New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A003	A. BUILDING: _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT MILLVILL	1125 VILLAGE DRIVE MILLVILLE, NJ 08332

(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: Complaint COMPLAINT #: NJ00185073 and NJ00183433 CENSUS: 143 SAMPLE SIZE: 4 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 355	8:36-4.1(a)(1) Resident Rights comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, 1. The right to receive personalized services and care in accordance with the resident's individualized general service and/or health service plan;	A 355		

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

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A 355	Continued From page 1	A 355		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00185073

Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents received personalized services and care in accordance with the resident's individualized Service Plan (SP) for 1 of 4 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 4/10/25 at 10:37 a.m., the surveyor interviewed Resident #2's Responsible Party (RP) via telephone. During this interview, Resident #2's RP stated that on [redacted], the facility had Resident #2 transported to his/her doctor's appointment, and that the resident was [redacted]. Resident #2's RP then stated that Resident #2 [redacted], and that the resident was [redacted]. Resident #2's RP stated that she received a call from the woman, who stated that she [redacted] in Resident #2's [redacted] In addition, Resident #2's RP stated that the resident's doctor also called her regarding the incident and stated that the [redacted]. Resident #2's RP stated that following the incident, the facility [redacted] Resident #2.

Further, Resident #2's RP stated that Resident #2 missed many doctor appointments in [redacted] and missed appointments in [redacted]. Resident #2's RP stated that the facility told her that it was not their job to make sure Resident

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A 355	Continued From page 2 #2 got to his/her doctor appointments. In addition, Resident #2's RP stated that the resident's doctor office would notify the facility of the resident's upcoming appointments and that she also notified the facility's Director of Nursing (DON) by E-Mail. The surveyor reviewed the Medical Record (MR) of Resident #2, who was NJ Ex Order 26. 4B1 [redacted]. The surveyor reviewed Resident #2's SP, revised on [redacted] which indicated that the resident would receive necessary assistance with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 At 11:06 a.m., the surveyor interviewed a staff person at Resident #2's NJ Ex Order 26. 4B1 to inquire if the resident missed any appointments. The staff person in patient registration stated that she could only see missed appointments from NJ Ex Order 26. 4B1, and that Resident #2 missed appointments on NJ Ex Order 26. 4B1. The staff person stated that on [redacted] Resident #2 was supposed to see the nurse practitioner and receive an NJ Ex Order 26. 4B1 [redacted] At 11:54 a.m., the surveyor interviewed a Certified Medical Assistant (CMA) at Resident #2's primary doctor's office to inquire if the resident missed any doctor appointments. The CMA stated that Resident #2 missed the following appointments: NJ Ex Order 26. 4B1 [redacted]	A 355		

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A 355	Continued From page 3 [redacted] During this interview, the CMA stated that the facility would drop Resident #2 off at the doctor's office and [redacted] The CMA stated that Resident #2 would come to appointments [redacted] and that the resident [redacted] the doctor would say to him/her. In addition, the CMA stated that on [redacted] Resident #2 [redacted] after his/her appointment while awaiting transportation. The CMA stated that Resident #2 waited [redacted] hours for transportation [redacted] and [redacted]. The CMA stated that when transport did arrive to pick up Resident #2, the resident was [redacted] The CMA stated that the doctor's office called the [redacted], and that Resident #2 was [redacted] away from the doctor's office. At 12:53 p.m. and 1:25 p.m., the surveyor interviewed Licensed Practical Nurse (LPN #1), to inquire who arranged transportation for residents to get to their appointments. LPN #1 stated that she made transportation arrangements for most doctor appointments on the [redacted]. The surveyor then inquired the reason Resident #2 missed multiple doctor's appointments. LPN #1 stated that she had just began arranging transportation for resident appointments [redacted] and that Resident #2 missed appointments in the past when transportation arrangements were done by the front desk concierge staff. At this time, LPN #1 stated that Resident #2's doctor's office would send the resident back with future appointments and that she would arrange transportation.	A 355		

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A 355	Continued From page 4 At 1:45 p.m., the surveyor interviewed LPN #1 and LPN #2 to inquire if Resident #2 had a doctor's appointment on NJ Ex Order 26. . LPN #1 and LPN #2 stated that Resident #2 went to a doctor's appointment on NJ Ex Order 26. NJ Exec Order 26.4b1. LPN #1 stated that she did not know about Resident #2's appointment on NJ Ex Order 26., and that she did not arrange transportation for that appointment. LPN #1 also stated that she did not know why the resident did not have an NJ Exec Order 2 scheduled to NJ Exec Order 26.4b1 him/her. LPN #1 and LPN #2 stated that the Director of Nursing (DON) arranged for NJ Exec Order 26 to NJ Exec Order 26.4b1 residents to appointments. At 2:07 p.m., the surveyor interviewed the DON and the Executive Director (ED) to inquire if there were any incidents at the facility regarding resident appointments and transportation. The DON stated that Resident #2 was sent to a doctor's appointment NJ Exec Order 26.4b1 and that there was "no good answer" as to why the resident did not have an NJ Exec Order 2 The surveyor inquired who was responsible for arranging for NJ Exec Order 26 to NJ Exec Order 26.4b1 residents to appointments and the DON stated that NJ Exec Order 26 were usually arranged by the nurse on the floor. The surveyor inquired if the DON knew that Resident #2 left his/her doctor's office NJ Exec Order 26.4b1. The DON stated that on NJ Ex Order 26., she was notified by Resident #2's RP that the resident left his/her doctor's office. The surveyor inquired if the facility conducted an investigation following notification of the incident, and the DON stated that there was no investigation completed. During this interview, the surveyor inquired if the ED was made aware of this incident and if the incident was reported to the Department of Health (DOH). The DON stated that the ED was aware	A 355		

