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 01/22/2025

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 & Revisit COMPLAINT #: NJ00178722 CENSUS: 151 SAMPLE SIZE: 16 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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

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 01/22/2025

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 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00178722

Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the Executive Director (ED) failed to ensure the implementation and enforcement of six medication policies and procedures for 4 of 5 residents reviewed, Resident #'s 1, 2, 4 and 5. This deficient practice was evidenced by the following:

1. On 11/20/24 at 9:55 a.m., the surveyor completed a medication pass observation with a Certified Medication Aide (CMA). During the medication pass, the CMA opened Resident #5's Medication Administration Record (MAR), and the surveyor observed an order for NJ Exec Order 26.4b1 [redacted], with instructions to NJ Exec Order 26.4b1 [redacted] once daily", however, the order did not indicate which [redacted] was the NJ Exec Order 26.4b1. The surveyor interviewed the CMA to inquire how she knew which [redacted] was NJ Exec Order 26.4b1 and the CMA stated that she did not know because she did not usually work on Resident #5's unit. Resident #5 requested to NJ Exec Order 26.4b1 his/her [redacted] and stated that the NJ Exec Order 26.4b1 were for both [redacted].

2. At 11:28 a.m., the surveyor completed a medication pass observation with Licensed Practical Nurse (LPN #3). During the medication pass, LPN #3 opened Resident #1's MAR, and both the surveyor and the LPN observed that

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 01/22/2025

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 310	Continued From page 2	A 310		

Resident #1 had a duplicate order for [redacted]. One order indicated that Resident #1 was to receive [redacted] at 12:00 p.m., and the other indicated that the resident was to receive [redacted] at 12:00 p.m. The surveyor interviewed LPN #3 to inquire how she knew which [redacted] order to administer, and the LPN stated that the pharmacy entered the new [redacted] order that morning, and that she had already called the pharmacy and Resident #1's Primary Care Provider (PCP) to confirm the order. The surveyor then inquired the reason the old [redacted] order was not discontinued, and the LPN stated that pharmacy discontinued orders and that she did not know why the pharmacy did not discontinue the old order.

The surveyor reviewed Resident #1's MAR for [redacted], which revealed that the resident had two orders for [redacted] in the morning, one for [redacted] at 8:00 a.m., and another for [redacted] at 9:00 a.m. The MAR also revealed two orders for evening [redacted] one for [redacted] at 5:00 p.m., and the other for [redacted] at 5:00 p.m. Lastly, the MAR revealed duplicate orders for [redacted] once daily at 9:00 a.m. (used for [redacted]). The surveyor observed that both [redacted] orders were documented as administered from [redacted]

At 10:51 a.m. and 11:00 a.m., the surveyor interviewed LPN #1 and LPN #2 to inquire if they noticed any duplicate orders in the MAR. LPN #1 stated that she observed duplicate orders for Resident #4's [redacted]) during her morning medication pass. LPN #2 stated that

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 01/22/2025

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 310	Continued From page 3 she saw duplicate medication orders in the past. 3. The surveyor then reviewed Resident #4's MAR for [redacted] and [redacted] of [redacted] and observed duplicate orders for [redacted] The surveyor observed that both [redacted] orders were documented as administered from [redacted] and both [redacted] orders were documented as administered from [redacted]. 4. In addition, the surveyor also reviewed Resident #2's MAR for [redacted] and [redacted] of [redacted] and observed duplicate orders for [redacted] 1 tablet by mouth once daily (used to [redacted]). The surveyor observed that both [redacted] orders were documented as administered from [redacted]. In addition, the surveyor observed that LPN #1 documented both [redacted] orders as administered on [redacted], and LPN #3 documented both [redacted] orders as administered 7 times in [redacted] and 18 times in [redacted] Further review of Resident #2's MAR from [redacted] and [redacted] of [redacted] revealed duplicate orders documented as administered for [redacted]	A 310		

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 01/22/2025

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 310	Continued From page 4	A 310		

NJ Exec Order 26.4b1). Further, the surveyor reviewed Resident #2's MAR for NJ Exec Order 26.4b1 of NJ Exec Orde and observed duplicate orders for NJ Exec Order 26.4b1 by mouth twice a day, which were both documented as administered on NJ Exec Order 26.4b at 9:00 a.m. The surveyor also observed an order for NJ Exec Order 26.4b1 3 tablets by mouth at bedtime and an order for NJ Exec Order 26.4b1 1 tablet by mouth every night at bedtime. Both NJ Exec Order 26.4b1 orders were documented as administered from NJ Exec Order 26.4b1

At 12:36 p.m. and 12:42 p.m., the surveyor interviewed LPN #1 and LPN #3 to inquire the reason they documented Resident #2's duplicate orders for NJ Exec Order 26.4b1 1 tablet by mouth once daily as administered. LPN #1 stated that she administered one dose of NJ Exec Order 26.4b1 to Resident #2 and that she did not know why she signed both orders as administered. LPN #3 stated that she also administered one dose of NJ Exec Order 26.4b1 to Resident #2 and that she "probably clicked it [the medication order] twice and did not realize that it was on the MAR twice".

