard, Contact and Droplet Precautions when caring for residents with an undiagnosed respiratory infection or for a known infectious respiratory disease, such as COVID-19...g. The Communitiy will provide the appropriate supplies to ensure easy and correct use of PPE: A sign will be posted at the entrance to the residents' room clearly describing the type of precautions needed, and the required PPE. PPE, including gowns, facemasks and protective eyewear will be avialaible immediately outside the resident room..."

Complaint#: NJ00174513
2. On 6/6/24, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by health care facilities to report incidents to the NJDOH which revealed a "date of event" [redacted] with a "time of event" 9:45 a.m. that Resident #1 was observed

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in his/her bed NJ Ex Order 26. 4B1 was called, nursing initiated NJ Ex Order 26. 4B1 [redacted] arrived and NJ Ex Order 26. 4B1 the resident.

At 1:25 p.m., while conducting a standard with complaint survey, the surveyor reviewed Resident #1's Electronic Medical Record (EMR) revealed a document titled, "MOVE IN RECORD", which revealed a move in date of NJ Ex Order 26. 4B1 [redacted]. Resident #1's EMR included a document titled, "Progress Notes *New*" which revealed a note written by the Licensed Practice Nurse (LPN# 1) on NJ Ex Order 26.4 at 4:15 p.m., the nurse was called to the room by the Certified Nursing Assistant (CNA), the aide observed the resident in bed, NJ Ex Order 26. 4B1 [redacted] activated, NJ Ex Order 26. 4B1 [redacted] and took over. A second EMR note written by the past ED revealed on NJ Ex Order 26.4 at 9:30 a.m., the aide went to Resident #1's room for a NJ Ex Order 26. 4B appointment and noticed that the resident was NJ Ex Order 26. 4B1 and immediately informed the nurse, the LPN called NJ Ex Order 26. 4B1 [redacted] arrived and started NJ Ex Order [redacted] and then the NJ Ex Order 26. 4B1 arrived and NJ Ex Order 26. 4B1 [redacted].

At 1:56 p.m., when the surveyor asked about Resident #1, the CNA stated that the resident was admitted NJ Ex Order 26. 4B1 and he/she had a NJ Ex Order 26. 4B [redacted] appointment on Monday. She continued to say, on Monday, the LPN asked her to get the resident for his/her appointment, the CNA knocked on the door twice without a NJ Ex Order 26. 4B1 [redacted], so she entered the room and observed the resident NJ Ex Order 26. 4B1 [redacted], so she ran to get the LPN. Then,

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A 310	Continued From page 7 another nurse got the AED then the nurse and the ED ran to [NJ Ex Order 26.4(b)(1)] At 2:45 p.m., the surveyor interviewed the LPN , she stated that when Resident #1 did not come to get his/her medications, she asked the CNA to check on him/her before his/her [NJ Ex Order 26. 4B] appointment. The LPN continued to say that she did not know Resident #1. At 2:51 p.m., when the surveyor asked about the investigation done for this FRE, unexpected [NJ Ex Order 26.], the ED replied that there were no investigations done. At 3:50 p.m., when the surveyor asked if she knew Resident #1, the ED stated that she never met him/her personally and she stated again that there was no investigation done. On 2/27/25 at 9:45 a.m., in the presence of the ED, the Director of Marketing (DM) stated that she was the Manager on Duty on [NJ Ex Order 26.4] and she remembered Resident #1, he/she was [NJ Ex Order 26. 4B1] [redacted]. When the surveyor asked her about the [NJ Ex Order 26. 4B] report and an investigation, she stated that most of the time, the nurses did the [NJ Ex Order 26. 4B] report, documented in a nurse's note then depending on the situation, did an investigation, warranted statements and called the [NJ Ex Order 26.], if needed. She continued to say that she did not think an [NJ Ex Order 26. 4B] report and investigation were done. In the same interview, when the surveyor asked why an incident and investigation were not done, the DM replied that there would not be an [NJ Ex Order 26. 4B] report, only documentation that he/she [NJ Ex Order 26. 4B]. The resident was *NJ Ex Order 26. 4B1*. There was	A 310		

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not always an investigation, depended on the incident and there was no summary and conclusion. The DM gave the surveyor all the information she had.

Surveyor review of an undated policy titled, "Incidents/Accidents" which revealed, "Procedure: Whenever an occurrence or event leads to unintentional consequence and an unfortunate happening to a resident ...on the grounds of [the facility], an Incident/Accident form must be completed. Notify the Manager as soon as possible if there was actual injury to the resident ...When in doubt, complete the form ..."

Surveyor review of an undated policy titled, "Incident Reporting Policy & Procedures" revealed that "Policy It is the policy of [the facility] that any incident or occurrence involving a resident, worker, visitor or vendor ....is reported in full. Definitions [-] Incident: Any happening or unusual occurrence, which is not consistent with the routine operation of the Community or the routine care of a particular resident ...Examples of incidents or occurrences which would be reported (not all-inclusive): ...Serious events, which are defined as unanticipated death ...Procedures: ...Resident Incidents: Complete all information and make appropriate contacts; Complete Incident reports required in community ...An investigation must be initiated within 24 hours of the occurrence by the Executive Director, Community Nurse or designee. The facility Nurse, designee and/or facility Executive Director investigates all incidents to identify or eliminate any possibility of abuse violation ..."
Complaint#: NJ00181075
3. On 12/05/2024 at 4:00 p.m., the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document

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used by health care facilities to report incidents to the NJDOH. The report included a "date of event" of [redacted] and a "time of event" of 2:45 p.m. The FRE revealed that on [redacted] at approximately 12:48 p.m., Resident #4 signed [redacted] out of the facility to go to [redacted]. Resident #4 was going to [redacted] on his/her NJ Ex Order 26. 4B1. At approximately 2:30 p.m. Resident #4 called the facility's front desk to report he/she had been [redacted] near [redacted] while on his/her NJ Ex Order 26. 4B1. The DON and ED went to the scene of the accident. NJ Ex Order 26. 4B1 [redacted] were also at the scene. Resident #4 was visibly [redacted] with an [redacted] NJ Ex Order 26. 4B1 but no NJ Ex Order 26.4(b)(1). Resident #4 refused to go to the [redacted] against medical advise.

On 2/26/25 at 9:00 a.m., Surveyor #1 observed that the [redacted] that Resident #4 was in NJ Ex Order 26.4(b)(1) off a [redacted], on the same side of the highway as the facility.

At 10:11 a.m., Surveyor #1 interviewed Resident #4 who stated that he/she traveled to the [redacted] via his/her NJ Ex Order 26. 4B1 [redacted] per week via the "[redacted]" where he/she doesn't have to cross the busy street. In the same interview, after being NJ Ex Order 26. 4B1 while on his/her [redacted], Resident #4 stated that he/she felt [redacted] going to the [redacted] on his/her [redacted] and the resident used NJ Ex Order 26. 4B1, a service for customers with [redacted] who are [redacted] Upon further interview, Resident #4 stated that the facility did not provide transportation to any activities outside of the facility such as shopping trips or entertainment.

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A 310	Continued From page 10 At 12:32 p.m., Surveyor #1 interviewed a facility Home Health Aide (HHA) who stated there were no regularly scheduled field trips or shopping trips for the residents. The facility HHA stated that if resident's wanted to go offsite for shopping centers, grocery shopping or to the bank they have to get there on their own. At 12:36 p.m., Surveyor #1 interviewed a Licensed Practical Nurse (LPN) who also stated that there were no organized trips for residents outside the facility as the facility does not have a vehicle to transport the residents. At 1:20 p.m., Surveyor #1 interviewed Resident #6 who stated that he/she was not aware of facility providing transportation for the residents to outside activities such as shopping or trips to the bank. At 1:28 p.m. Surveyor #1 interviewed Resident #8 who also stated that there were no field trips offered or available to the residents. At 1:46 p.m., Surveyor #1 interviewed the Activities Director (AD) who stated that the facility provided activities for the residents inside the facility such as chair exercises, a walking club, birthday parties. The AD also stated they provided cultural events for the residents. The AD stated he/she did not have an assistant and an Activity Committee. In the same interview, the AD stated that she was aware that the facility had a policy titled "Activity Committee." Upon further interview, the AD stated that the facility did not provide field trips, bank trips or trips to the grocery store for the residents due to not having access to a bus. Surveyor #1's review of the facility policy titled,	A 310		

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"Regularly Scheduled Transportation", revealed "Procedure: 1. Regularly Scheduled Transportation is available ....3. The bus schedule will be posted ...4. Regularly Scheduled Transportation will go to: the banks, a grocery store. Shopping centers or mall ..."

Continued review of additional facility policy titled, "Transportation" revealed, "Purpose: To provide residents access to services and shopping ..., To provide opportunity for trips through the activity program." "Policy Statement: Three kinds of transportation ...Regularly Scheduled Transportation, Special Request Transportation ... Staff members assigned to drive must have a motor vehicle license ..."
Complaint#: NJ00183196
4. On 2/5/25 the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE) regarding an incident that was reported to the facility's Executive Director (ED) on [redacted]. The FRE revealed that one of the facility's [redacted] was [redacted] with Resident #12 [redacted] and Resident #12 [redacted].

On 2/26/25 and 2/27/25, a survey was conducted at the facility which included a complaint investigation of this FRE.

On 2/26/25 at 12:10 p.m., the surveyor reviewed Resident #12's medical record (MR) which indicated that Resident #12 moved [redacted].

Upon review of Resident #12's MR, the surveyor observed a Progress Note (PN) written by the Director of Nursing (DON) on [redacted] at 2:10

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A 310	Continued From page 12 p.m. which revealed, "*NJ Ex Order 26. 4B1* ..." On 2/26/25 at 9:28 a.m., the survey team interviewed the ED and requested the investigation report that was related to the FRE. At 12:41 p.m., the surveyor reviewed the *NJ Ex Order 26. 4B1* report regarding Resident #12 and the *NJ Ex Order 26. 4B1* and observed the *NJ Ex Order 26. 4B1* written statement, dated NJ Ex Order 26.4(b) which revealed, "...*NJ Ex Order 26. 4B1* ." Upon further review of the investigation report, the surveyor observed a statement that was recorded by the ED on NJ Ex Order 26.4(b) at 12:45 p.m. which stated, "*NJ Ex Order 26. 4B1* ..." At 1:09 p.m., the surveyor interviewed the ED and inquired about the FRE regarding Resident #12 and the *NJ Ex Order 26. 4B1* The ED stated that the *NJ Ex Order 26. 4B1* reported the situation between NJ Ex Order 26. 4 and Resident #12 on NJ Ex Order 26.4(b). The ED stated that she investigated the situation and obtained statements from the *NJ Ex Order 26. 4B1* and Resident #12 on NJ Ex Order 26.4(b). The ED reported that the *NJ Ex Order 26. 4B1* and resident would spend time outside of the facility and the resident bought the *NJ Ex Order 26. 4B1* . The surveyor reviewed an undated facility policy	A 310		

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A 310	Continued From page 13 titled, "Gratuities" which indicated, " ...Policy Statement: Staff members are not permitted to accept tips. Monetary gifts are expressly forbidden ..." Additionally, the surveyor reviewed an undated facility procedure titled, "Guidelines for Accepting/Rejecting Gratuities" which indicated, "Procedure: When gratuities are offered, the following procedures will be followed: 1. The resident will be reminded of the stated policy prohibiting staff members from accepting gratuities ... If money is offered, it will be accepted only with the understanding that it will be placed in the activity fund or some other fund that will be of benefit to the entire community ..." 5. On 2/27/25 at 11:09 a.m., Surveyor #3 interviewed the facility's DON who stated that all the facility's residents were at [redacted]. At 11:30 a.m., the DON provided Surveyor #3 with a list containing [redacted] residents who have been identified as having a [redacted]. At 12:13 p.m., Surveyor #3 interviewed the facility's DON who stated the residents identified as being a [redacted] due to having [redacted]. At 12:18 p.m., Surveyor #3 reviewed the "[redacted] Evaluation" with the facility's DON who stated that he was not aware of the policy and that he did not complete [redacted] assessments after all residents [redacted]. On 2/27/25 at 2:03 p.m., the surveyor reviewed the Electronic Medical Records (EMR) for the [redacted] residents listed as having frequent recent [redacted]	A 310		