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A 355	Continued From page 5 of the incident and that the ED was present when Resident #2's RP called. In addition, the DON stated that the incident was not reported to the DOH and that she "did not consider" completing a reportable event report. The ED stated that Resident #2 went to a doctor's appointment without an [NJ Exec Order 2] and that she had no idea why the resident was [NJ Exec Order 26.4b1] [redacted] The ED stated that she was notified that Resident #2 did not have an [NJ Exec Order 2] on [NJ Ex Order 26.] , and that she was not notified that the resident left the doctor's office [NJ Exec Order 26.4b1] The surveyor reviewed the 10/1/2020 facility policy titled, "Protecting & Ensuring Resident Rights Policy:," which indicated, "Procedure: 1. The General Manager has responsibility for ensuring that Resident rights are respected and maintained...." The facility failed to ensure Resident #2 was provided the right to receive personalized services based on his care needs.	A 355		
A 555	8:36-5.8(a) General Requirements (a) The facility shall be capable of providing resident transportation, either directly or by arrangement, to and from health care services provided outside the facility, and shall promote reasonable plans for security and accountability for the resident and his or her personal possessions, as well as transfer of resident information to and from the provider of the service, as required by individual residents and specified in resident service plans. This REQUIREMENT is not met as evidenced by:	A 555		

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A 555	Continued From page 6 Complaint #: NJ00185073 Based on interview, record review, and review of pertinent facility documents it was determined that the facility failed to arrange resident transportation to and from outside health care services and ensure the security and accountability of the residents for 3 of 4 residents reviewed, Resident#s 2, 3, and 4. This deficient practice was evidenced by the following: 1. On 4/10/25 at 10:37 a.m., the surveyor interviewed Resident #2's Responsible Party (RP) via telephone. During this interview, Resident #2's RP stated that on [NJ Ex Order 26], the facility had Resident #2 transported to his/her doctor's appointment, and that the resident was left at the doctor's office [NJ Exec Order 26.4b1] Resident #2's RP then stated that Resident #2 left the doctor's office, and that the resident was [NJ Exec Order 26.4b1] Further, Resident #2's RP stated that Resident #2 missed many doctor appointments in [NJ Ex Order] and missed appointments in [NJ Ex Order 26. 4B1]. Resident #2's RP stated that the facility told her that it was not their job to make sure Resident #2 got to his/her doctor appointments. In addition, Resident #2's RP stated that the resident's doctor office would notify the facility of the resident's upcoming appointments and that she also notified the facility's Director of Nursing (DON) by E-Mail. The surveyor reviewed the Medical Record (MR) of Resident #2, who was [NJ Ex Order 26. 4B1]. The surveyor reviewed Resident #2's SP, revised on [NJ Exec Order 26] which indicated that the resident would receive necessary assistance with [NJ Exec Order 26.4b1] and	A 555		

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A 555	Continued From page 7 NJ Exec Order 26.4b1 At 11:54 a.m., the surveyor interviewed a Certified Medical Assistant (CMA) at Resident #2's primary doctor's office to inquire if the resident missed any doctor appointments. The CMA stated that Resident #2 missed the following appointments: NJ Ex Order 26. 4B1 During this interview, the CMA stated that the facility would drop Resident #2 off at the doctor's office and NJ Exec Order 26.4b1. In addition, the CMA stated that on NJ Ex Order 26., Resident #2 NJ Ex Order 26. 4B1 after his/her appointment while awaiting transportation. The CMA stated that Resident #2 waited NJ Ex O hours for transportation NJ Ex Order 26. 4B1. The CMA stated that when transport did arrive to pick up Resident #2, the resident was NJ Exec Orde. The CMA stated that the doctor's office called the NJ Ex Order 26. 4B1, and that Resident #2 was NJ Ex Order 26. 4B1 At 12:53 p.m. and 1:25 p.m., the surveyor interviewed Licensed Practical Nurse (LPN) #1, to inquire who arranged transportation for residents to get to their appointments. LPN #1 stated that she made transportation arrangements for most doctor appointments on the NJ Exec Order 26.4b1. The surveyor then inquired the reason Resident #2 missed multiple doctor's appointments. LPN #1	A 555		

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A 555	Continued From page 8	A 555		

stated that she had just began arranging transportation for resident appointments [redacted], and that Resident #2 missed appointments in the past when transportation arrangements were done by the front desk concierge staff.

At this time, LPN #1 stated that Resident #2's doctor's office would send the resident back with future appointments and that she would arrange transportation.