At 1:13 p.m., the surveyor interviewed the Director of Wellness (DOW) to inquire who entered physician prescribed orders for residents into the MAR. The DOW stated that the pharmacy transcribed the orders from PCPs, entered the orders, emailed a copy of the script to the facility, and then the facility confirmed the orders on their side. The surveyor then inquired if the DOW was aware that multiple residents had duplicate orders on their MAR, and the DOW stated that she was aware. The DOW stated that the PCPs would write scripts to change or renew orders but would not write scripts to discontinue the old orders. The DOW explained that PCPs

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 01/22/2025

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 310	Continued From page 5 had to write a script to the pharmacy to permanently discontinue orders because if the facility deleted the duplicate orders, the orders would delete temporarily and then repopulate at the beginning of the next cycle. At 1:56 p.m., the surveyor informed the ED, the DOW and the Senior Director of Wellness and Infection Control that all residents at the facility were in imminent danger due to the pharmacy entering several duplicate orders for several residents. At this time, the surveyor interviewed the ED to inquire if she was aware of the deficient practice, and the ED stated that she was. The surveyor reviewed the facility's policy and procedure titled, "The Process for Delegation of Medication Administration," which indicated, "... The nurse shall maintain full responsibility for: a. Communication with resident's physicians and pharmacists concerning medication issues ... Certified Medication Aide shall: a. Be advised to communicate exclusively with the delegating nurse regarding all [medication] matters." The surveyor also reviewed the facility's policy and procedure titled, "Provision of Pharmaceutical Services," which documented, "[The facility] shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and federal laws and regulations ... The Registered Nurse shall assume all responsibilities for supervising personnel administering medication." In addition, the surveyor reviewed the facility's policy and procedure titled, "Limits to Delegation	A 310		

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 01/22/2025

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 310	Continued From page 6	A 310		

of Medication Administration," which indicated, "The RN is responsible for the administration of medications."

The surveyor also reviewed the facility's policy and procedure titled, "Medication Administration Record, " which indicated, "When a medication is discontinued, write "DC'd" and the date, and using a yellow highlighter, make a line through the discontinued entry. When a new prescription changes the dosage or frequency of administration of a previously prescribed medication, discontinue the previous entry by writing "DC'd" and the date, and using a yellow highlighter make a line through the discolored entry. Enter the new prescription as a new medication order."

The surveyor then reviewed the facility's policy and procedure titled, "Prescriber Medication," which indicated, "Any dose or order that appears inappropriate considering the resident's age, allergies, diagnosis, or current medication regimen is verified with the prescriber."

Lastly, the surveyor reviewed the facility's policy and procedure titled, "Medication Administration Errors," which indicated, "LPNs/CMAs are to follow the seven (7) rights of medication administration ... 3. Right Dosage ... 5. Right Route ... All LPN/CMA staff shall clarify administration questions with the RN."

This deficient practice was identified as an imminent danger, and a removal plan was requested. The facility submitted a removal plan on 11/22/24 that was unacceptable. The surveyor requested that the facility make corrections to the removal plan.

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 01/22/2025

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 310	Continued From page 7 On 11/25/24, the facility submitted an acceptable removal plan, which indicated that the facility would review all resident orders to ensure all duplicate orders were discontinued. The removal plan also indicated that pharmacy would add an administration note to medications with identical orders that were to be administered in conjunction with each other to avoid the appearance of a duplicate order (Example: NJ Exec Order 26.4b1 [redacted]). In addition, the removal plan indicated that staff would be educated and in-serviced. Further, the removal plan indicated that all resident orders would be reviewed and audited for duplication by the registered nurse monthly for six months. Lastly, the removal plan indicated that all resident NJ Ex Order 26.4(b)(1) orders were reviewed and audited to ensure specific orders for the site of administration were included (Example: NJ Ex Order 26.4(b)(1) [redacted]). On 1/22/25, the surveyor conducted a re-visit survey at the facility. The surveyor reviewed documented evidence of staff education and in-service. However, the surveyor reviewed resident MARs and noted duplicate orders for six residents. The surveyor also noted that six residents had identical orders without administration notes from pharmacy. The surveyor noted that facility staff did not document duplicate orders as administered. Lastly, the surveyor noted that NJ Exec Order 26.4b1 orders included the NJ Ex Or[redacted] of administration. Refer to tag: 8:36-11.2 A-0925	A 310		
A 925	8:36-11.2 Pharmaceutical Services	A 925		

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 01/22/2025

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 925	Continued From page 8 The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00178722 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that pharmaceutical services were provided to residents in accordance with the prescriber's orders and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations, when the facility's pharmacy entered resident orders unsafely and inaccurately for 4 of 5 residents reviewed, Resident #'s 1, 2, 4, 5, and several unsampled residents. This deficient practice was evidenced by the following: 1. On 11/20/24 at 9:55 a.m., the surveyor completed a medication pass observation with a Certified Medication Aide (CMA). During the medication pass, the CMA opened Resident #5's Medication Administration Record (MAR), and the surveyor observed an order for NJ Exec Order 26.4b1 [redacted], with instructions to 'NJ Exec Order 26.4b1 [redacted] once daily", however, the order did not indicate which NJ Exec [redacted] was NJ Exec Order 26.4b1 [redacted] The surveyor interviewed the CMA to inquire how she knew which NJ Exec [redacted] was NJ Exec Order 26.4b1 [redacted] and the CMA stated that she did not	A 925		