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A 310	Continued From page 14 and being a NJ Ex Order 26. 4B1 revealed [redacted] of the [redacted] residents did not have a [redacted] assessment completed in the year of NJ Ex Order 2 [redacted] 1 of the [redacted] residents had one [redacted] assessment dated the day of survey and the remaining resident had two [redacted] assessments completed in NJ Ex Order 2 [redacted] Surveyor review of the facility's policy and procedure titled, "Post Fall Evaluation" revealed, "...Procedure: 1. The post fall assessment (form CS104) is completed after a resident falls by DON or designee."	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to enforce a resident's right to live in safe conditions for 17 of 19 residents, when their NJ Ex Order 26.4(b)(1) were not posted in the kitchen's serving area. This deficient practice was evidenced by the following:	A 401		

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A 401	Continued From page 15 On 2/26/25 at 9:56 a.m., the surveyor toured the serving area in the kitchen and observed a posted document titled, '[redacted] Restrictions as of [redacted]" The document listed the room numbers of residents who could not have NJ Ex Order 26.4(b)(1) [redacted] In addition, the document indicated which residents should receive [redacted] food [redacted] portions. On 2/27/25 at 11:29 a.m., the surveyor interviewed the Lead Culinary Assistant (LCA), who was serving lunch, to inquire how he knew which residents had [redacted] and/or [redacted] [redacted]. The LCA pointed to the posted document titled, '[redacted] Restrictions as of [redacted] and stated that he referred to the document. At 11:40 a.m., the surveyor interviewed the Director of Culinary Experience (DCE) to inquire how the cooks and servers knew which residents required a NJ Ex Order 26.4(b)(1) and/or had [redacted] [redacted]. The DCE confirmed that all [redacted] and NJ Ex Order 26.4(b)(1) were listed on the posted document titled, '[redacted] Restrictions as of [redacted]" At 2:06 p.m., the Director of Nursing (DON) provided the surveyor with the requested [redacted] list titled, "Diet Type Report," which listed [redacted] residents with [redacted] who were not listed on the document titled, "Dietary Restrictions as of [redacted] At 2:21 p.m., the surveyor interviewed the DCE a second time to inquire if the document titled, NJ Ex Order 26.4(b)(1) as of [redacted]," listed all resident [redacted] and NJ Ex Order 26.4(b)(1) The DCE stated that there was [redacted] resident who was [redacted] to [redacted] that was not listed on the	A 401		

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A 401	Continued From page 16 document. In addition, the DCE stated that there was a list of all resident [NJ Ex Order 26.4(b)] posted in the serving area. The surveyor in the presence of the DCE went to the serving area to look for the [NJ Ex Order 26.] list and did not observe one. The DCE then stated that there was an [NJ Ex Order 26.] list posted and that he did not know what happened to it. The surveyor showed the DCE the [NJ Ex Ord] Type Report that was provided by the DON and inquired if he was aware of all the listed food [NJ Ex Order 26.4(b)(1)] The DCE stated that he was not aware of all the [NJ Ex Order 26.4(b)(1)] that were listed on the Diet Type Report. At 2:41 p.m., the surveyor informed the Executive Director (ED) and the DCE that this noncompliance was an imminent danger. On 2/28/25, the ED submitted a removal plan to the Department of Health via email, which indicated that an updated [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] area. In addition, the removal plan indicated that [NJ Ex Order 26.] and nursing staff were educated on the new posted [NJ Ex Or] and [NJ Ex Order 26.] list and the importance of maintaining accurate and up-to-date diet orders and food [NJ Ex Order 26.4(b)(1)] The removal plan also indicated that a [NJ Ex Or] Change/Order Form would be completed whenever there was a new admission or whenever there was a [NJ Ex Order 26.4(b)(1)] change. Lastly, the removal plan indicated that the DCE and nursing department would conduct weekly audits of [NJ Ex Or] orders and [NJ Ex Order 26.4(b)(1)] to ensure compliance.	A 401		
A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and	A 517		

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A 517	Continued From page 17 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; 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		

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A 517	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview, personnel record review, and review of pertinent facility documents, it was determined that the facility failed to provide documented evidence that 3 of 10 employees received all mandatory in-service education upon hire and annually thereafter. This deficient practice was evidenced by the following: On 2/27/25, the surveyor reviewed the personnel records of the Executive Director (ED), who was NJ Ex Order 26. 4B1 and a Culinary Aide, who was NJ Ex Order 26. 4B1. The surveyor did not find the mandatory annual in-services on emergency drill, assisted living concepts, infection control, emergency training, Alzheimer/dementia, or pain management in their personnel records. The surveyor also reviewed the personnel record of the Director of Maintenance, who was NJ Ex Order 26. 4B, and did not find the mandatory annual in-services on Alzheimer/dementia or pain management. At 4:01 p.m., the surveyor interviewed the ED to inquire how often the mandatory in-services were completed, and the ED stated that the mandatory in-services were completed annually. The surveyor then inquired the reason the mandatory in-services were not completed for three of the facility's personnel, including herself. The ED stated that she did complete the mandatory annual in-services and stated that she could locate the documented evidence of the	A 517		

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A 517	Continued From page 19 completed in-services in her personnel record. The ED in the presence of the surveyor searched her personnel record and was not able to locate documented evidence of the completed annual in-services. At 4:13 p.m., the ED stated that she did not complete the mandatory annual in-services in 2024 or 2025. The ED explained that her mandatory annual in-services were due to be completed in September of 2024, however, the ED stated that the facility's new company took over at that time and switched to [NJ Ex: Order 36.] [an online training company]. At this time, the ED stated that if the mandatory annual in-services were not listed on her [NJ Ex: Order 36.] transcript, they were not completed. The surveyor reviewed the job description of the ED, which indicated that the ED was "Responsible for ensuring that [the] facility is in compliance with applicable federal, state, and local laws and regulations [and] Responsible for human resource related activities, including ... in-service/continuing education ..." The job description also indicated that the ED attended in-services and other required meetings and completed online training as assigned in order to maintain company, state, and federal compliance.	A 517		
A 589	8:36-5.12(a) General Requirements (a) The facility shall maintain an annual chronological listing of residents admitted and discharged, including the destination of residents who are discharged. This REQUIREMENT is not met as evidenced	A 589		

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A 589	Continued From page 20 by: Based on interview and record review, it was determined that the facility failed to maintain an accurate Admit/Discharge Register to accurately reflect resident who were NJ Ex Order 26. 4B1 , Resident #8. This deficient practice was evidence by the following: On 2/26/25 at 10:06 a.m., the surveyor team was provided with the facility's admit/discharge register dating NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) At 10:49 a.m., the surveyor reviewed the above mentioned admit/discharge register and did not see Resident #8 listed on the admit/discharge register as being NJ Ex Order 26. 4B1 . At 1:53 p.m., the surveyor interviewed the facility Administrator who stated that Resident #8 was NJ Ex Order 26. 4B1 and should have been listed on the admit/discharge register. At that time, the Administrator stated she would provide the surveyor with an updated register. On 2/27/25 at 11:10 a.m., the surveyor had not received an updated admit/discharge register reflecting Resident #8 was NJ Ex Order 26. 4B1 . At 1:55 p.m., the surveyor reviewed Resident #8 Medical Record (MR) which revealed a document titled, "TRANSFER/DISCHARGE REPORT" which revealed, Resident #8 had an Admission Date of NJ Ex Order 26. 4B1 and a Date of NJ Ex Order 26. 4B1 . The surveyor was not provided a policy in reference to this deficient practice.	A 589		

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A 695	Continued From page 21	A 695		
A 695	8:36-7.1(b) Resident Assessments and Care Plans (b) If this initial assessment indicates the resident has general service needs, a general service plan shall be developed within 14 days of the resident's admission. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility's Director of Nursing (DON) failed to ensure the development and implementation of a NJ Ex Order 26. 4B1 Plan (GSP) for a resident who required assistance with NJ Ex Order 26. 4B1, Resident [redacted]. This deficient practice was evidenced by the following: On 2/27/25 at 1:15 p.m., the surveyor reviewed Resident #5's Electronic Medical Record (EMR) which revealed a document titled, "ADMISSION RECORD" which revealed Resident #5 had an Admission Date of [redacted] and NJ Ex Order 26. 4B1 [redacted]. Continued surveyor review of Resident #5's EMR revealed a document titled, 'NJ Ex Order 26. 4B1 [redacted] Pan - V3" which revealed dated NJ Ex Order 26.4(b)(1) which revealed that the resident required assistance with NJ Ex Order 26. 4B1. The surveyor was unable to locate a GSP in the resident's EMR to alert caregivers that the resident required assistance with NJ Ex Order 26.4(and NJ Ex Order 26.4(b)(1) At 1:31 p.m., the surveyor interviewed the facility's Director of Nursing (DON) who stated that Resident #5 did not have a GSP.	A 695		

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A 695	Continued From page 22 Surveyor review of the undated facility's policy and procedure titled, "Assistance/Service Plan" revealed, "Procedure: ...6. Any Personal Care services will be indicated on the assistance/service plan."	A 695		
A 735	8:36-7.2(e)(1-5) Resident Assessments and Care Plans (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: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility's Director of Nursing (DON) failed to create, implement, and educate	A 735		

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nursing staff on health service plans for:
1) 10 out of 10 residents identified as being [redacted]
2.) 3 of 3 residents identified, Resident [redacted], and 2 unsampled residents receiving [redacted] treatments,
3.) [redacted] out of 10 residents identified receiving care for [redacted], and
4.) [redacted] out of 24 residents identified as receiving [redacted] services.

This deficient practice was evidenced by the following:

On 2/26/2025 at 9:28 a.m., during the survey's entrance conference, Surveyor #6 requested the facility DON provide the surveyor team with a list of residents who were identified as having a NJ Ex Order 26. 4B1 Plan (HSP).

At 11:00 a.m., the survey team had not received the list of residents identified as having an HSP.

At 11:09 a.m., Surveyor #3 interviewed the facility's DON who stated that all the facility's residents were at [redacted]. At that time, Surveyor #3 requested the DON provide the survey team with a list of residents who were at NJ Ex Order 26. 4B1 and have an HSP. During continued surveyor interview the DON stated that he did not know what a HSP was. The surveyor explained what a HSP was, and the DON stated that all the [redacted] residents in the facility had an HSP, in which he created in [redacted] and that he would provide the surveyor with a list of the residents identified as being a [redacted].