At 1:45 p.m., the surveyor interviewed LPN #1 and LPN #2 to inquire if Resident #2 had a doctor's appointment on [redacted]. LPN #1 and LPN #2 stated that Resident #2 went to a doctor's appointment on [redacted]. LPN #1 stated that she did not know about Resident #2's appointment on [redacted], and that she did not arrange transportation for that appointment. LPN #1 also stated that she did not know why the resident did not have an [redacted] scheduled to [redacted] him/her. LPN #1 and LPN #2 stated that the Director of Nursing (DON) arranged for [redacted] to [redacted] residents to and from appointments.

At 2:07 p.m., the surveyor interviewed the DON and the Executive Director (ED) to inquire if there were any incidents at the facility regarding resident appointments and transportation. The DON stated that Resident #2 was sent to a doctor's appointment without an [redacted] and that there was "no good answer" as to why the resident did not have an [redacted] The surveyor inquired who was responsible for arranging for [redacted] to [redacted] residents to appointments and the DON stated that [redacted] were usually arranged by the nurse on the floor. The surveyor inquired if the DON knew that Resident #2 left

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A 555	Continued From page 9	A 555		

his/her doctor's office NJ Exec Order 26.4b1 The DON stated that on NJ Ex Order 26. , she was notified by Resident #2's RP that the resident left his/her doctor's office. The surveyor inquired if the facility conducted an investigation following notification of the incident, and the DON stated that there was no investigation completed.

During this interview, the surveyor inquired if the ED was made aware of this incident and if the incident was reported to the Department of Health (DOH). The DON stated that the ED was aware of the incident and that the ED was present when Resident #2's RP called. In addition, the DON stated that the incident was not reported to the DOH and that she "did not consider" completing a reportable event report.

The ED stated that Resident #2 went to a doctor's appointment without an NJ Exec Order 2 and that she had no idea why the resident was NJ Exec Order 26.4b1 . The ED stated that she was notified that Resident #2 did not have an NJ Exec Order 2 on NJ Exec Order 26 and that she was not notified that the resident left the doctor's office NJ Exec Order 26.4b1

2. At 1:05 p.m., the surveyor interviewed Resident #3. During this interview, Resident #3 stated that he/she had a scheduled *NJ Ex Order 26. 4B1* . Resident #3 stated that the DON arranged for him/her to be transported to the scheduled NJ Ex Order 26. 4B1 . Resident #3 stated that on the day of the NJ Ex Order 26. 4B1 , he/she NJ Exec Order 26.4b1 "*NJ Ex Order 26. 4B1* " to await transport. In addition, Resident #3 stated that when he/she called the transport services, they stated that there was no confirmation of the transport and that they would NJ Exec Order 26.4b1 . Resident #3 then stated that "*NJ Ex Order 26. 4B1* " and that transport would come early, late, or not at all.

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A 555	Continued From page 10 Resident #3 stated that his/her RP had to [redacted] so that he/she could get to the [redacted]. In addition, Resident #3 stated that he/she missed appointments in the past. The surveyor reviewed the MR of Resident #3, which indicated that the resident was [redacted]. At 2:07 p.m., the surveyor interviewed the DON to inquire the reason transportation was not arranged for Resident #3 to get to his/her scheduled [redacted]. The DON stated that she arranged transport for Resident #3 to get to the [redacted] and that the transport was approved. The DON stated that she did not know why the transport servicer did [redacted] Resident #3 [redacted] 3. At 1:37 p.m., the surveyor interviewed Resident #4. During this interview, Resident #4 stated that he/she missed [redacted] doctor appointments. Resident #4 stated that he/she missed [redacted] appointments in [redacted] after he/she [redacted] for transport, and [redacted] arrived. The surveyor reviewed the 10/1/2020 facility policy titled, "General Resident Transportation Policy," which indicated, "Procedure: ... 3. The Community will provide resident transportation, either directly or by arrangement, to and from health care services provided outside the center and will promote reasonable plans for security and accountability for the resident and his or her personal transfer of resident information to and from the provider of the service, as required by individual residents and specified in the resident's service plans. 4. Team members assigned to accompany the resident or residents on the trip	A 555		

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A 555	Continued From page 11 will be adequate in number to provide for resident safety, security [of] personal possessions and confidentiality of resident information. 5. The Community may aid in arranging transportation, including, but not limited to, medical and dental appointments upon Resident request ... 7. Team members will remind Residents of such appointed scheduled transportation ...."	A 555		
A 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, any elopements; and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00185073	A 563		