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 01/22/2025

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 925	Continued From page 9 know because she did not usually work on Resident #5's unit. 2. At 11:28 a.m., the surveyor completed a medication pass observation with Licensed Practical Nurse (LPN) #3. During the medication pass, LPN #3 opened Resident #1's MAR, and both the surveyor and the LPN observed that Resident #1 had a duplicate order for [redacted]. One order indicated that Resident #1 was to receive [redacted] of NJ Exec Order 26.4b1 at 12:00 p.m., and the other indicated that the resident was to receive [redacted] of NJ Exec Order 26.4b1 at 12:00 p.m. The surveyor interviewed LPN #3 to inquire how she knew which [redacted] order to administer, and the LPN stated that the pharmacy entered the new [redacted] order that morning, and that she had already called the pharmacy and Resident #1's Primary Care Provider (PCP) to confirm the order. The surveyor then inquired as to the reason the old [redacted] order was not discontinued, and the LPN stated that the pharmacy discontinued orders and that she did not know why the pharmacy did not discontinue the old order. The surveyor then reviewed the Medical Record (MR) for Resident #1 who was admitted to the facility in [redacted] of [redacted] with a diagnosis of NJ Exec Order 26.4b1. The surveyor's continued review of Resident #1's MAR for NJ Exec Order 26.4b1, revealed that the resident also had two orders for NJ Exec Order 26.4b1 in the morning, one for NJ Exec Order 26.4b1 at 8:00 a.m., and another NJ Exec Order 26.4b1 at 9:00 a.m. In addition, the MAR revealed two orders for evening NJ Exec Order 26.4b1, one for [redacted] of [redacted] at 5:00 p.m., and the other for [redacted] of [redacted] at 5:00 p.m. Lastly, the MAR revealed	A 925		

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 01/22/2025

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 925	Continued From page 10	A 925		

duplicate orders for NJ Exec Order 26.4b1 [redacted] in each [redacted] once daily at 9:00 a.m. (used for [redacted]. The surveyor noted that both [redacted] orders were documented as administered from [redacted].

At 10:51 a.m. and 11:00 a.m., the surveyor interviewed LPN #1 and LPN #2 to inquire if they noticed any duplicate orders in the MAR. LPN #1 stated that she observed duplicate orders for Resident #4's NJ Exec Order 26.4b1 during her morning medication pass. LPN #2 stated that she saw duplicate medication orders in the past, and when she did, she deleted the oldest order after she checked the MAR, the medication cart, and checked with the Director of Wellness (DOW).

3. The surveyor then reviewed the MR for Resident #4, who was admitted to the facility in [redacted] with a diagnosis of [redacted] The surveyor reviewed the MAR for [redacted] and observed duplicate orders for [redacted] once daily and [redacted] once daily (used to [redacted] The surveyor observed that both aspirin orders were documented as administered from [redacted], and both [redacted] orders were documented as administered from [redacted]

4. In addition, the surveyor also reviewed the MR of Resident #2 who was admitted to the facility in [redacted] with diagnoses of [redacted] The surveyor reviewed Resident #2's MAR for [redacted] and [redacted] of [redacted] and observed

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 01/22/2025

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 925	Continued From page 11 duplicate orders for NJ Exec Order 26.4b1 1 tablet by mouth once daily (used to prevent and treat NJ Exec Order 26.4b1). The surveyor observed that both NJ Exec Order 26.4b1 orders were documented as administered from NJ Exec Order 26.4b1 In addition, the surveyor observed that LPN #1 documented both NJ Exec Order 26.4b1 orders as administered or NJ Exec Order 26.4b1 and LPN #3 documented both NJ Exec Order 26.4b1 orders as administered 7 times in NJ Exec Ord and 18 times in NJ Exec Ord Further review of Resident #2's MAR from NJ Exec Ord revealed duplicate orders documented as administered for NJ Exec Order 26.4b1 Further, the surveyor reviewed Resident #2's MAR for NJ Exec Order 26.4b1 of NJ Exec Orde and observed duplicate orders for NJ Exec Order 26.4b1 by mouth twice a day, which were both documented as administered on NJ Exec Order 26.4b at 9:00 a.m. The surveyor also observed an order for NJ Exec Order 26.4b1 by mouth at bedtime and an order for NJ Exec Order 26.4b1 1 tablet by mouth every night at bedtime. Both NJ Exec Order 26.4b1 orders were documented as administered from NJ Exec Order 26.4b1 At 12:36 p.m. and 12:42 p.m., the surveyor interviewed LPN #1 and LPN #3 to inquire the reason they documented Resident #2's duplicate orders for NJ Exec Order 26.4b1 1 tablet by mouth	A 925		

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 01/22/2025

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 925	Continued From page 12 once daily as administered. LPN #1 stated that she administered one dose of [NJ Exec Order 26.4b1] to Resident #2 and that she did not know why she signed both orders as administered. LPN #3 stated that she also administered one dose of [NJ Exec Order 26.4b1] to Resident #2 and that she "probably clicked it [the [NJ Exec Order 26.4b1] order] twice and did not realize that it was on the MAR twice". At 1:13 p.m., the surveyor interviewed the Director of Wellness (DOW) to inquire who entered physician prescribed orders for residents into the MAR. The DOW stated that the pharmacy transcribed the orders from PCPs, entered the orders, emailed a copy of the script to the facility, and then the facility confirmed the orders on their side. The surveyor then inquired if the DOW was aware that multiple residents had duplicate orders on their MAR, and the DOW stated that she was aware. The DOW stated that the PCPs would write scripts to change or renew orders but would not write scripts to discontinue the old orders. The DOW explained that PCPs had to write a script to the pharmacy to permanently discontinue orders because if the facility deleted the duplicate orders, the orders would delete temporarily and then repopulate at the beginning of the next cycle. During the interview, the surveyor inquired if the DOW knew which of Resident #5's eyes required [NJ Exec Order 26.4b1] and the DOW stated that she would find out. At 1:56 p.m., the surveyor informed the Executive Director (ED), the DOW and the Senior Director of Wellness and Infection Control that all residents at the facility were in imminent danger due to the pharmacy entering duplicate orders for several residents.	A 925		