At 11:30 a.m., the DON provided Surveyor #3 with a list containing nine residents who have

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A 735	Continued From page 24 been identified as having a NJ Ex Order 26. 4B1. 1. At 11:33 a.m., Surveyor #3 reviewed the facility's Electronic Medical Records (EMRs) for the nine facility residents that were identified for being a NJ Ex Order 26. 4B1. Further review of the [redacted] residents' EMRs revealed no HSP for [redacted]. At 12:13 p.m., Surveyor #3 interviewed the facility's DON who stated the residents identified as being a NJ Ex Order 26. 4B1 did not have an HSP. In the same interview, the DON continued to say that there were [redacted] residents on [redacted]. When Surveyor #6 asked if residents who received special services had a HSP, the DON replied "no." At 1:05 p.m., the facility's DON provided the surveyor with a list of [redacted] residents who were identified as having [redacted] and receiving treatment for their [redacted]. The facility also provided the surveyor with a list of [redacted] residents receiving [redacted] services at that time. 2. On 2/27/2025 at 10:54 a.m., during surveyor interview, Surveyor #3 requested the facility's DON provide the surveyor with HSPs for the residents receiving [redacted] services. 3. At 10:47 a.m., Surveyor #6 reviewed the "Admission Record" for Resident #2 that revealed an Admission Date of NJ Ex Order 26. 4B1 [redacted] Continued surveyor review of the NJ Ex Order 26. 4B1 Report" did not reveal that the resident was receiving [redacted] and there was no HSP for this resident. 3. At 11:26 a.m., the surveyor reviewed the EMRs HSPs for the [redacted] residents identified which	A 735		

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A 735	Continued From page 25 revealed [redacted] of the 10 residents did not have a HSP regarding receiving treatment to their [redacted]. 4. At 1:30 p.m., the surveyor received requested HSPs for residents receiving [redacted] services. Review of the requested HSPs revealed that [redacted] of the 24 residents identified as receiving [redacted] services, HSP did not reveal that the residents were receiving [redacted] services. During continued surveyor review of the requested HSPs revealed that [redacted] residents did not have an HSP. Surveyor review of the undated facility's policy and procedure titled, "Assistance/Service Plan" did not reveal a procedure for ensuring the development and implementation of an HSP for the above-mentioned residents.	A 735		
A 749	8:36-7.3(a) Resident Assessments and Care Plans (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently 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: Complaint#: NJ00183196 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that	A 749		

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A 749	Continued From page 26	A 749		

the resident's general service plan (GSP) was reviewed and revised as needed for any changes in the resident's[NJ Ex Order 26. 4B1] for 1 of 21 residents reviewed, Resident [NJ Ex Or]. This deficient practice is evidenced by the following:

On 2/5/25, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE) regarding an incident that was reported to the facility's Executive Director (ED) on [NJ Ex Order 26.4(b)(1)]. The FRE revealed that one of the facility's [NJ Ex Order 26. 4B1] with Resident #12 outside of the facility and when the [NJ Ex Order 26. 4B1] did not progress any further, Resident #12 left the [NJ Ex Order 26. 4B1] and went to [NJ Ex Order 26. 4B1].

On 2/26/25 and 2/27/25, a survey was conducted at the facility which included a complaint investigation of this FRE.

On 2/26/25 at 12:10 p.m., the surveyor reviewed Resident #12's medical record (MR) which indicated that Resident #12 moved [NJ Ex Order 26. 4B1] [redacted]. The surveyor observed the GSP, dated [NJ Ex Order 26.4(b)(1)] which did not include any goals or interventions to address Resident #12's behavior.

Upon review of Resident #12's MR, the surveyor observed a Progress Note (PN) written by the Director of Nursing (DON) on [NJ Ex Order 26.4(] at 2:10 p.m. which revealed, '[NJ Ex Order 26. 4B1] [redacted]

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A 749	Continued From page 27 NJ Ex Order 26. 4B1 ..." On 2/27/25 at 9:39 a.m., the surveyor interviewed the Licensed Practical Nurse (LPN) who had Resident #12 on her assignment. The LPN reported that Resident #12 had always been pleasant and did not present with any aggressive behaviors before the incident with the NJ Ex Order 26. 4B1. The LPN stated that Resident #12 had no issues since the incident. On 2/26/25 at 12:32 p.m., the surveyor reviewed the 'NJ Ex Order 26. 4B1 Assessment V 1.1" which was completed on NJ Ex Order 26.4(by the Director of Wellness at the time of the assessment. The NJ Ex Order 26.4(b)(1)" section of the assessment stated that Resident #12 was 'NJ Ex Order 26.4(b)(1) and did not require NJ Ex Order 26.4(b)(1) The surveyor observed that NJ Ex Order 26.4(b)(1) " choice was not marked off in this assessment. At 12:41 p.m., the surveyor reviewed the NJ Ex Order 26. 4B1 report regarding Resident #12 and the NJ Ex Order 26. 4B1 and observed the NJ Ex Order 26. 4B1 written statement, dated NJ Ex Order 26.4(b) which revealed, " ..NJ Ex Order 26. 4B1 ..." At 1:09 p.m., the surveyor interviewed the ED and inquired about the FRE regarding Resident #12 and the NJ Ex Order 26. 4B1. The ED stated that the NJ Ex Order 26. 4B1 reported the situation between	A 749		

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A 749	Continued From page 28 NJ Ex Order 26.4 and Resident #12 on NJ Ex Order 26.4(b). The ED stated that she investigated the situation and obtained statements from the NJ Ex Order 26. 4B1 and Resident #12 on NJ Ex Order 26.4(b). The ED reported that the NJ Ex Order 26. 4B1 and resident would NJ Ex Order 26. 4B1 and the resident bought the NJ Ex Order 26. 4B1 . Additionally, the surveyor reviewed the investigation report with the ED. The ED stated that the copies of the handwritten notes, which were included in the NJ Ex Order 26. 4B1 report, were from Resident #12 to the NJ Ex Order 26. 4B1 The ED stated that the letters were slid under doors at the NJ Ex Order 26. 4B1 . On 2/27/25 at 9:05 a.m., the surveyor interviewed the DON and inquired about when a GSP should be reviewed and revised. The DON stated that the GSP should be initiated at admission and reviewed quarterly. When the surveyor inquired specifically about updated the GSP after a NJ Ex Order 26.4(b)(1), the DON stated, "I haven't always done that." The DON acknowledged that he should have done assessments after a NJ Ex Order 26.4(b)(1) At 9:07 a.m., during continued surveyor interview with the DON, the surveyor inquired about the situation between Resident #12 and the NJ Ex Order 26. 4B1. The DON confirmed that Resident #12's GSP was not updated and acknowledged that it should have been updated to reflect the NJ Ex Order 26.4(b)(1) that Resident #12 exhibited. The surveyor reviewed an undated facility policy titled, "Assistance/Service Plan" which indicated, "Procedure: 1. An assistance/service plan will be completed by the Resident Services Coordinator prior to move-in ..." The policy did not include and	A 749		

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A 749	Continued From page 29 address reviewing and revising residents' GSPs as needed for any changes in the resident's physical or cognitive status.	A 749		
A 765	8:36-7.4(c)(1) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00175431 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility 1.) failed to ensure that a Registered Nurse (RN) performed a [redacted] assessment for a resident's NJ Ex Order 26. 4B1 upon return from the [redacted] for 1 of 21 residents, Resident # 18 and 2.) failed to ensure the written policies and procedures were developed and implemented to ensure that assessment of all residents with a NJ Ex Order 26. 4B1 plan (GSP) at least semi-annually. This deficient practice was evidenced by the following:	A 765		

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A 765	Continued From page 30 1. On 2/26/25 and 2/27/25 during a Standard Survey, the Department of Health investigated a Facility Reportable Event dated [NJ Ex Order 26] regarding *NJ Ex Order 26. 4B1* . On 2/26/25 at 10:45 a.m., the surveyor reviewed the medical record (MR) of Resident #18 which revealed that the resident moved *NJ Ex Order 26. 4B1* . In addition, the surveyor reviewed the residents '*NJ Ex Order 26. 4B1* Assessment" dated [NJ Ex Order 26.4] that revealed the resident was mobile and used a *NJ Ex Order 26. 4B1* . During MR review, the surveyor observed that on [NJ Ex Order 26] at 4:09 p.m., a Licensed Practical Nurse (LPN) documented in the "Progress Notes (PN)" that Resident #18 '*NJ Ex Order 26. 4B1* " In addition, the surveyor observed that on [NJ Ex Order 26] at 6:04 p.m., a LPN documented in the PN that Resident #18 *NJ Ex Order 26. 4B1* ." Upon further review of Resident #18's MR, the surveyor observed an '*NJ Ex Order 26. 4B1* Instruction" report dated [NJ Ex Order 26] which revealed	A 765		

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A 765	Continued From page 31 that the resident was NJ Ex Order 26. 4B1 " Additional surveyor review of the MR, revealed that there was no documentation that reflected a return from NJ Ex Order 26. 4B1 assessment was completed. At 2:50 p.m., the surveyor requested copies from the current Executive Director (ED) of assessments completed for Resident #18 for the month of NJ Ex Order 26.4 status post the residents NJ Ex Order 26. 4B1 visit on NJ Ex Order 26.4(b The ED stated that the facility was under new management, and she would have to locate the resident's assessments for that time NJ Ex Order 26.4(b)(1) On 2/27/25 at 9:05 a.m., the surveyor interviewed the Director of Nursing (DON) regarding resident assessments. The DON stated that he was employed at the facility in NJ Ex Order 26. 4B1 and was still learning facility procedure. In addition, the DON stated that resident assessments were done upon admission, quarterly, and sometimes after an incident. At 11:00 a.m., the ED provided the surveyor with a copy of assessments for NJ Ex Order 26. 4B1 dated NJ Ex Order 26 for Resident #18. The ED stated that there were no other NJ Ex O assessments located post the residents return from the NJ Ex Order 26. 4B1 on NJ Ex Order 26.4 2. On 2/26/25 at 9:28 a.m., the survey team requested the Executive Director (ED) to provide facility's policy and procedure manual. At 1:32 p.m., the surveyor reviewed the facility's 'NJ Ex Order 26. 4B1 Plan" policy and procedure and observed that the policy did not include GSP	A 765		

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A 765	Continued From page 32 review and revision guidelines. On 2/27/25 at 9:05 a.m., the surveyor interviewed the Director of Nursing (DON) and inquired about when a GSP should be reviewed and revised. The DON stated that the GSP should be initiated at admission and reviewed quarterly. When the surveyor inquired about updated GSP after a [redacted] the DON stated, "I haven't always done that." The DON acknowledged that he should have done assessment after a [redacted]. At 11:47 a.m., the surveyor interviewed the ED and inquired if there were any other policies regarding service plans. The ED confirmed that the '*NJ Ex Order 26. 4B1* Plan" policy was the only policy regarding [redacted] plans. The surveyor reviewed an undated facility policy titled, "Assistance/Service Plan" which indicated, "Procedure: 1. An assistance/service plan will be completed by the Resident Services Coordinator prior to move-in ... 3. The Resident Services Coordinator will establish a schedule for services based on the assistance/service plan and inform the Resident Assistants of assistance needed ...." The policy did not include reviewing and revising the residents' GSPs at least semi-annually or a *NJ Ex Order 26. 4B1* Plan developed for any changes in the resident's condition, including behavioral, physical or cognitive status change.	A 765		
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	A 891		

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A 891	Continued From page 33 Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to store and label food 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," which placed the highly susceptible population of residents at risk for foodborne illnesses. This deficient practice was evidenced by the following: On 2/26/25 at 9:59 a.m., the surveyor toured the refrigerator in the kitchen and observed the following: 1. One opened 10-pound bag of [redacted] Sliced Pepperoni unwrapped and unlabeled inside of an open box. The box indicated that the pepperoni was ordered on 1/31/25 and that the pepperoni should have been kept frozen. 2. One unopened 12-pound box of [redacted] Fully Cooked Smoked Deli Sliced Turkey Breast with a label that indicated that the turkey breast should be used or frozen by 2/20/25.	A 891		

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A 891	Continued From page 34 3. One unopened 5-pound package of NJ Ex Order 26.4(b)(1 [redacted] Hot Dogs with a label that indicated that the hot dogs were ordered on 2/18/25 and that the hot dogs should be kept frozen. 4. One opened 4-pound 8-ounce container of coleslaw that was not dated or labeled after it was opened and used. 5. (4) squeeze bottles of what appeared to be salad dressing (two with blue tape, one labeled mayo and the other labeled french, 2 unlabeled) all unlabeled without a use-by date. At 10:29 a.m., the Director of Culinary Experience (DCE) entered the refrigerator, and the surveyor interviewed him to inquire the reason there was opened and unlabeled pepperoni in the refrigerator. The DCE stated that the kitchen served pizza a few days ago and that the open package of pepperoni should have been wrapped and labeled. The surveyor then asked the DCE what he would do with the pepperoni that was left open and unlabeled, and the DCE stated that he would go wrap it. The surveyor then inquired how long the pepperoni was open to air inside the refrigerator, and the DCE stated that the pepperoni was open for 1-2 days. At this time, the surveyor requested that the DCE dispose of the pepperoni. In addition, the surveyor inquired when the coleslaw was opened, and the DCE stated that the coleslaw was served on 2/25/25. The surveyor then asked the reason the coleslaw was not dated after it was used, and the DCE stated that he did not know. The surveyor inquired the reason the squeeze bottles were not labeled, and the DCE stated, "Yes, we have to label them." The surveyor reviewed the "Week At a Glance,"	A 891		

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A 891	Continued From page 35	A 891		

menus for February of 2025, which revealed that cheese pizza was last served on 2/12/25 for lunch, and coleslaw was last served on 2/25/25 for lunch.