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A 563	Continued From page 12 Based on interview, record review, and review of pertinent facility documents it was determined that the facility failed to notify the Department of Health (DOH) immediately by telephone and in writing within 72 hours after 1 of 4 residents went [redacted] Resident #2. This deficient practice was evidenced by the following: On 4/10/25 at 10:37 a.m., the surveyor interviewed Resident #2's Responsible Party (RP) via telephone. During this interview, Resident #2's RP stated that on [redacted], the facility had Resident #2 transported to his/her doctor's appointment, and that the resident was [redacted]. Resident #2's RP then stated that Resident #2 left the doctor's office, and that the resident was [redacted]. Resident #2's RP stated that she [redacted] who stated that she [redacted] in Resident #2's [redacted] In addition, Resident #2's RP stated that the resident's doctor also called her regarding the incident and stated that the office called the [redacted]. Resident #2's RP stated that following the incident, the facility sent someone to [redacted] Resident #2. Further, Resident #2's RP stated that Resident #2 missed many doctor appointments in [redacted] and missed appointments in [redacted]. Resident #2's RP stated that the facility told her that it was not their job to make sure Resident #2 got to his/her doctor appointments. In addition, Resident #2's RP stated that the resident's doctor office would notify the facility of the resident's upcoming appointments and that she also notified the facility's Director of Nursing (DON) by E-Mail. The surveyor reviewed the Medical Record (MR)	A 563		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT MILLVILL	1125 VILLAGE DRIVE MILLVILLE, NJ 08332

(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 563	Continued From page 13 of Resident #2, who was [redacted]. The surveyor reviewed Resident #2's SP, revised on [redacted] which indicated that the resident would receive necessary [redacted] with [redacted] and appointments. At 11:06 a.m., the surveyor interviewed a staff person at Resident #2's [redacted] to inquire if the resident missed any appointments. The staff person in patient registration stated that she could only see missed appointments from [redacted], and that Resident #2 missed appointments on [redacted]. The staff person stated that on [redacted] Resident #2 was supposed to see the nurse practitioner and receive [redacted] At 11:54 a.m., the surveyor interviewed a Certified Medical Assistant (CMA) at Resident #2's primary doctor's office to inquire if the resident missed any doctor appointments. The CMA stated that Resident #2 missed the following appointments: [redacted] During this interview, the CMA stated that the facility would [redacted] Resident #2 [redacted] at the [redacted]. In addition, the CMA stated that on [redacted], Resident #2 [redacted] after his/her appointment while	A 563		

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A 563	Continued From page 14 awaiting transportation. The CMA stated that Resident #2 waited [redacted] hours for transportation [redacted] and [redacted]. The CMA stated that when transport did arrive to pick up Resident #2, the resident was [redacted]. The CMA stated that the doctor's office called the [redacted], and that Resident #2 was [redacted] At 12:53 p.m. and 1:25 p.m., the surveyor interviewed Licensed Practical Nurse (LPN #1), to inquire who arranged transportation for residents to get to their appointments. LPN #1 stated that she made transportation arrangements for most doctor appointments on the [redacted]. The surveyor then inquired the reason Resident #2 missed multiple doctor's appointments. LPN #1 stated that she had just began arranging transportation for resident appointments [redacted], and that Resident #2 missed appointments in the past when transportation arrangements were done by the front desk concierge staff. At this time, LPN #1 stated that Resident #2's doctor's office would send the resident back with future appointments and that she would arrange transportation. At 1:45 p.m., the surveyor interviewed LPN #1 and LPN #2 to inquire if Resident #2 had a doctor's appointment on [redacted]. LPN #1 and LPN #2 stated that Resident #2 went to a doctor's appointment on [redacted]. LPN #1 stated that she did not know about Resident #2's appointment on [redacted], and that she did not arrange transportation for that appointment. LPN #1 also stated that she did not know why the	A 563		

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A 563	Continued From page 15	A 563		

resident did not have an [NJ Exec Order 2] scheduled to [NJ Exec Order 26.4b1] him/her. LPN #1 and LPN #2 stated that the Director of Nursing (DON) arranged for [NJ Exec Order 26] to [NJ Exec Order 26.4b1] residents to appointments.

At 2:07 p.m., the surveyor interviewed the DON and the Executive Director (ED) to inquire if there were any incidents at the facility regarding resident appointments and transportation. The DON stated that Resident #2 was sent to a doctor's appointment [NJ Exec Order 26.4b1] and that there was "no good answer" as to why the resident did not have an [NJ Exec Order 2]. The surveyor inquired who was responsible for arranging for [NJ Exec Order 26] to [NJ Exec Order 26.4b1] residents to appointments and the DON stated that [NJ Exec Order 26] were usually arranged by the nurse on the floor. The surveyor inquired if the DON knew that Resident #2 [NJ Exec] his/her doctor's office *NJ Ex Order 26. 4B1*. The DON stated that on [NJ Ex Order 26.], she was notified by Resident #2's RP that the resident left his/her doctor's office. The surveyor inquired if the facility conducted an investigation following notification of the incident, and the DON stated that there was no investigation completed.

During this interview, the surveyor inquired if the ED was made aware of this incident and if the incident was reported to the Department of Health (DOH). The DON stated that the ED was aware of the incident and that the ED was present when Resident #2's RP called. In addition, the DON stated that the incident was not reported to the DOH and that she "did not consider" completing a reportable event report.