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 01/22/2025

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 925	Continued From page 13 On 11/21/24 at 1:25 p.m., the surveyor interviewed the DOW and the Senior Director of Wellness and Infection Control to inquire if they were able to determine which of Resident #5's [redacted] required NJ Exec Order 26.4b1 and the Senior Director of Wellness and Infection Control stated that they were awaiting a response from Resident #5's doctor. The surveyor reviewed the undated facility's policy and procedure titled, "The Process for Delegation of Medication Administration," "Procedure" indicated, "... 5. The nurse shall maintain full responsibility for: a. Communication with resident's physicians and pharmacists concerning medication issues ... 6. Certified Medication Aide shall: a. Be advised to communicate exclusively with the delegating nurse regarding all medication matters." The surveyor also reviewed the facility's policy and procedure titled, "Provision of Pharmaceutical Services," which documented, "Policy" "[The facility] shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and federal laws and regulations ... Procedure ...5. The Registered Nurse shall assume all responsibilities for supervising personnel administering medication." In addition, the surveyor reviewed the undated facility's policy and procedure titled, "Medication Administration Record, " which indicated, "When a medication is discontinued, write "DC'd" and the date, and using a yellow highlighter, make a line through the discontinued entry. When a new prescription changes the dosage or frequency of	A 925		

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 01/22/2025

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 925	Continued From page 14 administration of a previously prescribed medication, discontinue the previous entry by writing "DC'd" and the date, and using a yellow highlighter make a line through the discolored entry. Enter the new prescription as a new medication order." Lastly, the surveyor reviewed the undated facility's policy and procedure titled, "Prescriber Medication," which indicated, "Procedure...3. Any dose or order that appears inappropriate considering the resident's age, allergies, diagnosis, or current medication regimen is verified with the prescriber." This deficient practice was identified as an imminent danger, and a removal plan was requested. The facility submitted a removal plan on 11/22/24 that was unacceptable. The surveyor requested that the facility make corrections to the removal plan. On 11/25/24, the facility submitted an acceptable removal plan, which indicated that the facility would review all resident orders to ensure all duplicate orders were discontinued. The removal plan also indicated that pharmacy would add an administration note to medications with identical orders that were to be administered in conjunction with each other to avoid the appearance of a duplicate order (Example: NJ Exec Order 26.4b1 [redacted]). In addition, the removal plan indicated that staff would be educated and in-serviced. Further, the removal plan indicated that all resident orders would be reviewed and audited for duplication by the registered nurse monthly for six months. Lastly, the removal plan indicated that all resident NJ Exec Order 26.4b1 [redacted] were	A 925		

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 01/22/2025

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 925	Continued From page 15 reviewed and audited to ensure specific orders for the [redacted] of administration were included (Example:NJ Exec Order 26.4b1 [redacted]). On 1/22/25, the surveyor conducted a re-visit survey at the facility. The surveyor reviewed documented evidence of staff education and in-service. However, the surveyor reviewed all resident MARs and noted duplicate orders for six residents. The surveyor also observed that six residents had identical orders without administration notes and clarification from the pharmacy. Surveyor's further review revealed that facility staff did not document duplicate orders as administered. Lastly, the surveyor observed that topical, optic, otic, and nasal orders included the site of administration.	A 925		
A 937	8:36-11.5(a) Pharmaceutical Services (a) The administration of medications is within the scope of practice and remains the responsibility of the registered professional nurse. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00178722 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the Registered Nurse (RN) failed to ensure the appropriate supervision of	A 937		

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 01/22/2025

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 937	Continued From page 16 medication administration tasks delegated to Licensed Practical Nurses (LPNs) and Certified Medication Aides (CMAs), when a CMA administered an incomplete medication order and 14 nursing staff documented the administration of duplicate medication orders for 4 of 5 residents reviewed, Resident #'s 1, 2, 4, and 5. This deficient practice was evidenced by the following: 1. On 11/20/24 at 9:55 a.m., the surveyor completed a medication pass observation with a CMA. During the medication pass, the CMA opened Resident #5's Medication Administration Record (MAR), and the surveyor observed an order for NJ Exec Order 26.4b1 [redacted]), with instructions to NJ Exec Order 26.4b1 [redacted]", however, the order did not indicate which [redacted] was affected. The surveyor observed as the CMA took the [redacted] into Resident #5's room to administer them, however, the resident stated that he/she would NJ Exec Order 26.4b1 [redacted]. Resident #5 proceeded to apply [redacted] into each [redacted] The surveyor interviewed the CMA to inquire how she knew which eye was affected, and the CMA stated that she did not know because she did not usually work on Resident #5's unit. 2. The surveyor reviewed a Medication Administration Record (MAR) for Resident #1, which revealed duplicate orders for [redacted] in each [redacted] once daily at 9:00 a.m. (used to treat [redacted] symptoms). The surveyor observed that both [redacted] orders were documented as administered from [redacted] 3. The surveyor then reviewed Resident #4's MAR for [redacted] and [redacted] of [redacted] and	A 937		