At 10:44 a.m., the surveyor interviewed the cook to inquire when the kitchen served coleslaw, and the cook stated that coleslaw was served two days ago (2/24/25).

At 10:45 a.m., the surveyor toured the freezer and observed the following:

1. One tray of unlabeled and undated biscuits.
2. One closed bag of NJ Ex Order 26.4(b)(1) Beer Battered Thick Cut Onion Rings without a label or date.

At 11:29 a.m., the surveyor toured the dry storage area and observed the following:

1. One opened jar of NJ Ex Order 26.4(b)(1) Salsa without a label to indicate when it was opened.
2. Five undated 4-pound 8-ounce jars of NJ Ex Order 26.4(b)(1) Large Maraschino Cherries with Stems
3. One undated 1-pound 8-ounce container of NJ Ex Order 26.4(b) Grits
4. One dented 6-pound can of NJ Ex Order 26.4(b)(1) Mashed Potatoes
5. One dented 7-pound 5-ounce can of NJ Ex Order 26.4(b)(1) Jellied Cranberry Sauce
6. Three dented 6-pound 8-ounce cans of NJ Ex Order 26.4(b)(1) Sliced Apples
7. One open package of NJ Ex Order 26.4(b)(1) Flame Raisins plastic wrapped without a label or date.
8. Two undated 1-pound 8-ounce bags of NJ Ex Order 26.4(b)(1) Crispy Onions

At 11:48 p.m., the surveyor showed the DCE the previously mentioned dented cans, and the DCE began to remove the cans from the shelf. The

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A 891	Continued From page 36	A 891		

surveyor inquired what the protocol was for dented cans. The DCE stated that the staff who received the food truck should remove any dented cans and send them back with the food product supplier. The DCE also stated that dented cans that were found after the food product supplier truck left should be removed from the dry storage area and placed on a shelf in the back until the food product supplier could pick them up.

During this interview, the surveyor also inquired the reason the raisins and crispy onions were not labeled, and the DCE stated that they should have been labeled. The surveyor showed the DCE the opened jar of salsa, and the DCE stated, "I'll chuck this." At this time, in the presence of the DCE, the surveyor observed four 2-pound bags of [redacted] Powdered Sugar that were not labeled or dated and one open and unlabeled bag of [redacted] pasta. The DCE stated that the powdered sugar and pasta should have been labeled and dated.

At 12:05 p.m., the surveyor toured the emergency food supply and observed one dented 6-pound 6-ounce can of [redacted] White Potatoes. The can of potatoes was removed by a line cook.

At 1:41 p.m., the surveyor interviewed the Executive Director (ED) to inquire what the protcol was when the facility received a delivery from their food product supplier. The ED stated that once the food was delivered, it was put away. The ED explained that if food was opened, it should be covered with wrap or put in a container and labeled with a date. The surveyor then inquired how often food was checked for expiration dates, and the ED stated that foods should be checked for expiration daily. In

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A 891	Continued From page 37 addition, the surveyor inquired what should be done with dented cans, and the ED stated that all dented cans were supposed to be returned to the food product supplier. The surveyor reviewed the facility's policy titled, "Food Safety," which indicated, "Policy Statement: ... All staff will be trained and aware of proper food handling and storage procedures as per local and state regulations...." The surveyor also reviewed the facility's policy titled, "Storage of Refrigerated and Dry Foods," which indicated, "Procedure: ... 4. All containers must be labeled with the contents and date food item was placed in storage... 7. All dry foods must be dated and stored in a temperature-controlled environment ...."	A 891		
A 907	8:36-10.5(c)(7) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 7. Between-meal snacks and beverages shall be available at all times for each resident, unless medically contraindicated as documented by a physician in the resident's health care plan; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to ensure that between-meal snacks were available for residents at all times. This deficient practice was evidenced by the	A 907		

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NEW STANDARD SENIOR LIVING AT EGG HAR	6817 EBLACK HORSE PIKE EGG HARBOR TOWNSHIP, NJ 08234

(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 907	Continued From page 38 following: On 2/26/25, the surveyor toured the facility and did not observe any snacks that were left out for residents at all times. At 3:00 p.m., the surveyor interviewed the Director of Culinary Experience (DCE) to inquire if between meal snacks were always available to residents and to inquire where the snacks were located. The DCE stated that the facility provided snacks to residents including apple sauce, pudding, sugar-free individually packed cookies, and peanut butter crackers, which were located at each nursing station. The DCE explained that the facility used to keep snacks out in the open and some residents would take them all. The DCE stated that residents were aware that snacks were located at the nursing stations and that residents would receive snacks upon request from staff. On 2/27/25 at 9:54 a.m., the surveyor interviewed a Licensed Practical Nurse (LPN) at nursing station "Wellness 1," to inquire if there were any snacks for residents. The LPN stated that there was chocolate pudding and apple sauce in the back room. At 9:57 a.m., the surveyor interviewed another LPN at nursing station "Wellness 2," to inquire if there were any snacks for residents. The LPN stated that there were no snacks for residents at the nursing stations and that snacks had not been kept at the nursing stations since she started [redacted] months ago. At 10:15 a.m., the surveyor interviewed two Home Health Aides (HHAs) at nursing station "Wellness 3," to inquire if there were any snacks for	A 907		

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A 907	Continued From page 39	A 907		

residents. Both HHAs stated that there were no snacks for residents at the nursing station. However, both HHAs stated that the nursing station had apple sauce and pudding that was used by the nurses to administer medications.

At 10:22 a.m. and 10:26 a.m., the surveyor interviewed Resident #13 and Resident #15 to inquire if the facility provided snacks. Resident #13 stated that NJ Ex Order 26. 4B1 [redacted]. Resident #13 stated that NJ Ex Order 26. 4 [redacted].
Another resident, Resident #15 stated that NJ Ex Order 2 [redacted].

At 10:58 a.m., the surveyor interviewed another LPN at nursing station "Wellness 4," to inquire if there were any snacks for residents. The LPN stated that snacks were not kept at the nursing station for residents. The LPN explained that there was a refreshment cart in the activities room at 2:30 p.m.

At 11:40 a.m., the surveyor interviewed the DCE a second time to inquire the reason there was only apple sauce and pudding at two of four nursing stations and the reason some staff stated that the apple sauce and pudding was for medication administration. The DCE stated that the apple sauce and pudding were snacks for the residents and that if the nursing stations were out of snacks, they had to inform dietary. The surveyor inquired if dietary refilled the snacks each day, and the DCE stated that no one from dietary checked to see if the nursing stations were out of snacks and that it was the responsibility of the nursing station to request

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A 907	Continued From page 40 snacks if they needed them. The surveyor then inquired the reason four of five staff interviewed at the nursing stations were not aware that snacks were located at the nursing stations. The DCE stated that he did not know why staff were not aware that snacks were kept at the nursing stations. At 4:01 p.m., the surveyor interviewed the Executive Director (ED) to inquire where snacks for the residents were located. The ED confirmed that snacks were kept at the nursing stations. The ED also stated that the snacks were not left for "free grab," because some residents would take them all. The surveyor reviewed a facility policy titled, "Bistro Area," which indicated, "Procedure: 1. Food will be available 24-hours a day in the Bistro Area ... 3. Foods available in the Bistro Area will include: a. snack foods (crackers, chips, pretzels, etc). b. beverages (fruit juices, milk, coffee, tea). c. fresh fruits in season. d. desserts ..." At 4:01 p.m. and 4:35 p.m., the surveyor interviewed the Executive Director (ED) and the DCE to inquire if the facility had a bistro, and they both stated that the facility did not have a bistro.	A 907		
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: 10. All meals shall be served at the proper temperature and shall be attractive when served to residents. Place settings and condiments	A 913		

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A 913	Continued From page 41 shall be appropriate to the meal; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to ensure meals were served at the proper temperature, in accordance with New Jersey Administrative Code (N.J.A.C.) 8:24, to remain palatable and prevent the risk of foodborne illnesses. This deficient practice was evidenced by the following: On 2/26/25 at 1:03 p.m. and 1:12 p.m., the surveyor interviewed Resident #13 and Resident #14 to inquire how they liked the food at the facility. Resident #13 stated that NJ Ex Order 26. 4B1 [redacted]. Resident #13 also stated that NJ Ex Order 26. 4B1 [redacted]. In addition, Resident #13 stated that NJ Ex Order 26. 4B1 [redacted]. Another resident, Resident #14, stated that NJ Ex Order 26. 4B1 [redacted]. On 2/27/25 at 9:24 a.m., the surveyor interviewed the Director of Culinary Experience (DCE) to inquire if he received complaints from residents about cold food. The DCE stated that the facility did not have a box warmer to transport food trays to the residents and that some residents had complained that since NJ Ex Order 26. 4 [redacted] precautions were put in place, the food was served cold.	A 913		

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A 913	Continued From page 42 The surveyor reviewed the, "Resident Council Meeting Minutes," dated [redacted] which indicated that the food was cold. At 10:26 a.m., the surveyor interviewed Resident #15 to inquire how the resident liked the food, and Resident #15 stated that [redacted]. At 11:29 a.m., the surveyor observed a Lead Culinary Assistant (LCA) plating lunch trays while Culinary Aides placed the finished trays onto a cart to deliver the trays to residents. The surveyor asked the LCA to do a temperature check on one of the trays from the cart. The temperature of the chicken was 137.8 degrees Fahrenheit (F), and the French fries were 125 degrees F. The surveyor reviewed the facility's policy titled, "Procedure: Title: Food Temperatures" which indicated,"Procedure: "Hot foods should be maintained at a minimum of 140 degrees F..."	A 913		
A 935	8:36-11.4(b) Pharmaceutical Services (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.	A 935		

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A 935	Continued From page 43 This REQUIREMENT is not met as evidenced by: Complaint#: NJ00174513 Based on interview and record review, it was determined that the facility failed to ensure that medication was administered in accordance with the prescriber's orders for 1 of 21 residents reviewed, Resident # 1. This deficient practice was evidenced by the following: On 6/6/24, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by health care facilities to report incidents to the NJDOH which revealed a "date of event" [redacted] with a "time of event" 9:45 a.m. that Resident #1 was observed in his/her bed [redacted] was called, nursing initiated [redacted] the [redacted] arrived and [redacted]. At 1:25 p.m., while conducting a standard with complaint survey, the surveyor reviewed Resident #1's Electronic Medical Record (EMR) revealed a document titled, "MOVE IN RECORD", which revealed a move [redacted]. The surveyor reviewed Resident #1's Medication Administration Record (MAR) dated [redacted] that revealed on [redacted] all the following medications were coded as "[redacted]" (not confirmed administered): '[redacted] 1 tablet	A 935		

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A 935	Continued From page 44	A 935		