In addition, the ED stated that Resident #2 went to a doctor's appointment without an [NJ Exec Order 2] and that she had no idea why the resident was sent to the [NJ Exec Order 26.4b1]. The ED stated that she

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A 563	Continued From page 16 was notified that Resident #2 did not have an [redacted] on [redacted], and that she was not notified that the resident *NJ Ex Order 26. 4B1* [redacted]. The surveyor reviewed the undated facility policy titled, "Missing Resident Plan Policy," which indicated, "[This facility] will respond immediately with emergency procedures when a Resident has been identified as missing ... Missing Resident Procedure: ...7. The Executive Director will report the incident to the appropriate state licensing agency per state regulations ...."	A 563		
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.	A 735		

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A 735	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop a Health Service Plan (HSP) for 1 of 4 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 4/10/25 at 1:05 p.m., the surveyor entered Resident #3's room and observed that the resident had [redacted]. The surveyor interviewed Resident #3 to inquire about the resident's [redacted], and the resident stated that [redacted] During this interview, Resident #3 stated that he/she returned to the facility on [redacted]. The surveyor reviewed the Medical Record (MR) of Resident #3, who was [redacted]. The surveyor reviewed a Progress Note (PN) dated [redacted], written by a Licensed Practical Nurse (LPN), which indicated that Resident #3 [redacted] from the [redacted], vital signs were taken, and [redacted] paperwork was given to the Director of Nursing (DON). However, the surveyor did not observe a health care assessment or HSP that was completed following Resident #3's [redacted] from [redacted]. In addition, the surveyor reviewed a '[redacted] and [redacted] visit" note dated [redacted] written by an Advanced Practice Nurse (APN), which confirmed that	A 735		

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A 735	Continued From page 18 Resident #3 had NJ Ex Order 26. 4B1 . The APN's note also indicated that NJ Ex Order 26. 4B1 included a NJ Ex Order 26. 4B1 assessment, NJ Ex Order 26. 4B1 as needed, NJ Ex Order 26. 4B1 prevention, and NJ Ex Order 26. 4B1 management. Additionally, the APN's note indicated, NJ Ex Order 26. 4B1 ". However, the surveyor did not observe a HSP or updated general service plan to address Resident #3's NJ Ex Order 26. 4B1 or the APN's plan for NJ Ex Order 26. 4B1. Resident #3 did not have a HSP, and the resident's general service plan was last updated on NJ Exec Order 26. . At 5:54 p.m., the surveyor interviewed the DON to inquire if Resident #3 was assessed upon his/her NJ Exec Order from NJ Ex Order 26. 4B. The DON stated that Resident #3 was not assessed upon NJ Exec Order from NJ Ex Order 26. 4B, "because it was scheduled and [Resident #3] NJ Exec Order 26.4b1." The surveyor then inquired when an assessment should be completed, and the DON stated that assessments should be completed with NJ Ex Order 26. 4B . The surveyor then asked the DON if the NJ Exec Order 26 in Resident #3's NJ Ex Order 26. 4B1 would be considered a NJ Ex Order 26. 4B1, and the DON stated, "I guess I didn't think of it that way." Additionally, the surveyor inquired if the DON updated Resident #3's general service plan, and the DON stated that there was no change to the resident's general service plan. The surveyor then inquired if the DON developed a HSP for Resident #3's NJ Ex Order 26. 4B1, and the DON stated that she did not.	A 735		
A 745	8:36-7.2(f) Resident Assessments and Care Plans	A 745		

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A 745	Continued From page 19 (f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00185073 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a health care assessment was documented by a Registered Nurse (RN) as required in accordance with the rules of this chapter and professional standards of practice for 2 of 4 residents reviewed, Resident #s 2 and 3. This deficient practice was evidenced by the following: 1. On 4/10/25 at 10:37 a.m., the surveyor interviewed Resident #2's Responsible Party (RP) via telephone. During this interview, Resident #2's RP stated that on [NJ Exec Order 2], the facility had Resident #2 transported to his/her doctor's appointment, and that the resident was *NJ Ex Order 26. 4B1* [redacted]. Resident #2's RP then stated that Resident #2 [NJ Exec] the doctor's office, and that the resident was [NJ Exec O] *NJ Ex Order 26. 4B1* [redacted] The surveyor reviewed the Medical Record (MR) of Resident #2, who *NJ Ex Order 26. 4B1* [redacted]. The surveyor did not observe a health care assessment or Progress Note (PN) that was completed following	A 745		

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A 745	Continued From page 20 Resident #2's [NJ Exec Order] to the facility after the resident [NJ Ex Order 26. 4] from his/her doctor's office on [NJ Ex Order 26.]. At 11:54 a.m., the surveyor interviewed a Certified Medical Assistant (CMA) at Resident #2's primary doctor's office. During this interview, the CMA confirmed that on [NJ Ex Order 26.], Resident #2 [NJ Ex Order 26. 4B1] after his/her appointment while awaiting transportation. The CMA stated that Resident #2 waited [NJ Ex Order 26. 4B1] hours for transportation [NJ Exec Orde] and [NJ Ex Order 26. 4B1]. The CMA stated that when transport did arrive to pick up Resident #2, the resident was [NJ Exec Orde]. The CMA stated that the doctor's office called the [NJ Ex Order 26. 4B1], and that Resident #2 was [NJ Ex Order 26. 4B1] At 2:07 p.m., the surveyor interviewed the Director of Nursing (DON) to inquire if there were any incidents at the facility regarding resident appointments and transportation. The DON stated that Resident #2 was sent to a doctor's appointment without an [NJ Exec Order] and that there was "no good answer" as to why the resident did not have an [NJ Exec Order 2] The surveyor then inquired if the DON was aware that Resident #2 left his/her [NJ Ex Order 26. 4B1], when the resident was sent to his/her appointment without an [NJ Exec Order 4] The DON stated that she was notified by Resident #2's RP on [NJ Exec Order], that the resident left his/her doctor's office. At 5:54 p.m., the surveyor interviewed the DON a second time to inquire if Resident #2 was assessed upon his/her return to the facility after the resident was [NJ Ex Order 26. 4B1]	A 745		