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 01/22/2025

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 937	Continued From page 17 observed duplicate orders for NJ Exec Order 26.4b1 [redacted]. The surveyor observed that both [redacted] orders were documented as administered from NJ Exec Order 26.4b1 [redacted], and both NJ Exec Order 26.4b1 orders were documented as administered from NJ Exec Order 26.4b1 [redacted]. 4. In addition, the surveyor reviewed Resident #2's MAR for [redacted] and [redacted] of [redacted] and observed duplicate orders for NJ Exec Order 26.4b1 [redacted] The surveyor observed that both NJ Exec Order 26.4b1 orders were documented as administered from NJ Exec Order 26.4b1 [redacted]. In addition, the surveyor observed that Licensed Practical nurse (LPN) #1 documented both NJ Exec Order 26.4b1 orders as administered on [redacted], and LPN #3 documented both NJ Exec Order 26.4b1 orders as administered 7 times in [redacted] and 18 times in [redacted] Further review of Resident #2's MAR for [redacted] and [redacted] of [redacted] also revealed duplicate orders that were both documented as administered for NJ Exec Order 26.4b1 [redacted] Further, the surveyor reviewed Resident #2's MAR for [redacted] of [redacted] and observed duplicate orders for NJ Exec Order 26.4b1	A 937		

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 01/22/2025

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 937	Continued From page 18 by mouth twice a day, which were both documented as administered on NJ Exec Order 26.4b at 9:00 a.m. The surveyor also observed an order for NJ Exec Order 26.4b1 3 tablets by mouth at bedtime and an order for NJ Exec Order 26.4b1 1 tablet by mouth every night at bedtime. Both NJ Exec Order 26.4b1 orders were documented as administered from NJ Exec Order 26.4b1 . At 12:36 p.m. and 12:42 p.m., the surveyor interviewed LPN #1 and LPN #3 to inquire the reason they documented Resident #2's duplicate orders for NJ Exec Order 26.4b1 1 tablet by mouth once daily as administered. LPN #1 stated that she administered one dose of NJ Exec Order 26.4b1 to Resident #2 and that she did not know why she signed both orders as administered. LPN #3 stated that she also administered one dose of NJ Exec Order 26.4b1 to Resident #2 and that she "probably clicked it [the medication order] twice and did not realize that it was on the MAR twice". At 1:13 p.m., the surveyor interviewed the Director of Wellness (DOW) to inquire if she was aware that multiple residents had duplicate medication orders on their MAR, and the DOW stated that she was aware. The DOW stated that Primary Care Providers (PCPs) would write scripts to change or renew orders but would not write scripts to discontinue the old orders. The DOW explained that PCPs had to write a script to the pharmacy to permanently discontinue orders because if the facility deleted the duplicate orders, the orders would delete temporarily and then repopulate at the beginning of the next cycle. The surveyor then inquired if nursing staff signed duplicate orders as administered, and the DOW stated that "they shouldn't". The DOW stated that only one order should be documented as administered. During the interview, the surveyor	A 937		

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 01/22/2025

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 937	Continued From page 19 also inquired if the DOW knew which of Resident #5's [NJ Exec Orders] required [NJ Exec Order 26.4b1], and the DOW stated that she would find out. At 1:56 p.m., the surveyor informed the Executive Director (ED), the DOW, and the Senior Director of Wellness and Infection Control that all residents at the facility were in imminent danger due to the pharmacy entering duplicate orders for several residents, incomplete orders, and duplicate orders being documented as administered. On 11/21/24 at 1:25 p.m., the surveyor interviewed the DOW and the Senior Director of Wellness and Infection Control to inquire if they were able to determine which of Resident #5's [NJ Exec Orders] required [NJ Exec Order 26.4b1], and the Senior Director of Wellness and Infection Control stated that they were awaiting a response from Resident #5's doctor. The surveyor reviewed the undated facility's policy and procedure titled, "The Process for Delegation of Medication Administration," "Procedure" indicated, "... 5. The nurse shall maintain full responsibility for: a. Communication with resident's physicians and pharmacists concerning medication issues ... 6. Certified Medication Aide shall: a. Be advised to communicate exclusively with the delegating nurse regarding all medication matters." The surveyor also reviewed the undated facility's policy and procedure titled, "Provision of Pharmaceutical Services," which documented, "Policy" "[The facility] shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in	A 937		

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 01/22/2025

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 937	Continued From page 20 accordance with the rules of this chapter and all applicable State and federal laws and regulations ... Procedure ...5. The Registered Nurse shall assume all responsibilities for supervising personnel administering medication." In addition, the surveyor reviewed the undated facility's policy and procedure titled, "Limits to Delegation of Medication Administration," which indicated, "Policy the RN is responsible for the administration of medications..." Lastly, the surveyor reviewed the undated facility's policy and procedure titled, "Medication Administration Errors," which indicated, "... 12. All LPN/CMA staff shall clarify administration questions with the RN...." This deficient practice was identified as an imminent danger, and a removal plan was requested. The facility submitted a removal plan on 11/22/24 that was unacceptable. The surveyor requested that the facility make corrections to the removal plan. On 11/25/24, the facility submitted an acceptable removal plan, which indicated that the facility would review all resident orders to ensure all duplicate orders were discontinued. The removal plan also indicated that pharmacy would add an administration note to medications with identical orders that were to be administered in conjunction with each other to avoid the appearance of a duplicate order (Example: NJ Exec Order 26.4b1 [redacted]). In addition, the removal plan indicated that staff would be educated and in-serviced. Further, the removal plan indicated that all resident orders would be reviewed and audited for duplication by	A 937		