NJ Ex Order 26. 4B1
NJ Ex Order 26. 4B1 2 tablets times a day with meals
NJ Ex Order 26. 4B1 1 tablet a day
NJ Ex Order 26. 4B1 t tablet
NJ Ex Order 26. 4B1 tablet
NJ Ex Order 26. 4B1 tablet
NJ Ex Order 26. 4B1 tablet
NJ Ex Order 26. 4B1 tablet
NJ Ex Order 26. 4B1 NJ Ex Order 26.4(b)(1) times a day before meals
NJ Ex Order 26. 4B1 Capsule
NJ Ex Order 26. NJ Ex Order 26.4(b)(1) Tablet
NJ Ex Order 26. 4B1 NJ Ex Order 26.4(b)(1)
NJ Ex Order 26. 4B1 NJ Ex Order 26.4(b)(1)

Continued Surveyor review of the MAR dated NJ Ex Order 26.4(b)(1) revealed that the following medications were coded as on the following dates:

'NJ Ex Order 26. 4B1 1 tablet at 5pm on
NJ Ex Order 26. 2 tablets times a day with meals at 8am & 12pm on and at 5pm on
NJ Ex Order 26. 4B1 1 tablet a day at 8am on
NJ Ex Order 26. 4B1 t tablet at 8am on
NJ Ex Order 26. 4B1 tablet at 8am on
NJ Ex Order 26. 4B1 1 tablet at 8am or
NJ Ex Order 26. 4B1 1 tablet at 8am or
NJ Ex Order 26. 4B1 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) times a day before meals at 7am on NJ Ex Order 26.4(b)(1) and at 11am on NJ Ex Order 26.4(b)(1)
NJ Ex Order 26. 4B1 Capsule at 8am on

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A 935	Continued From page 45 NJ Ex Order 26. 4B1 (NJ Ex Order 26.4(b)(1) (NJ Ex at 8am on NJ Ex Order 26.4(b)(1) NJ Ex Order 26. 4B1 NJ Ex Order 26.4(b)(1) (NJ Ex at 8am on NJ Ex Order 26.4(b)(1) Surveyor review of Resident #1's "Progress Notes *New* (PNN) written by the nurses revealed the following: 1) on NJ Ex Order 26.4(, the medication had not arrived, 2) on NJ Ex Order 26.4, the medication was on order and was coming from the pharmacy tonight and 3) on NJ Ex Order 26.4 the medication was still on order. At the time of the survey, the nurses who cared for Resident #1 were not available for interview. Surveyor review of a revised 11/25/23 policy titled, "Resident Medication Administration" revealed "Policy: To ensure that medications are administered to residents in accordance to the prescribed schedule. If medication(s) are not received on schedule from pharmacy the Director of Nursing and/or designee will make a phone call to the pharmacy and get an expected arrival date. Procedure: ... Medications are to [be] administered as ordered by the provider ...If the medication is not available, the qualified staff member will investigate as to why, and notify the Director of Nursing, the provider, the resident, and residents['] family of the missed dose of medication."	A 935		
A1011	8:36-11.7(k) Pharmaceutical Services (k) Controlled dangerous substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts, N.J.S.A. 24:21-1 et seq. and all other Federal and State laws and regulations	A1011		

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A1011	Continued From page 46 concerning the procurement, storage, dispensation, administration, and disposition of same. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure staff consistently documented the shift-to-shift narcotic counts to ensure accountability of the Controlled Substance Inventory on 4 of 4 sampled medication carts (MC), MC #1, MC#2, MC#3, and MC #4 as evidenced by the following: On 2/26/25 at 10:07 a.m., following a narcotic count with the Licensed Practical Nurse (LPN #1), the surveyor reviewed the "Controlled Drug Count Record (CDCR)" for MC #1. Upon review, the surveyor observed that there were blank spaces on the 2/2025 CDCR where staff signed to indicate that controlled narcotic count was correct upon change of shift. Continued surveyor review of the CDCR, revealed that there were twenty-two missing on-coming and off-going signature blanks from 2/1/25 through 2/24/25, and 97 missing signature blanks from 1/1/25 through 1/31/25 for MC#1 shift-to-shift controlled substance count. During the narcotic count, the surveyor interviewed LPN #1 regarding the procedure for controlled substance counts. LPN #1 stated that on-coming staff performed counts with off-going staff and signed the shift-to-shift CDCR record to indicate that the count of controlled substances was correct. In addition, LPN#1 stated that some staff forget to sign the CDCR record after the controlled substance shift count.	A1011		

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A1011	Continued From page 47 At 10:54 a.m., the surveyor reviewed the CDCR record for MC #2 for the months of January 2025 and February 2025 that revealed 76 missing on-coming and off-going signature blanks that were not initialed from 1/2025 through 2/26/25 indicating that the controlled substance medication quantity was accurate. During review of the CDCR record, the surveyor interviewed LPN #2 regarding the procedure for controlled substance record maintenance. LPN #2 stated that the on-coming shift conducted controlled substance count with the off-going shift, and both staff initialed the record to acknowledge that the quantity recorded was accurate. In addition, LPN #2 stated that the off-going staff member forgot to initial the record that morning of 2/26/25. At 12:20 p.m., the surveyor reviewed the CDCR record for MC #3 for the months of December 2024, January 2025, and February 2025 that revealed 96 missing on-coming and off-going signatures with blanks that were not initialed to indicate that the quantity of controlled substance medication quantity was accurate and completed. During review of the CDCR record for MC #3, the surveyor interviewed LPN #3 regarding the missing initials on the CDCR record. LPN #3 stated that she always initials the CDCR record during shift-to-shift controlled substance count, but some staff forget to sign. At 1:24 p.m., the surveyor reviewed the CDRC record for MC #4 for the months of December 2024 and February 2025 that revealed 42 missing on-coming and off-coming signature blanks that were not initialed to indicate that the controlled	A1011		

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A1011	Continued From page 48 substance medication quantity was accurate and completed. During review of the CDCR record for MC #4, the surveyor interviewed LPN #4 regarding the missing initials on the CDCR record. LPN #4 stated that sometimes staff forget to initial the CDCR record to indicate that a controlled substance medication count was completed at the change of shift. On 2/27/25 at 2:50 p.m., the surveyor interviewed the Director of Nursing regarding the missing staff initials on the CDCR record for shift-to-shift controlled substance count. The DON stated that he was not aware that staff were not consistently signing out the controlled substance count record. The surveyor reviewed the revised 11/25/23 facility policy and procedure titled,"Narcotic/Controlled Substance Monitoring" that revealed "Procedure: ...A narcotic count is to be completed and the narcotic shift change form is to be signed by 2 qualified staff prior to accepting responsibility for the medication cart keys...."	A1011		
A1051	8:36-15.2 Resident Records 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. This REQUIREMENT is not met as evidenced by: Complaint#: NJ 00175431	A1051		

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A1051	Continued From page 49 Based on interview and record review it was determined that the facility failed to maintain records for NJ Ex Order 26. 4B1 investigations, regarding a NJ Ex Order 26. 4B1 NJ Ex Order 26.4(b)(1) for 2 of 21 residents, Resident #18, and Resident #20 as evidenced by the following: On 2/26/25 and 2/27/25 during a Standard Survey, the Department of Health investigated a Facility Reportable Event (FRE) dated NJ Ex Order 26 regarding NJ Ex Order 26. 4B1 . According to the FRE, Resident #18 was outside smoking and Resident #20 called him/her NJ Ex Order 26. 4B and then Resident #18 stated that he/she NJ Ex Or " Resident #20 then NJ Ex Order 26. 4B Resident #20 NJ Ex Order 26. 4B1 . In addition, Resident #20 acknowledged that he/she called Resident #18 NJ and asked the resident to leave the NJ Ex Order 26.4(b)(area. Resident #20 stated that NJ Ex Order 26. 4B1 ." On 2/26/25 at 2:50 p.m., the surveyor interviewed the Executive Director (ED) regarding the NJ Ex Order 26 NJ Ex Order 26. 4B1 NJ Ex Order 26.4(b)(1) and the FRE. The ED stated that she was not the ED at the time of the NJ Ex Order 26.4 incident. The surveyor then requested a copy of the NJ Ex Order 26. 4B1 report and facility investigation summary from the ED. The ED provided the surveyor with a copy of the FRE that was submitted to DOH. The ED explained that she would have to locate the NJ Ex Order 26. 4B1 report and investigation summary in the facility's online system. On 2/27/25 at 4:33 p.m., the ED stated that she	A1051		

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A1051	Continued From page 50 was unable to locate documentation of an [redacted] report or investigation summary related to the [redacted] *NJ Ex Order 26. 4B1* altercation. The surveyor reviewed the undated facility policy and procedure titled, "Resident Records" that revealed "Procedure: ...6. A resident's record will be retained for at least one year or per state requirements...." In addition, the surveyor reviewed the undated facility policy and procedure titled, "Incidents/Accidents" that revealed "Procedure: ...Whenever an occurrence or event leads to unintentional consequences and an unfortunate happening to a resident, visitor or staff member on the grounds of [Facility], an Incident/Accident Report must be completed. ..." The surveyor also reviewed the undated facility policy and procedure titled,"Incident Reporting" that revealed "Procedures: ...An investigation must be initiated within 24 hours of the occurrence by the Executive Director, Community Nurse, or designee. ..."	A1051		
A1097	8:36-16.6 Physical Plant All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23.	A1097		

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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
A1097	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a fire suppression system was installed that met the requirements of the New Jersey Uniform Construction Code and National Fire Protection Association (NFPA) 13, Standard for the Installation of Sprinkler Systems. The deficiency had the potential to affect all 151 residents who reside in the facility. Findings included: During a concurrent observation and interview on 02/26/2025 at 11:55 AM, the surveyor noted the front entrance overhang inclusive of the driveway drop-off area had a combustible overhang that projected 25 feet off the main building that lacked fire sprinkler coverage as required by NFPA 13. The Director of Maintenance stated he was unaware of the requirements of fire sprinkler coverage on combustible overhangs that projected more than four feet from a structure. The Director of Maintenance stated the facility did not have a policy related to environmental surveillance checks that ensured the regulatory requirements were met. During a concurrent observation and interview on 02/26/2025 at 1:35 PM, the surveyor noted a combustible overhang at the rear entrance of the facility that projected out 33 feet that lacked fire sprinkler coverage as required by NFPA 13. The Director of Maintenance stated he was unaware of the requirements of fire sprinkler coverage on combustible overhangs that projected more than	A1097		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	al0101	A. BUILDING: _____ B. WING _____	C 02/27/2025

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A1097	Continued From page 52 four feet from a structure. During an interview on 02/27/2025 at 9:40 AM, the Executive Director stated the facility did not have a formal policy in place for conducting environmental checks related to the sprinkler system.	A1097		
A1225	8:36-17.3(b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition; i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and ii. The written statement shall be available for review by the Department during survey. This REQUIREMENT is not met as evidenced by:	A1225		

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A1225	Continued From page 53 Based on document review and interview, the facility failed to conduct and maintain record of the annual inspection of the facility's electrical circuits and wiring. This deficiency affected 9 of 9 smoke compartments and had the potential to affect all 151 residents who reside in the facility. Findings included: The facility annual electrical circuits and wiring inspections revealed no evidence to indicate an inspection had been conducted in the previous year (2024). During an interview on 02/26/2025 at 10:27 AM, the Director of Maintenance stated he did not know an inspection was to be completed annually. The Director of Maintenance stated there was no written facility policy to conduct an annual electrician inspection. During an interview on 02/27/2025 at 9:40 AM, the Executive Director stated the facility did not have a formal policy in place for conducting environmental checks to address annual inspections of the facility's electrical circuits and wiring.	A1225		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.	A1249		

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A1249	Continued From page 54	A1249		

This REQUIREMENT is not met as evidenced by:
Based on observation, document review, and interview, the facility failed to ensure the building and grounds were kept free from fire hazards and other hazards to residents' health and safety. Specifically, the facility failed to: 1) maintain their fire alarm system according to National Fire Protection Association (NFPA) 72, National Fire Alarm and Signaling Code; 2) maintain their fire sprinkler system according to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems; and 3) ensure exit discharges provided direct and unobstructed access to a public way according to the International Fire Code. These deficiencies affected 9 of 9 smoke compartments and had the potential to affect all 151 residents who reside in the facility.