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A 745	Continued From page 21	A 745		

NJ Ex Order 26. 4B1 the doctor's officem on NJ Ex Order 26. 4B1. The DON confirmed that Resident #2 was not assessed following the NJ Ex Order 26. 4B1.

2. On 4/10/25 at 1:05 p.m., the surveyor entered Resident #3's room and observed that the resident had NJ Ex Order 26. 4B1. The surveyor interviewed Resident #3 to inquire about the resident's NJ Ex Order, and the resident stated that on NJ Ex Order 26. 4B1. During this interview, Resident #3 stated that he/she NJ Exec Order 26.4B to the facility on NJ Ex Order 26. 4B1.

The surveyor reviewed the MR of Resident #3, who NJ Ex Order 26. 4B1. The surveyor reviewed a PN dated NJ Exec Order 26.4, written by a Licensed Practical Nurse (LPN), which indicated that Resident #3 NJ Exec Order 26.4B from the NJ Ex Order 26. 4B1 vital signs were taken, and NJ Exec Order 26.4b1 paperwork was given to the DON. However, further review of the resident's MR revealed no documnted evidence of a health care assessment completed following Resident #3's return from the NJ Ex Order 26. 4B1.

At 5:54 p.m., the surveyor interviewed the DON to inquire if Resident #3 was assessed upon his/her NJ Exec Order from NJ Ex Order 26. 4B. The DON stated that Resident #3 was not assessed upon NJ Exec Order from NJ Exec Order 26.4 "because it was scheduled and [Resident #3] NJ Exec Order 26.4b1". The surveyor then inquired when an assessment should be completed, and the DON stated that assessments should be completed with NJ Ex Order 26. 4B. The surveyor then asked the DON if the change in Resident #3's NJ Ex Order 26. 4B1 would be considered a NJ Ex Order 26. 4B1, and the

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A 745	Continued From page 22 DON stated, "*NJ Ex Order 26. 4B1* [redacted]." The surveyor reviewed the undated facility policy titled, "Resident Assessment Process Policy," which indicated, "... A complete reassessment will be performed every 6 months or per state requirements and/or whenever a change in condition occurs ...."	A 745		

RCD 9/17/25

NEW STANDARD
Senior Living

POC 04.10.25
Correction 09.17.25

TagA355:

In response to deficient practice related to 8:36-4.1 (a)(1)-Resident Rights: Each resident is entitled to the following rights: (a) 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: (1) The right to receive personalized services and care in accordance with the residents individualized general service and/or health service plan.

Resident #2 [redacted] from doctors' appointment on [redacted]. Following notification an investigation was initiated on [redacted] The Executive Director spoke with doctors practice manager on [redacted] Resident #2 Health Service Plan for assistance with [redacted] needed was not followed. The Executive Director educated staff on following Health Service Plans on April 10, 2025. Resident #2 had an assessment on [redacted] following incident by the Director of Nursing and Health Service Plan was reviewed and updated as needed on [redacted] Executive Director verified this was completed on [redacted] and continues to monitor. The resident remains in the community. Following notification of Resident #2 missing an [redacted] appointment on [redacted] the Executive Director spoke to the [redacted] practice on [redacted] and requested telephone notification of all appointments going forward. The Executive Director reviews all upcoming resident appointments weekly to ensure transportation and [redacted] needed are in place beginning April 18, 2025, and going forward.

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

All residents have been educated on resident rights and the reporting process by the Executive Director completed on 5/16/2025. Staff educated by the Executive Director and training was completed on 05/16/2025 regarding Resident Rights and the need to report any suspected violation of rights to the Executive Director immediately for investigation. To ensure that the deficient practice doesn't recur, staff will receive training upon hire and annually regarding residents' rights and reporting violations immediately. A reading of the residents' rights was added to each resident council meeting monthly and recorded in the meeting minutes by the Activities Director beginning 05/16/2025 and ongoing. The Executive Director and Director of Wellness in serviced all nursing staff on the General Resident Transportation Policy, how to assist residents with scheduling appointments, arranging transportation, receiving confirmation of scheduled appointments and documenting scheduled appointments in [redacted] communications and calendar, on April 10, 2025. The Executive Director and Wellness Director in serviced all healthcare staff on April 14, 2025, on how to identify residents in need of escorts, how to assign escorts and how to ensure residents in need of escorts do not leave the building without an escort completed April 18, 2025. Director of Wellness in served healthcare staff on providing needed paperwork to be given to the residents and/or escort to take to the scheduled appointment, completed April 18, 2025.