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 01/22/2025

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 937	Continued From page 21 the registered nurse monthly for six months. Lastly, the removal plan indicated that all resident NJ Exec Order 26.4b1 orders were reviewed and audited to ensure specific orders for the site of administration were included (Example: NJ Exec Order 26.4b1 [redacted] On 1/22/25, the surveyor conducted a re-visit survey at the facility. The surveyor reviewed documented evidence of staff education and in-service. However, the surveyor reviewed all resident MARs and observed duplicate orders for six residents. The surveyor also observed that six residents had identical orders without administration notes from pharmacy. The surveyor observed that facility staff did not document duplicate orders as administered. Lastly, the surveyor observed that NJ Exec Order 26.4b1 [redacted] orders included the site of administration. Reference: 8:36-11.2 A-0925	A 937		
A 963	8:36-11.5(f) Pharmaceutical Services (f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00178722	A 963		

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 01/22/2025

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 963	Continued From page 22 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure medication was accurately administered and documented in accordance with prescriber's orders and facility medication policies for unsampled residents and 3 of 5 residents reviewed for medication administration, Resident #'s 1, 2, and 4. This deficient practice was evidenced by the following: 1. On 11/20/24, the surveyor reviewed Resident #1's Medication Administration Record (MAR), which revealed duplicate orders for NJ Exec Order 26.4b1 [redacted] once daily at 9:00 a.m. (used to treat [redacted] symptoms). The surveyor observed that both NJ Exec Order 26.4b1 orders were documented as administered from NJ Exec Order 26.4b1. 2. The surveyor also reviewed Resident #4's MAR for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 of [redacted] and observed duplicate orders for NJ Exec Order 26.4b1 [redacted] The surveyor observed that both [redacted] orders were documented as administered from NJ Exec Order 26.4b1 [redacted], and both NJ Exec Order 26.4b1 orders were documented as administered from NJ Exec Order 26.4b1 [redacted]. 3. In addition, the surveyor reviewed Resident #2's MAR for NJ Exec Order 26.4b1 and [redacted] of [redacted] and noted duplicate orders/written twice for NJ Exec Order 26.4b1 1 tablet by mouth once daily NJ Exec Order 26.4b1 [redacted] The surveyor observed that both NJ Exec Order 26.4b1 orders were documented as administered from NJ Exec Order 26.4b1 [redacted] In addition, the surveyor observed	A 963		

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 01/22/2025

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 963	Continued From page 23 that Licensed Practical nurse (LPN) #1 documented both [redacted] orders as administered on [redacted], and LPN #3 documented both [redacted] orders as administered 7 times in [redacted] and 18 times in [redacted]. Further review of Resident #2's MAR for [redacted] and [redacted] of [redacted] also revealed duplicate orders that were both documented as administered for [redacted] Further, the surveyor reviewed Resident #2's MAR for [redacted], and observed duplicate orders for [redacted] by mouth twice a day, which were both documented as administered on [redacted] at 9:00 a.m. The surveyor also observed an order for [redacted] 3 tablets by mouth at bedtime and an order for [redacted] 1 tablet by mouth every night at bedtime. Both [redacted] orders were documented as administered from [redacted]. At 12:36 p.m. and 12:42 p.m., the surveyor interviewed LPN #1 and LPN #3 to inquire the reason they documented Resident #2's duplicate orders for [redacted] 1 tablet by mouth once daily as administered. LPN #1 stated that she administered one dose of [redacted] to Resident #2 and that she did not know why she signed both orders as administered. LPN #3 stated that she also administered one dose of	A 963		

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 01/22/2025

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 963	Continued From page 24 NJ Exec Order 26.4b1 to Resident #2 and that she "probably clicked it [the order for NJ Exec Order 26.4b1 twice and did not realize that it was on the MAR twice". At 1:13 p.m., the surveyor interviewed the Director of Wellness (DOW) to inquire if she was aware that multiple residents had duplicate medication orders on their MAR, and the DOW stated that she was aware. The DOW stated that Primary Care Providers (PCPs) would write scripts to change or renew orders but would not write scripts to discontinue the old orders. The surveyor then inquired if nursing staff signed duplicate orders as administered, and the DOW stated that "they shouldn't". The DOW stated that only one order should be documented as administered. At 1:56 p.m., the surveyor informed the Executive Director (ED), the DOW and the Senior Director of Wellness and Infection Control that all residents at the facility were in imminent danger due to the pharmacy entering duplicate orders for several residents, and duplicate orders being documented as administered. The surveyor also reviewed the facility's policy and procedure titled, "Provision of Pharmaceutical Services," which documented, "Policy" "[The facility] shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and federal laws and regulations ... Procedure ...5. The Registered Nurse shall assume all responsibilities for supervising personnel administering medication."	A 963		

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 01/22/2025

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 963	Continued From page 25 In addition, the surveyor reviewed the undated facility's policy and procedure titled, "Limits to Delegation of Medication Administration," which indicated, "Policy the RN is responsible for the administration of medications..." Lastly, the surveyor reviewed the undated facility's policy and procedure titled, "Medication Administration Errors," which indicated, "... 12. All LPN/CMA staff shall clarify administration questions with the RN...." This deficient practice was identified as an imminent danger, and a removal plan was requested. The facility submitted a removal plan on 11/22/24 that was unacceptable. The surveyor requested that the facility make corrections to the removal plan. On 11/25/24, the facility submitted an acceptable removal plan, which indicated that the facility would review all resident orders to ensure all duplicate orders were discontinued. The removal plan also indicated that pharmacy would add an administration note to medications with identical orders that were to be administered in conjunction with each other to avoid the appearance of a duplicate order (Example: NJ Exec Order 26.4b1 [redacted]). In addition, the removal plan indicated that staff would be educated and in-serviced. Lastly, the removal plan indicated that all resident orders would be reviewed and audited for duplication by the registered nurse monthly for six months. On 1/22/25, the surveyor conducted a re-visit survey at the facility. The surveyor reviewed documented evidence of staff education and in-service. However, the surveyor reviewed all	A 963		