Findings included:

1. The facility life safety code systems inspection and maintenance documentation revealed the most recent documentation of an inspection and testing of the system was dated 06/14/2023. There was no documentation to indicate the facility's fire alarm system was inspected and tested semi-annually in the past year (2024), which did not comply with the standard set forth by NFPA 72.

During an interview on 02/26/2025 at 9:56 AM,

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A1249	Continued From page 55 the Director of Maintenance stated that he was unaware of the semi-annual requirement. The Director of Maintenance stated the facility did not have a policy in place regarding how often the fire alarm system should be serviced. During an interview on 02/27/2025 at 9:40 AM, the Executive Director stated the facility did not have a formal policy in place for conducting environmental checks related the fire alarm system. 2. The facility life safety code systems inspection and maintenance documentation revealed the facility's fire sprinkler system had an annual inspection completed on 01/02/2024 and an invoice indicated that a quarterly inspection was completed on 10/22/2024. The documentation revealed no other evidence an inspection or testing to indicate an inspection and quarterly testing according to NFPA 25. During an interview on 02/26/2025 at 9:56 AM, the Director of Maintenance stated the facility did not have a policy in place regarding how often the fire sprinkler system should be serviced. During an interview on 02/27/2025 at 9:40 AM, the Executive Director stated the facility did not have a formal policy in place for conducting environmental checks related to the sprinkler system. 3. During a concurrent observation and interview on 02/26/2025 at 11:41 AM, the surveyor noted the exit discharge door on the first floor adjacent to Nurses' Station 2 did not give the residents a clear path to the public way as evidenced by a concrete pad installed outside the exit discharge door that had an 11-inch step down to an uneven	A1249		

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A1249	Continued From page 56 surface that led to the public way, which did not meet the standards set forth by the International Fire Code. The Director of Maintenance stated he was unaware of the requirements related to exit discharge paths to a public way and the facility did not have a policy related to environmental surveillance checks that ensured the regulatory requirements were met.	A1249		
A1399	8:36-21.1(b)(3) Quality Improvement (b) Quality improvement activities shall include, but not be limited to, the following: 3. Establishment of objective criteria for evaluation of the resident care provided by each service area; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to collect and analyze available data in order to determine the timeliness of call bell response times through the facility's quality improvement program. The deficient practice was evidenced by the following: On 2/26/25 at 12:31 p.m., the surveyor interviewed the facility's Home Health Aide (HHA), HHA#1 who stated that she believed a call bell should be answered by within 5 minutes. At 12:44 p.m., the surveyor interviewed the facility's Licensed Practical Nurse (LPN), who stated that the call bell should be answered within one minute.	A1399		

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A1399	Continued From page 57 On 2/27/25 at 11:18 a.m., the surveyor interviewed the facility's Executive Director (ED) who stated that call bells should be answered within 30 minutes. During continued surveyor interview, the ED stated that the front desk calls the nursing staff after 10 minutes to see if the nursing staff can go and if the nursing staff couldn't, the front desk staff would go and check on the resident. The ED also stated that once a month she meets with the facility's Director of Nursing (DON) to review call bell compliance and discuses call bell times over 30 minutes with the nursing staff. The ED stated that the meeting with the DON and the call bell review with the nursing was not documented. At 1:53 p.m., during surveyor interview with the facility's ED, the ED stated that she could provide the surveyor with the log and check to see if the facility has a policy regarding call bell response time. At 2:34 p.m., the ED emailed the surveyor team with the call bell log. On 2/27/25 at 11:15 a.m., the surveyor reviewed the emailed call bell log from 1/1/2025 to 2/27/025 revealed that the call bell response exceeded 30 minutes before being answered, 18 times ranging from 30 minutes to 8 hours and 19 minutes. The facility had the capability to receive a print out of the call bell response times in order to monitor the timeliness of pendant response times. There was no documented evidence that this information was evaluated as part of the facility's quality improvement program in order to evaluate the effectiveness and implementation of the call bell system.	A1399		

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POC #3 received 6/11/25

New Standard Senior Living at Egg Harbor Township
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A 310 8:36-3.4(a)(1)

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
Education was provided to the Executive Director (ED) and Director of Nursing (DON) on 3/7/2025 by Administrator Consultant for Policies:
1. Best practice guidelines: Infection Control Guidelines: for Infectious Respiratory Disease Outbreak.
2. Incidents and Accidents and Incident Reporting
3. Regularly Scheduled Transportation
4. Transportation
5. Gratuities
6. Guidelines for Accepting/Rejecting Gratuities
7. Post Fall Evaluation
8. Activity Committee Policy
On 3/7/25, the Administrator Consultant educated the Activities Director (AD) on the Activity Committee Policy.

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
On 2/27/25, an in-service calendar was developed to ensure that all staff receive the required mandatory training. Facility-specific policy reviews were added to the schedule and reviewed at monthly all-staff meetings on 4/23/25 and 5/21/25. The 12-month calendar clearly identifies each mandatory and facility-specific training that every staff member is required to complete throughout the year. Additional topics will be added as new needs are identified.
The ED presented these trainings, covering the relevant policies and ensuring staff understood them. Mandatory training topics include abuse and neglect, pain management, emergency plans and procedures, dementia, the Health Insurance Portability and Accountability Act (HIPAA), residents' rights, and the core concepts of Assisted Living (AL).
Going forward, education for all staff will be provided during orientation, monthly meetings, and as needed to review company policies for care and service and to address any identified concerns or issues.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
Compliance with education will be monitored by the ED and DON. Review of the materials covered and staff compliance will be reviewed utilizing the Relias online training platform and in-house trainings. The results of the findings will be presented at the monthly Quality Assurance

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Performance Improvement (QAPI) committee meetings. This will be presented at the June 18th meeting of QAPI when we will review the month of MAY.

5. Completion Date: May 21, 2025

[redacted] approved/ verified 6/16/25

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A 401 8:36-4.1(a)(22) Resident Rights

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

On February 27, 2025 the Executive Director (ED) conducted mandatory training sessions for all dietary staff and the Director of Nursing (DON) on the importance of maintaining accurate and up-to-date diet orders and food allergies. This included posting a new up-to-date dietary allergy list posted in the kitchen. These training sessions began on February 27, 2025, and continued as staff members were scheduled. This training occurred before all employees started their scheduled shift and was completed March 4, 2025.

The DON or designee complete the Priority Life Care (PLC) diet order communication form. All nurses were educated on diet orders by the ED beginning on Feb 27, 2025 and completed on March 4, 2025.

The ED reviewed and updated all current diet orders and allergies in the kitchen to ensure correlations with resident medical charts. On February 27, 2025, the ED and Dietary Director ran the diet order and allergy report and created a new list. The old list entitled "Dietary Restrictions as of 2/24/2025" was removed from all locations posted and replaced with the new list in the kitchen and service areas. On February 27, 2025, a binder was created by the ED and Dietary Director that contained the full Diet Order and Allergy report pulled from Point Click Care (PCC) as well as face sheets with picture, name, and room number with allergies highlighted.

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

All residents have the potential to be affected by the deficient practice.

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

Starting February 27, 2025, the Dietary Director or designee will maintain and update the posted diet orders and allergies in the kitchen upon resident admission and on as needed basis when changes are reported or identified.

Starting February 27, 2025 the DON or designee will also ensure that dietary orders and allergies correlate with the residents' medical charts and are communicated with the Dietary Director upon admission or change.

Beginning February 27, 2025 the Dietary Director or designee will maintain a log of all diet orders and allergy updates obtained from the nursing department. The log was updated on February 27, 2025.

Monthly meetings have been scheduled between the Dietary Director or designee and Assisted Director of Nursing (ADON) or designee to review diet order and food allergy processes and

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address any challenges. The meeting has
been scheduled for the first Wednesday of each month, beginning on May 8, 2025. Any identified discrepancy will be addressed immediately.
Beginning February 27, 2025, the Dietary Director will provide ongoing education on the importance of accurate diet orders and food allergies as part of dietary staff in-service training annually.
The ED or designee asks for any changes in diet orders or allergies each morning at the manager's meeting which includes the Dietary Director, DON and ADON.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
The audits reflecting consistency between medical chart orders and dietary orders will be submitted to the Quality Assurance Performance Improvement (QAPI) committee meeting for review. Starting February 2025, data will be reviewed monthly for the next four quarters and continue monthly until compliance is determined to be sustained by no discrepancies noted.

5. Completion Date: May 31, 2025

NJ Ex Order 36, 4)

approved/verified
6/16/25

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A 517 8:36-5.6(b)(1-7) General Requirements

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
The facility cannot change the deficient results regarding education retroactively.
The following mandatory in-services shall be completed for all staff on orientation at the time of employment and at least annually regarding at a minimum the following:
-The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment:
-emergency plans and procedures
-the infection prevention and control program
-resident rights
-abuse and neglect
-pain management
-the care of residents with Alzheimer's and related dementia conditions and in accordance with NJAC. 8:36-19.
Education of staff will be overseen by the ED, who will designate the personnel responsible for training. Scheduled in-services via the on-line program initiated by the Executive Director (ED) on 04/01/2025 and completed on May 21, 2025.

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
All staff will be educated on the requirement for mandatory education. Education meetings will be scheduled for all staff by the ED to address facility specific policies. Several Education topics will be presented at each all-staff meeting. On April 23, 2025, the staff were re-educated by the ED on Principles of Assisted Living and Infection Control.
Staff members will be counseled individually or provided alternative means in the event they are non-compliant with completion of the requirements. Alternative methods that may be offered include, but are not limited to, printed materials, group education sessions, and computer access within the facility for staff who may not have independent access to a computer outside of the facility.

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4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

Compliance with completion of scheduled in-services via the on-line program will be audited monthly by the ED or designee initiated on 04/01/2025 and completed on May 21, 2025.
The Administration or designee will present the outcome of the compliance audits at the monthly QAPI meeting for the next three quarters until substantial compliance is deemed sustained by the Committee.

5. Completion Date: May 21, 2025



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A589-8:36-5.15 General requirements

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
The facility maintains chronological records of residents admitted and discharged, including the destination for those discharged. On 2/28/25, the Executive Director (ED) designee educated the Business Office Manager (BOM) on the using the current electronic health record (EHR) system, Point Click Care (PCC), including how to input data and generate reports. On 5/23/25, the BOM received refresher training on using the current electronic health record (EHR) system, Point Click Care (PCC), including how to input data and generate reports.
Resident #8 was [redacted]

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
The BOM starting on 04/17/2025 will reconcile the daily census, enter it into PCC and report on changes/discrepancies in the daily Manager's meeting.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
The ED will audit the Transfer/Discharge report monthly times three, starting the month of March 2025, and then quarterly thereafter. The data for March was reviewed on April 23, 2025 during the monthly Quality Assurance Performance Improvement (QAPI). The ED will present the findings monthly at the Quality Assurance Performance Improvement (QAPI) meetings until it is determined that compliance has been achieved.

5. Completion Date: May 23, 2025 [redacted]

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6/10/25

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A695-8:36-7.1 (b) Resident Assessments and Care Plans

1. How will corrective action be accomplished for those residents who are found to have been affected by the deficient practice?
Starting on 3/20/25, the Director of Nursing (DON) began running a weekly Point Click Care (PCC) report to monitor General Service Plan (GSP) compliance. The results are included in the weekly DON report sent to the Regional Director of Clinical Services (RDCS). The DON sent the initial weekly report to the RDCS on 3/27/25. Any deficiencies identified were and will continue to be addressed immediately.
The DON was re-educated by the RDCS on 4/3/25 in the proper usage of PCC and the assessment process. This included education that the GSP is generated from the nursing assessment in PCC.
Resident #5 remains at the facility. The residents' current GSP indicates that the resident needs assistance with NJ Ex Order 26. 4B1 in AM and NJ Ex Order 26. 4B1 in PM.
The resident is independent in all other NJ Ex Order 26. 4B1

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
On 4/9/25, the DON was re-educated on GSPs by the Nurse Consultant using the New Jersey (NJ) Assisted Living (AL) State regulations. The DON was then provided with a complete copy of the NJ State Regulations.
The Executive Director (ED) was re-educated by the Nurse consultant on 4/9/25 as to the location of the GSP report in PCC.
All GSPs will be completed by the DON or designee within 14 days of resident admission, semiannually and as needed as per NJ regulation 8:36-7.1.

4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and does not recur?
The ED will conduct an audit of GSPs completion using PCC monthly times six months and then quarterly times two until the Quality Assurance Performance Improvement (QAPI) Committee determines that compliance is met by no deficiencies noted. Audits were initiated in April 2025.

5. Completion Date: April 30, 2025 NJ Ex Order 26.

approved/ verified
6/16/25

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A735-8:36-7.2 (e) Resident Assessments and Care Plans

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
Resident #2 remains in the facility and receives [redacted] days a week, which is reflected on his current health service plan (HSP).
An HSP list was created by the Nurse Consultant on 4/1/25, as a baseline/reference document. The document includes [redacted] services. PT and OT assist to address [redacted]. The DON was educated on this document, by the Nurse Consultant, who stressed the importance of maintaining an accurate list of those who require more monitoring. The Director of Nursing (DON) is updating the health service plans and HSP list as needed and emailing the list to the Executive Director (ED) weekly, and when revised.

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
The Director of Nursing (DON) was re-educated by the Director of Clinical Services in the proper usage of Point Click Care (PCC) and the health service plan process.
The DON was re-educated by the Nurse Consultant using the New Jersey Assisted Living (NJ AL) State regulations for the explanation of a [redacted] Plan (HSP), The DON was then provided with a copy of these regulations.
A weekly meeting has been initiated with third party provider/visiting nurse service (VNS) to review all residents receiving care through their service. This meeting began on 4/16/25 and occurs weekly on Thursday. Prior to the meeting, the DON will receive an email with the week's current therapy list and wound report from the VNS. This meeting will ensure communication of treatments/services and assist the DON with keeping HSPs updated and accurate. The third party provider's nurses and therapists speak directly to the DON to keep DON current even before or after the weekly meeting.
A meeting is scheduled with the Program of All-inclusive Care for the Elderly (PACE) to review all residents receiving care through their service. A bi-weekly meeting was initiated on 4/30/25 and is ongoing. The DON has coordinated a system to receive email updates prior to each meeting, to ensure communication of treatments/services is accurate. This will assist DON with keeping all HSPs updated and accurate.
The DON or designee reviews the 24-hour report daily and discusses changes/the need for changes identified by the nursing staff.

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The Nurse consultant created a binder with a complete copy of the NJ AL State Regulations on 4/9/25 and presented it to DON. Going forward, any new health service needs identified will be added to the service plan and addressed, examples are: chemotherapy and radiation.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
The Executive Director (ED) is reviewing the HSP list with regional director of operations (RDO) weekly times four beginning on 4/4/25, then monthly times three, and then quarterly thereafter to ensure HSPs are updated. Any issues will be reviewed with the DON. Results will be reported at the Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendation.
Beginning April 2025, the DON will report the numbers of residents receiving services and those being monitored by the Registered Nurse (RN) at the monthly QAPI meetings times four months, then quarterly thereafter to assure compliance with NJ State regulations.

5. Completion Date: May 16, 2025 [redacted] approved/ verified 6/11/25

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A 749 Resident Assessments and Care Plan GSP 8:36-7.3(a)

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
Resident #12 has [redacted]

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
The policy, Resident Assessment and Care Plan was updated on 4/9/25 to address reviewing and revising the residents' Assessment/General Service Plan (GSP) as per New Jersey (NJ) state regulations; upon admission, semiannually, and change of condition. The Director of Nursing (DON) and Executive Director (ED) were educated on the revised Policy by the Nurse Consultant on 5/7/25.
Residents who are on the 24-hour report are discussed daily in the morning manager's meeting. The DON or designee who is a registered nurse (RN) is responsible for completing all assessments when a change of condition is noted and updating service plans as needed. The clinical staff was educated on the revised policy by Nurse Consultant on 5/7/25.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
Beginning on 4/1/25, the ED will review updated residents' GSPs monthly to ensure they are complete. Results of these audits will be documented with results reported at the Quality Assurance Performance Improvement (QAPI) meetings quarterly starting 5/16/25.

5. Completion Date: May 7, 2025 [redacted]

approved/verified
6/16/25

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A765 8:36-7.4 (c) Resident assessments and care plans

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice
The facility cannot retroactively address the identified issue that resident #18 had no documented RN assessment up on return from hospital. To ensure the deficiency is addressed, the Director of Nursing (DON) was educated by the Regional Director of Clinical Services (RDCS) regarding the proper procedure for registered nurse (RN) assessments on 3/19/25 and re-educated on 4/16/25. The Nurse Consultant re-educated the DON regarding New Jersey (NJ) regulations regarding creating, updating and reviewing of the residents' general service plan (GSP) as stated in NJ 8:36-7.4 on 3/19/25. The Nurse Consultant then provided the DON with a complete copy of the NJ State Regulations for Assisted Living (AL) and marked the sections that refer to the nursing department for ease of reference. Resident #18 remains at the community.

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

3. What measures will be put into place or systemic changes be made to ensure that the deficient practice will not recur?
On 4/9/25, a policy, Resident Assessments and Care Plans-Assessments and Resident General Service Plans, was revised for health and general service plan updates to include timeliness to be at least semi-annually and as needed with general service plans and at least quarterly for health service plans, along with proper procedure for service plans by the RN. The Executive Director (ED) will monitor progress daily in morning meeting by requiring the DON to provide daily reports regarding service plans and report to the ED regarding any assessment needs/GSP updates. The DON will report daily to the ED regarding completion of assessments for change of condition, readmission, and semiannually, as per NJ State regulations. The DON will report monthly at the Quality Assurance and Performance Improvement (QAPI) meeting regarding compliance.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and does not recur?
Beginning in April 1, 2025 the ED or designee conducted an audit of GSP completion using PCC monthly times six months and then quarterly times two until the QAPI Committee determines that compliance is met.

5. Completion Date: April 16, 2025 [redacted] approved/ verified 6/16/25

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A891 8:36-10.5 Dining Services

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
All food products were reviewed by the Director of Culinary Experience (DCE) to determine if the product was properly dated and labeled on 2/26/25. DCE addressed partially opened containers and made corrections with labeling, dating and sealing/disposing partially exposed products. Dented cans were removed from stock and secured to be returned to the Vendor by 2/28/25.

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
The Chef(s) is assigned to audit all refrigerators, freezers and dry storage area daily beginning 2/27/25. The DCE conducts audits of these areas as well. The DCE signs off weekly confirming labeling, dating and storage has taken place appropriately, and the department is in compliance to ensure the prevention of food borne illness.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
The audits initiated on 2/27/2025 conducted by the Chefs and the DCE. Audits will be submitted monthly to the Quality Assurance Performance Improvement (QAPI) committee for review for the next three quarters. Audit submitted for March and reviewed during April 23, 2025, QAPI meeting. Any identified issue or pattern of non-compliance will be brought to the attention of the Executive Director (ED) immediately, and remedial actions will be further developed as deemed necessary.

5. Completion Date: February 28, 2025 [redacted]

approved/verified
6/16/25

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A 907 8:36-10.5(c) (7) Dining Services

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

The facility cannot retroactively address the identified issue. Resident #15 was NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 . Resident #13 remains in the facility and was informed on 02/27/2025 during dinner service about the availability of snacks; there are no current dining issues. The Director of Culinary Service (DCE) informed all residents during dinner service on 2/27/25 about the availability of a hydration station that has water and between meal snacks, which may include but is not limited to, crackers, seasonal fresh fruit, cookies, and pretzels. Residents may obtain snacks between 7:00AM and 7:00PM in the main dining area. After 7:00PM between meal snacks are available at each nursing station.

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

All residents have the potential to be affected by the deficient practice.

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

The Snack Policy was revised by the Executive Director (ED) on 4/12/25. Education was provided to all staff regarding the distribution and location of snacks by the Assistant Director of Nursing (ADON) on 4/14/25 and completed on 5/21/25.
The residents were reminded of the availability of snacks at the Resident Council meeting on May 13, 2025, by the Activities Director.
The DCE developed an par level amount of 200 for the number of snacks needed on each unit in collaboration with each nursing station on 5/6/25. New Residents will be notified of the snack policy on admission during new resident orientation.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

The DCE initiated the audit on 04/11/2025 on the delivery of snacks at each nursing station to determine if the periodic automatic replenishment (par) level is an adequate amount provided. Results of the audits and the appropriate adequate par levels will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee starting 05/16/2025 for three months, then quarterly thereafter, for review and recommendations.
The Activity Director or designee will randomly interview 10 residents a month starting 05/09/2025 to determine their satisfaction and knowledge of the in-between snack locations and availability. Results of these audits will be reported to the QAPI Committee monthly x3 months then quarterly for review and recommendations.

5. Completion Date: May 21, 2025 NJ Ex Order 26. 4B1 approved/ verified 6/16/25

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A 913 8:36-10.5(c) (10) Dining Services

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
The facility cannot retroactively address the identified issue. Temperature audits began on 2/28/25. Microwaves are provided in resident rooms to ensure that food can be warmed to palpable temperature prior to consumption.
In addition to microwaves provided to residents, on 4/3/25 the Director of Culinary Experience (DCE) purchased insulated bags to maintain food temperatures at or above 140 degrees Fahrenheit (F) during meal distribution for residents receiving room service. Resident #15 [redacted] *NJ Ex Order 26. 4B1* [redacted]. Residents #13 and #14 are still in the facility with no further dining issues expressed.

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
Food temperatures will be checked at the point of service in the main dining room by the DCE or designee at each meal to ensure temperatures are a minimum of 140 degrees F. Food temperature audits were implemented starting 2/28/25. Insulated bags were purchased by the DCE on 4/3/25 to transfer meals to residents' rooms. The bags are used for resident room service to ensure temperature.
Residents #13 and #14 have been interviewed by the DCE to determine their satisfaction with food temperature on a weekly basis for four weeks starting on 4/30/25. One additional random resident from the community was interviewed as well. The responses related to food temperature satisfaction have been documented by the DCE. Interviews were conducted on 4/30, 5/7, 5/14, and 5/21/25.
Going forward, any identified concern will be brought to the attention of the Executive Director (ED) immediately with the proposed intervention as deemed necessary.
A Food Committee meeting was developed to be held monthly by DCE, Activities Director and interested residents. The Food Committee meeting was initiated on 5/22/25. Satisfaction with food temperatures and related topics will be discussed. Residents were advised of the committee by the DCE during dining services and at Resident Council on 05/13/2025. All residents are welcome to attend.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
Beginning May 16, 2025, food temperature audits and resident satisfaction interview results will be submitted monthly to the Quality Assurance Performance Improvement (QAPI) committee for

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review for the next three months and quarterly thereafter until the committee determines that improvement has been sustained and no further audits or interviews necessary.

5. Completion Date: February 28, 2025 [redacted]

approved/verified
6/16/25

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A935 Pharmaceutical Services 8:36-11.4(b)

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

The Facility cannot retrospectively address this deficiency. Resident #1 is [redacted] The Director of Nursing educated the staff regarding usage of the [redacted] Pharmacy portal for communication, in addition to phone calls for medication needs 02/28/2025. On 4/18/25, the Director of Nursing (DON) was informed by the Executive Director (ED) to reach out to the pharmacy to set up a meeting to discuss medication deliveries and discrepancies. The pharmacy agreed to a meeting date of 5/15/25. The DON began educating nursing staff on 2/28/25 on the policy "Resident Medication Administration" and completed on 3/7/25. Nursing staff were re-educated by the Assistant Director of Nursing (ADON) on the Policy "Resident Medication Administration" on 5/5/25 to ensure understanding.

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

Current residents have the potential to be affected by the deficient practice.

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

A meeting was held with the current pharmacy on 5/15/25 with the DON and the ED to review medication availability and delivery on a timely basis. Any discrepancies with medication will be discussed between the DON and the ED to determine next steps on a case by case basis.
The DON will reviewed [redacted] resident medication administration records (MARs) and progress notes in PCC weekly for four weeks for unavailable/missing medications starting 5/5/25. If unavailable/missing medications are found, the DON or designee will re-educate the staff member. The staff member will contact the physician for any new orders, as well as inform the resident and or family as appropriate.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?

Cumulative data will be kept on missing/unavailable medications and reported at the Quality Assurance Performance Improvement (QAPI) Committee starting 5/5/2025, then monthly for three months and then quarterly thereafter for review and interventions as determined to be necessary until the QAPI committee determines that compliance is met.

Completion Date: March 7, 2025 [redacted] approved/ verified 6/16/25

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A1011 8:36-11.7(k) Pharmaceutical services

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
The Director of Nursing (DON) implemented a narcotic count sheet and educated nursing staff on 2/28/25. Upon review of the sign in sheets, the DON created a new narcotic form 4/8/25 for ease of understanding and provided it to the nursing staff along with education on its completion. The licensed nurses were re-educated by the DON and Assistant Director of Nursing (ADON) regarding the procedure and importance of accuracy starting on 4/18/25 and completed on 5/21/25.

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
Education was provided by the DON for all nurses from 4/18/25 to 5/21/25 (confirmed with sign in sheet). Mandatory narcotic counts and required accompanying signatures were reviewed. Starting May 28, 2025, the DON or designee is performing daily reviews of all narcotic books. If an error or omission is found the staff member will be contacted and given further training if warranted. The Executive Director (ED) is reviewing daily, during the morning manager's meeting with DON.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
Beginning May 28, 2025, the DON or designee will audit the narcotic books weekly for four weeks, and then monthly for three months. The DON will report audit findings monthly at Quality Assurance Performance Improvement (QAPI) for four months until the QAPI committee determines that compliance is sustained as evidenced by no errors or omissions.

5. Completion Date: February 28, 2025 [redacted] approved/verified 6/16/25

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A 1051 8:36-15.2 Resident Records

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
The facility cannot retroactively address the identified issue. Residents #18 remains in facility with no further incidents. Resident #20 was [redacted] NJ Ex Order 26. 4B1

The Executive Director (ED) and Director of Nursing (DON) were educated by Administrator Consultant on Incident Reporting and Resident Records, Incidents and Accidents policies on May 2, 2025.

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
The ED provided education to all staff regarding maintenance of Resident Records, Incidents and Accidents as well as Incident Reporting on May 19, 2025, and completed on May 21, 2025. An Incident Report Summary and Conclusion log will be reviewed monthly by the ED and or designee at the morning manager's meeting. Incident reports will be retained in the resident record for a period of 10 years after discharge of a resident. The ED or designee will maintain the logs for a period of two (2) years.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
The ED and DON will present a summary of the Incidents and Reportable Events at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. The QAPI committee will analyze the data and determine improvement actions as deemed necessary.

5. Completion Date: May 21, 2025 [redacted] NJ Ex Order 26.

approved/verified
6/16/25

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A 1097 Physical Plant- Sprinkler [redacted] verified/Approved 6/16/25

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
The Facility cannot retrospectively address this deficiency. The Executive Director (ED) directed the Maintenance Director to contact a vendor for an evaluation of the overhangs to determine sprinkler needs.

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
The Maintenance Director contacted the vendor for evaluation of the identified potential issue. Per the vendor evaluation on March 10, 2025, the building was permitted and installed under the 2013 edition of NFPA 13 and was originally approved without fire sprinklers needed at the exterior overhangs. The code states the following: Section 8:15.7.2 "Sprinklers shall be permitted to be omitted where the exterior projections are constructed with materials that are non-combustible, limited-combustible, or fire–retardant-treated wood as specified in NFPA 703."
"The exterior skin of the overhang is constructed with Vinyl material. Vinyl siding/covering, composed primarily of PVC, is inherently flame retardant due to its chlorine base, meaning it's more difficult to ignite. We feel that vinyl material falls into the limited combustible category. The Vendor's professional opinion is that, with the vinyl being limited combustible and the fact that there is no combustible material being stored on the floor area underneath the overhang, fire sprinklers are not needed for this application."
The concern related to the request for sprinklers in the entrance and exit overhangs was reviewed with the Maintenance Director and the Executive Director (ED) on 4/23/25 with the Administrator Consultant.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur?
Going forward, any identified concern regarding the sprinkler system will be reported to the ED immediately for attention and follow up at the managers' morning meeting. The results of the environmental surveillance will be reported to the Quality Assurance Performance Improvement (QAPI)Committee meeting quarterly.

5. Completion Date: April 23, 2025

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A 1225 Housekeeping Sanitary Maintenance [redacted] Verified/ Approved 6/16/25

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
The facility cannot retrospectively address the deficiency on annual inspection of electrical circuits and wiring. An annual electrical inspection was completed on March 18 and 19, 2025 by the electrical contractors. The Facility passed the inspection.

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
Reviews of the maintenance concerns including electrical inspection identified during survey were reviewed with the Executive Director (ED) and Director of Maintenance on 4/23/25 by the Administrator Consultant. The Director of Maintenance added inspection of the facility electrical circuits and wiring to the Monthly Preventative Maintenance Schedule to address annual inspections of the facility's electrical circuits and wiring. Any issues will be reported immediately to the ED. Results of the annual inspection by the outside vendor will be maintained by the ED and Director of Maintenance and uploaded into the community's electronic system, TELS, that houses building maintenance information.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?
Beginning April 2025, the results of the monthly electrical circuits and wiring will be reported to the Quality Assurance Performance Improvement (QAPI) Committee quarterly so that the annual inspection is scheduled and completed timely.

5. Completion date: April 23, 2025

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A 1249 Housekeeping-Sanitary-Safety-Maintenance [redacted] verified / Approved 6/16/25

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

The Facility cannot retrospectively address this deficiency. A semi-annual inspection of the fire alarm system was conducted on March 28, 2025 and was passed successfully. The next fire alarm system inspection is scheduled for September 28, 2025.

A quarterly fire sprinkler system inspection was conducted on 4/21/25 and was passed successfully. An electrical inspection was conducted on March 18th and 19th, 2025 and was passed successfully. Landscaping has been completed to level the path of egress on 6/4/25. The Environmental Services Policies and Procedures was developed 05/06/2025 and education was provided by Executive 05/06/2025.

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

All current residents have the potential to be affected by the deficient practice.

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

The Executive Director (ED) Consultant reviewed Maintenance concerns identified in the survey with the Maintenance Director and ED on 4/23/25. The Maintenance Director consulted with the local Fire Marshall for guidance on remediation of the concern. The Maintenance Director secured a proposal from a vendor to repair the identified area of concern related to the exit egress 03/13/2025. A contractor leveled the egress area with soil and installed sod over the exit area to achieve a clear and level means of egress.

A Policy was developed by the ED to address the Fire Alarm System inspections and how often the Fire Sprinkler System should be serviced/inspected on May 6, 2025.

A calendar was created by the Maintenance Director to track annual, semi-annual and quarterly inspections, including Fire Alarm Systems and Fire Sprinkler System inspections on May 23, 2025 .

The Director of Maintenance added environmental surveillance checks to his daily Preventive Maintenance routine, with results documented on 03/31/2025. Any issues will be addressed immediately and reported to the ED.

4. How will the facility monitor its corrective actions to ensure the deficient practice is being corrected and does not recur?

Beginning May 23, 2025, the results of fire alarm system inspections, electrical inspections, sprinkler needs and remediation of the exit egress will be reported at the quarterly Quality Assurance

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Performance Improvement (QAPI) Meeting. A summary and findings related to surveillance will be included quarterly during QAPI meetings for review.

Completion Date: May 23, 2025

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A 1399 8:36-21.1(b) (3) Quality Improvement

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice?
The facility cannot retroactively address the identified deficiency. Re-education related to timely call bell response was provided to all staff on 04/18/25 by Executive Director (ED).

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

3. What measures will be put into place or systemic changes made, to ensure that the deficient practice will not recur?
Appropriate Call Bell response was a topic addressed at the monthly all staff meeting on 4/23/25. Random call bell audits were assigned by the ED, initiated on 5/5/25 and conducted on a weekly basis for four weeks, to ensure compliance and appropriate response. These audits were performed during the weeks of May 5-9, May 12-16, May 19-23, and May 26-30, 2025. These results were reported at morning meetings; staff educated and counseled as appropriate per audits. Audits will continue for the next three months and then quarterly thereafter.

4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and does not recur?
Beginning June 2025, the ED will present the results of the audits at the monthly Quality Assurance Performance Improvement (QAPI) meeting for three months and then quarterly thereafter until compliance is determined by the committee.

5. Completion Date: May 30, 2025 [redacted] approved/verified 6/16/25

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
al0101 Y1	A. Building B. Wing Y2	6/17/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT EGG HARBOR TOWNSHIP	6817 EBLACK HORSE PIKE EGG HARBOR TOWNSHIP, NJ 08234

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 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 05/21/2025	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 05/31/2025	ID Prefix A0517 Reg. # 8:36-5.6(b)(1-7) LSC	Correction Completed 05/21/2025
ID Prefix A0589 Reg. # 8:36-5.12(a) LSC	Correction Completed 05/23/2025	ID Prefix A0695 Reg. # 8:36-7.1(b) LSC	Correction Completed 04/30/2025	ID Prefix A0735 Reg. # 8:36-7.2(e)(1-5) LSC	Correction Completed 05/16/2025
ID Prefix A0749 Reg. # 8:36-7.3(a) LSC	Correction Completed 05/07/2025	ID Prefix A0765 Reg. # 8:36-7.4(c)(1) LSC	Correction Completed 04/16/2025	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 02/28/2025
ID Prefix A0907 Reg. # 8:36-10.5(c)(7) LSC	Correction Completed 05/21/2025	ID Prefix A0913 Reg. # 8:36-10.5(c)(10) LSC	Correction Completed 02/28/2025	ID Prefix A0935 Reg. # 8:36-11.4(b) LSC	Correction Completed 03/07/2025
ID Prefix A1011 Reg. # 8:36-11.7(k) LSC	Correction Completed 02/28/2025	ID Prefix A1051 Reg. # 8:36-15.2 LSC	Correction Completed 05/21/2025	ID Prefix A1097 Reg. # 8:36-16.6 LSC	Correction Completed 04/23/2025

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
al0101 Y1	A. Building B. Wing Y2	6/17/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT EGG HARBOR TOWNSHIP	6817 EBLACK HORSE PIKE EGG HARBOR TOWNSHIP, NJ 08234

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 A1225	Correction	ID Prefix A1249	Correction	ID Prefix A1399	Correction
Reg. # 8:36-17.3(b)(8)(i-ii)	Completed	Reg. # 8:36-17.7	Completed	Reg. # 8:36-21.1(b)(3)	Completed
LSC	04/23/2025	LSC	05/23/2025	LSC	05/30/2025

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/27/2025	☐ YES ☐ NO