TagA555:

In response to deficient practice related to 8:36-5.8 (a) General Requirements-(a) the facility shall be capable of providing resident transportation, either directly or by arrangement, to and from health care services provided by outside the facility, and shall promote reasonable plans for security and accountability for the resident and his or her personal possessions, as well as transfer of resident information to and from the provider of the service, as required by the individual residents and specified in resident service plans.

Resident #2 [redacted] from doctors' appointment on [redacted] Following notification an investigation was initiated on [redacted] The Executive Director spoke with doctors practice manager on [redacted] Resident #2 Health Service Plan for assistance with [redacted] needed was not followed. The Executive Director educated staff on following Health Service Plans on April 10, 2025. Resident #2 had an assessment on [redacted]

following incident by the Director of Nursing and Health Service Plan was reviewed and updated as needed on Executive Director verified this was completed on and continues to monitor.
Resident #3 scheduled transportation failed to arrive and Resident #3 Following this incident all resident transportation will be confirmed with transportation company 24 hours in advance of transportation beginning April 10, 2025, monitored by the Director of Nursing. Resident #3 had an assessment by the Director of Wellness on and Health Service Plan was updated as needed. Resident #2, #3 and Resident #4 had missed appointments and/or arrived at appointment without the proper documents for the appointment. Moving forward Nursing staff are responsible for assisting with scheduling transportation to appointments as needed and will be monitored by the Executive Director. The Executive Director and Director of Wellness in serviced all nursing staff on the General Resident Transportation policy and ensuring residents have the documents needed on April 10, 2025. No further appointments have been missed and documents are provided.
All residents have the potential to be affected by this deficient practice.
The Executive Director and Wellness Director educated all healthcare staff regarding the General Resident Transportation policy and procedures April 10, 2025. Nursing staff in serviced by the Executive Director and Director of Wellness on how to assist residents with scheduling appointments, arranging transportation, receiving confirmation of scheduled appointments and documenting scheduled appointments in communications and calendar, on April 10, 2025. Nursing staff to notify residents of the scheduled appointment along with reminders of the approaching appointment. Residents needing escorts to appointments have special instructions added "requires escorts to appointments" in their care profile in in which all users will view in the header each time the resident is accessed in the electronic medical records. The Executive Director and Wellness Director in serviced all healthcare staff on April 14, 2025, on how to identify residents in need of escorts, how to assign escorts and how to ensure residents in need of escorts do not leave the building without an escort completed April 18, 2025. Director of Wellness in served healthcare staff on providing needed paperwork to be given to the residents and/or escort to take to the scheduled appointment, completed April 18, 2025.
To ensure that this deficient practice will not recur, beginning April 10, 2025 the Executive Director will conduct a weekly audit of appointments, escorts and transportation. The Executive Director will discuss appointments, escorts and transportation once a week during clinical review meetings that started on 3/25/2025 and will be on going. Completion date 4/10/2025 and ongoing weekly.

TagA563:
In response to deficient practice related to 8:36-5.10 (a) (2) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609)633-9034 (609)392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including but not limited to , all fires, disasters, any elopements and all deaths resulting from accidents or incidents in the facility or related to facility services Reports of such incidents shall contain information about injuries to residents and/or personal, disruptions of services, and extent of damages.
The facility failed to follow regulation 8:36-5.10. Resident #2 . Resident #2 was not provided with an or an appointment on Resident #2 for scheduled transportation. Resident #2 was to the appointment Resident 2# to the facility. Resident #2 had an assessment by the Director of Nursing on and Health Service Plan was updated as needed. Full investigation began once the Executive Director was notified on . The Executive Director spoke with the practice manager at the appointment . The Executive Director spoke to the and filed an request form on On notified no was made. Investigation was completed
All residents have the potential to be affected by this deficient practice.
Staff educated by the Executive Director and training was completed by 7/10/2025 on Missing Resident Policy, General Resident Transportation policy and the need to respond immediately to report with emergency procedures when a

resident is identified [redacted] The Executive Director and/or designee will report the incident to the appropriate state licensing agency per state regulations. The Executive Director and Wellness Director educated all healthcare staff regarding the General Resident Transportation policy and procedures April 10, 2025. Nursing staff in serviced by the Executive Director and Director of Wellness on how to assist residents with scheduling appointments, arranging transportation, receiving confirmation of scheduled appointments and documenting scheduled appointments in [redacted] communications and calendar, on April 10, 2025. Nursing staff to notify residents of the scheduled appointment along with reminders of the approaching appointment. Residents needing escorts to appointments have special instructions added "requires escorts to appointments" in their care profile in [redacted] in which all users will view in the header each time the resident is accessed in the electronic medical records. The Executive Director and Wellness Director in serviced all healthcare staff on April 14, 2025, on how to identify residents in need of escorts, how to assign escorts and how to ensure residents in need of escorts do not leave the building without an escort completed April 18, 2025. Director of Wellness in serviced healthcare staff on providing needed paperwork to be given to the residents and/or escort to take to the scheduled appointment, completed April 18, 2025.
To ensure that the deficient practice doesn't recur, all staff to receive training regarding Missing Resident Policy and reporting/responding immediately upon hire and annually. Completion date 07/10/2025 and ongoing.

TagA735:
In response to deficient practice related to 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 residents 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.
Resident #2 was not provided with an escort for an appointment on [redacted] Resident #2 [redacted] Resident #2 was [redacted] to the appointment [redacted] Resident 2# [redacted] to the facility. Resident #2 had an assessment by the Director of Nursing on [redacted] and [redacted] Plan was updated as needed. Full investigation began once the Executive Director was notified on April [redacted] The Executive Director spoke with the practice manager at the appointment [redacted] 25 . The Executive Director spoke to the [redacted] and filed an [redacted] request form on [redacted]. On [redacted] report was made. Investigation was completed [redacted] Resident #3 scheduled transportation failed to arrive and Resident #3 [redacted] Following this incident all resident transportation will be confirmed with transportation company 24 hours in advance of transportation beginning April 10, 2025, monitored by the Director of Nursing. Director of Wellness failed to assess Resident #3 on he/she [redacted] to the facility following [redacted] The Executive Director educated the Director of Wellness on regulation 8:36-7.2(a) 1-5 Resident assessments and care plans on April 10, 2025. The Director of Wellness assessed resident #3 and his/her individual service plan was revised as needed on April 10, 2025. A health service plan was initiated on April 11, 2025. Moving forward Nursing staff are responsible for assisting with scheduling transportation to appointments as needed and will be monitored by the Executive Director. The Executive Director and Director of Wellness in serviced all nursing staff on the General Resident Transportation policy and ensuring residents have the documents needed on April 10, 2025. No further appointments have been missed and documents are provided.
All residents have the potential to be affected by this deficient practice.
The Executive Director educated the Director of Wellness on regulation 8:36-7.2(a) on April 10, 2025.
The Director of Wellness and/or designee will monitor [redacted] dashboard for any [redacted] plans that are due for review and residents receiving [redacted] services and/or [redacted] services post hospitalization daily for [redacted] and monthly going forward beginning on [redacted] to ensure GSP remain compliant and updated.
To ensure that the deficient practice doesn't recur This will be discussed during monthly QA meetings beginning July

NEW STANDARD
Senior Living

2025. Completion date 5/19/2025 and ongoing moving forward.

TagA745:

In response to deficient practice related to 8:36-7.2 (f) (1) Resident Assessments and Care Plans- (f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice.

Facility failed to ensure that a health care assessment was documented by the Director of Wellness as required in accordance with the rules of regulation 8:36-7.2(f) (1) and professional standards of practice for Resident #2 and #3.

The Executive Director reviewed the policy and procedures for assessments on residents with general service plans semi-annually and quarterly on residents with health service plans on April 10, 2025. Resident #2 had an assessment by the Director of Nursing on NJ Exec Order 26.4b1 and Health Service Plan was updated as needed. The Director of Wellness assessed resident #3 and his/her individual service plan was revised as needed on NJ Exec Order 26.4b1 A health service plan was initiated on NJ Exec Order 26.4b1 The Executive Director educated the Director of Wellness on regulation 8:36-7.2(a) 1-5 Resident assessments and care plans on April 10, 2025. The Executive Director educated the Director of Wellness on the policy and procedures for assessments of residents with general service plans on April 10, 2025. All residents will be re-assessed upon readmission from hospital stays, semi annually and quarterly of residents with health service plans beginning April 11, 2025

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

Policy will be reviewed during monthly QA meetings beginning in July 2025. The Director of Wellness and/or designee will monitor Point Click Care dashboard resident assessments and care plans daily going forward beginning May 19, 2025 going forward.

To ensure that the deficient practice doesn't recur, the policy Resident Assessment Process Policy will be discussed during monthly QA meetings beginning July 2025. Completion date July 10, 2025, and ongoing moving forward.

NJ Ex Order 26. 4B

NJ Exec Order 26.4b1

Executive Director

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
06A003	A. Building B. Wing	9/17/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT MILLVILLE	1125 VILLAGE DRIVE MILLVILLE, NJ 08332

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0745 Reg. # 8:36-7.2(f) LSC	Correction Completed 09/17/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
06A003 Y1	A. Building B. Wing Y2	9/17/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT MILLVILLE	1125 VILLAGE DRIVE MILLVILLE, NJ 08332

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0355	Correction	ID Prefix A0555	Correction	ID Prefix A0563	Correction
Reg. # 8:36-4.1(a)(1)	Completed	Reg. # 8:36-5.8(a)	Completed	Reg. # 8:36-5.10(a)(2)	Completed
LSC	09/17/2025	LSC	09/17/2025	LSC	09/17/2025
ID Prefix A0735	Correction	ID Prefix A0745	Correction	ID Prefix	Correction
Reg. # 8:36-7.2(e)(1-5)	Completed	Reg. # 8:36-7.2(f)	Completed	Reg. #	Completed
LSC	09/17/2025	LSC	09/17/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON 4/10/2025

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