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 01/22/2025

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 963	Continued From page 26 resident MARs and observed duplicate orders for six residents. The surveyor also observed that six residents had identical orders without administration notes from pharmacy. Lastly, the surveyor observed that facility staff did not document duplicate orders as administered. Refer to tag: 8:36-11.2 A-0925	A 963		

NEW STANDARD
Senior Living

POC January
06.03.25

TagA355: **A310 - 8:36-3.4(a)(l} Administration**

(a) **The administrator or designee shall be responsible for, but not limited to, the following:**

1. **Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights.**

Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the Executive Director (ED) failed to ensure the implementation and enforcement of six medication policies and procedures for 4 of 5 residents.

1. The DOW provided initial in-service training to nurses and CMAs on November 20, 2024. Nurses and CMAs were re-educated on May 22, 2025 regarding medication administration protocols, documentation procedures, and identification of duplicate orders. On November 20, 2024, NJ Exec Order 26.4b1 medication orders for residents #1, #2, #4, and #5 were reviewed and audited by the Director of Wellness (DOW) to ensure site-specific instructions were included. Orders requiring clarification were sent to the prescriber, with corrections made on the Medication Administration Record (MAR) upon receiving clarification. Following a change in management and leadership on May 1, 2025, a comprehensive review of all resident orders was conducted. By May 29, 2025, the DOW and/or designee re-reviewed and audited all resident topical, optic, otic, and nasal orders to check for duplication. Completion date May 29, 2025
2. All residents have the potential to be affected by this deficient practice.
3. The Executive Director reviewed Medication Policy and Procedures on November 20, 2024. The Executive Director (ED) communicated updated expectations regarding duplicate orders to the pharmacy on November 20, 2024 . Beginning March 25, 2025, collaborative meetings with facility staff were held to prevent order duplication. (these are not meetings with the pharmacy. These are weekly meetings with the DOW and/or designee and nursing staff. Regional Director of Clinical Operations reviewed May 29, 2025, and Assistant Director of Nursing (ADON) hasn't been holding these despite the directive to do this 2 weeks ago.) June 3, 2025, The ADON was reeducated on holding collaborative meetings and has not missed any meetings since. The Executive Director and DOW and/or designee is now responsible for notifying the pharmacy of any duplicate orders to ensure appropriate discontinuation.
With the introduction of new leadership, on May 20, 2025, revised medication administration policies were implemented and reviewed by ED. Starting May 20, 2025, the Regional Director of Clinical Operations re-educated all medication-passing staff on updated procedures,

including order verification and reconciliation of duplicate orders. This re-education process was completed by May 30, 2025. In addition, a full review of all resident MARs was initiated on May 14, 2025, and completion May 29, 2025.

4. Beginning June 2, 2025, the DOW or designee will generate a daily duplicate order report for two weeks. If no issues are identified, reporting will shift to a weekly schedule until two consecutive weeks pass without incident. Additionally, on May 14, 2025, the facility began exploring contracts with a new pharmacy. Policies and procedures related to order duplication will be reviewed monthly during Quality Assurance (QA) meetings, with the first completion date set for June 30, 2025, and ongoing review thereafter as needed.

NJ Exec Order 26

accepted 7/9/25

A925 - 8:36-11.2 Pharmaceutical Services

The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations.

Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that pharmaceutical services were provided to residents in accordance with the prescriber's orders and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations, when the facility's pharmacy entered resident orders unsafely and inaccurately for 4 of 5 residents reviewed.

1. On November 20, 2024, the Director of Wellness (DOW) reviewed and audited NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 medication orders for residents #1, #2, #4, and #5 to ensure appropriate site-specific instructions were included. Orders requiring clarification were sent to the prescriber, and updates were made to the Medication Administration Record (MAR) upon receiving clarification on November 23, 2024. Following a change in leadership on May 1, 2025, the Regional Clinical Director of Operations initiated a comprehensive audit of all resident MARs against prescriber orders beginning May 14, 2025. This included re-verification that no duplicate orders remained for residents #1, #2, #4, and #5. The audit of all residents' records was completed by May 29, 2025.
2. All residents have the potential to be affected by this deficient practice.
3. On November 20, 2024, the DOW and/or designee provided in-service training to nurses and Certified Medication Aides (CMAs) regarding proper order documentation and the identification of duplicate orders. On May 14, 2025, a full MAR audit began and concluded on May 29, 2025, confirming no duplicate orders remained for any residents. Nurses and CMAs were re-educated on May 20, 2025, and May 22, 2025 on the procedure for contacting the pharmacy and documenting actions when duplicate orders appear on the MAR. Completion date May 29, 2029 and on going.
4. Beginning May 14, 2025, the DOW and/or designee will review and confirm all new medication

orders on a monthly basis, continuing as needed. Starting June 2, 2025, weekly reviews of order confirmations will be conducted for four weeks, followed by monthly reviews for three months. By ED and DOW and or designee. Further monitoring will continue as needed. Completion date June 30, 2025 and will be on going.

accepted 7/9/25 [NJ Exec Order 26.4b1]

A 937 - 8:36-11.S(a) Pharmaceutical Services

The administration of medications is within the scope of practice and remains the responsibility of the registered professional nurse.

Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the Registered Nurse (RN) failed to ensure the appropriate supervision of medication administration tasks delegated to Licensed Practical Nurses (LPNs) and Certified Medication Aides (CMAs), when a CMA administered an incomplete medication order and 14 nursing staff documented the administration of duplicate medication orders.

1. On November 20, 2024, the Director of Wellness (DOW) conducted an in-service training for nurses and Certified Medication Aides (CMAs) on proper medication administration and documentation. That same day, the DOW reviewed and audited [NJ Exec Order 26.4b1] medication orders for residents #1, #2, #4, and #5 to ensure appropriate site-specific instructions were included. Orders requiring clarification were sent to the prescriber, and once clarification was received, corrections were made to the Medication Administration Record (MAR) on November 23, 2024.
   Following a change in leadership on May 1, 2025, the DOW's designee began a full audit of all resident MARs against prescriber orders on May 14, 2025. This included confirming the absence of duplicate orders for residents #1, #2, #4, and #5. The review of all resident records was completed by May 29, 2025.
2. All residents have the potential to be affected by this deficient practice.
3. The DOW provided initial in-service training to nurses and CMAs on November 20, 2024. Staff were re-educated on May 22, 2025 regarding medication administration protocols, documentation procedures, and identification of duplicate orders. Beginning in June 2025, the DOW or designee will randomly select nurses and CMAs for competency evaluations to ensure continued compliance. The previous DOW is no longer employed at the community; in their absence, the regional nurse is providing oversight. The Executive Director (ED) or designee remains responsible for ensuring appropriate training and education for the registered nurse.
4. Starting June 2, 2025, the DOW or designee will generate a daily report to identify duplicate medication orders for two weeks. If no further issues are identified, reporting will shift to a weekly basis until two consecutive weeks show no discrepancies. On May 14, 2025, the community also began exploring partnerships with alternative pharmacy providers. Medication policies and pharmacy-related duplication issues will be reviewed monthly during Quality Assurance (QA) meetings, with the first completion deadline set [NJ Exec Order 26]

accepted 7/9/25

NEW STANDARD
Senior Living

for June 30, 2025, and ongoing reviews thereafter as needed.

A 963 8:36-11.S(f) Pharmaceutical Services

(f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders.

Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure medication was accurately administered and documented in accordance with prescriber's orders and facility medication policies for unsampled residents and 3 of 5 residents reviewed for medication administration

1. On November 20, 2024, the Director of Wellness (DOW) conducted an in-service training for nurses and Certified Medication Aides (CMAs) on proper medication administration and documentation. That same day, the DOW reviewed and audited NJ Exec Order 26.4b1 medication orders for residents #1, #2, #4, and #5 to ensure appropriate site-specific instructions were included. Orders requiring clarification were sent to the prescriber, and once clarification was received, corrections were made to the Medication Administration Record (MAR) on November 23, 2024.
   Following a change in leadership on May 1, 2025, the Clinical Director of Clinical Operations began a full audit of all resident MARs against prescriber orders on May 14, 2025. This included confirming the absence of duplicate orders for residents #1, #2, #4, and #5. The review of all resident records was completed by May 29, 2025.
2. All residents have the potential to be affected by this deficient practice.
3. The DOW provided initial in-service training to nurses and CMAs on November 20, 2024. Staff were re-educated on May 20 &22, 2025 regarding medication administration protocols, documentation procedures, and identification of duplicate orders. Beginning in June 2025, the DOW or designee will randomly select nurses and CMAs for competency evaluations to ensure continued compliance. The previous DOW is no longer employed at the community; in their absence, the regional nurse is providing oversight. The Executive Director (ED) or designee remains responsible for ensuring appropriate training and education for the registered nurse. Completions date May 22, 2025 and on going.
4. Starting June 2, 2025, the DOW or designee will generate a daily report to identify duplicate medication orders for two weeks. If no further issues are identified, reporting will shift to a weekly basis until two consecutive weeks show no discrepancies. On May 14, 2025, the community also began exploring partnerships with alternative pharmacy providers. Medication policies and pharmacy-related duplication issues will be reviewed monthly during Quality Assurance (QA) meetings, with the first completion deadline set for June 30, 2025, and ongoing reviews thereafter as needed.

NJ Exec Order 26.4b1

Executed 7/9/25

NJ Exec Order 26.4b1

Executive Director

NEW STANDARD
Senior Living

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
06A003 Y1	A. Building B. Wing Y2	7/9/2025 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 A0310	Correction	ID Prefix A0925	Correction	ID Prefix A0937	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-11.2	Completed	Reg. # 8:36-11.5(a)	Completed
LSC	07/09/2025	LSC	07/09/2025	LSC	07/09/2025
ID Prefix A0963	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-11.5(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/09/2025	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	
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	
1/22/2025	☐ 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	7/9/2025 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 A0310	Correction	ID Prefix A0925	Correction	ID Prefix A0937	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-11.2	Completed	Reg. # 8:36-11.5(a)	Completed
LSC	07/09/2025	LSC	07/09/2025	LSC	07/09/2025
ID Prefix A0963	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-11.5(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/09/2025	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	
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	
1/22/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO