STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millville Center	54 Sharp Street Millville, NJ 08332

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on interviews, record reviews, and facility policy review, the facility failed to thoroughly investigate an allegation of staff to resident abuse and take action to prevent further potential abuse for 1 of 10 residents (Resident [R] #3) R#3 reviewed for abuse. R2 alleged that a Certified Nurse Aide (CNA) abused R3. The facility failed to follow its abuse and neglect policy titled OPS300 Abuse Prohibition, conduct a thorough investigation of the incident, and failed to remove the CNA assigned to R3 on the shift identified in the allegation. On 03/04/26, an Immediate Jeopardy (IJ) was identified at S483.12(c)2 and 483.12(c)3 related to the facility's failure to ensure a thorough investigation was completed after an allegation of staff to resident abuse was made on 02/10/26 and to prevent further potential abuse. On 03/04/26 at 8:20 PM, the Director of Nursing was notified of the IJ, which also constituted Substandard Quality of Care (SQC). The facility provided an acceptable Plan of Removal on 03/05/26 at 4:40 PM, which included staff training and suspension of staff. The IJ ran from 2/10/26 until 3/5/26 at 6:43 PM when the facility implemented an acceptable plan of correction.Findings include:Review of R2's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 01/15/26 and located in the electronic medical record (EMR) under the MDS tab, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderate cognitive impairment.Review of R3's quarterly MDS with an ARD of 03/02/26 and located in the EMR under the MDS tab, revealed R3 was unable to complete the BIMS due to the inability to speak or be understood.Review of the facility's LTC (Long Term Care) Reportable Event Survey, dated 02/10/26, revealed R2 reported that on Saturday (02/07/26), a CNA hit their roommate, R3, and pulled R3's hair. R2 stated the CNA cared for R3 but not for R2. At that time, R2 did not know the identification of CNA1.Review of the facility's Summary and Conclusion, dated 02/16/26, revealed R2 reported to the Social Worker (SW) that R2 observed R3's CNA, CNA1, the previous Saturday, or (02/07/26), punch R3 and pull their hair. R2 described the perpetrator as Caucasian, heavy, with brown hair and arm tattoos. R2 was shown headshot photos of three CNA staff (CNA1, CNA2, and CNA3) and denied that the staff involved was the person in the photos. R2 later complained that the faces were too small to correctly identify the perpetrator.Further review revealed there was no documentation of staff or thorough resident interviews. There was no documented evidence that CNA1, who was assigned to R3 and fit the description, was suspended during the investigation.During an interview on 03/04/26 at 4:22 PM, CNA1 (a Caucasian female, heavyset, with brown hair and tattoos on her arms, who fit the description) revealed that she was assigned to R3 on Saturday, 02/07/26. CNA1 stated she was completely unaware that R2 had made an allegation of abuse, and this was the first time she had been told about the abuse. CNA1 stated she was not interviewed by staff regarding an allegation and had never been suspended or removed from a shift pending the outcome of an investigation. She stated she was working on the 3-11 PM shift that day. CNA1 denied ever hitting either R2 or R3.During an interview on 03/04/26 at 5:10 PM, the SW stated R2 called the SW over during lunch in the dining room and told her there was a CNA abusing R3, who was R2's roommate at the time. The SW stated that R2 stated the CNA1 had punched R3 in the face, pulled R3's hair, and pushed them. R2 was unable to identify the CNA by name but said it was a white female who was heavy set with brown hair. The SW stated she informed the Director of Nursing (DON). The DON (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	brought the SW and R2 into her office along with the Assistant Director of Nursing (ADON). The DON showed R2 pictures of staff, but the SW was unsure of whose pictures were shown because she could not see what was shown to R2. The SW stated R2 said no to all the photos, and she took R2 back to the unit and asked the resident if they saw the CNA in the surrounding area. R2 said no, they did not see the CNA, but the SW was unsure which staff were in the area. None of the CNAs present that day were interviewed. The SW stated she was unsure if any staff had been interviewed and did not interview any other residents. The SW further stated she assumed the DON would interview other staff.During an interview on 03/04/26 at 5:27 PM, the DON stated she was unsure who the facility's abuse coordinator was. The DON stated she was made aware of the allegation by the SW. The DON stated the SW, along with R2, came to her office, and R2 showed photos of all the staff that fit the description (CNA1, CNA2, and CNA3). The DON stated R2 could not distinguish the actual perpetrator from the photos. The DON stated she did not interview any CNA staff or other staff, as R2 could not identify the alleged perpetrator from the three photos shown. The DON stated that she ruled out all other staff based on the description. The DON shared the photos of CNA1, CNA2, and CNA3 that were shown to R2 with the surveyor. The photos were small, nail sized photos of only their faces and could only be slightly enlarged. The DON stated that no staff were suspended because R2 could not identify the perpetrator from the photos.On 03/04/26 during the 3-11 shift, CNA1 was observed providing care to residents.During an interview on 03/05/26 at 10:27 AM, R2 stated they saw the CNA, who was referred to as the fat one, pull R3's hair and hit them. R2 explained that it was a CNA they had seen before and since the incident, but they didn't know the CNA's name. R2 described the CNA as an obese, white female with brown hair and tattoos on her arms. R2 stated they told the SW what they saw and were shown some photos, but they could not recognize any of the faces in the photos.During an interview on 03/05/26 at 2:46 PM, CNA4 stated she worked the shift on 02/07/26 when the alleged incident occurred and was not interviewed by any staff. CNA4 stated she was unaware of any concerns that occurred during that shift. CNA4 stated that the given description matched the description of CNA1, and she did not know of anyone else who would fit that description.During an interview on 03/05/26 at 4:11 PM, CNA5 stated that on 02/07/26, she switched one of her assigned residents with CNA1 for R3. CNA5 stated they had done this several times in the past. CNA5 stated she was not interviewed about anything related to that shift or an allegation of abuse. CNA5 stated CNA1 was the only person who fit the description given by R2.Review of the facility policy titled, OPS300 Abuse Prohibition, updated 11/14/25, revealed, . physical abuse includes hitting, slapping, pinching, kicking . anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately regardless of the shift . The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation . immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will . initiate an investigation within 24 hours of abuse and . the investigation will be thoroughly documented within the Risk Management Portal. Ensure the documentation of interviews witnessed is included . NJAC 8:39-4.1(5) NJAC 8:39-13.4(c)(1)(i-iv).

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record review, and interviews, the facility failed to ensure 1 of 3 residents (Resident [R] 1) reviewed for food allergies was not served foods to which the resident was allergic. R1 was noted to have food allergies to ketchup, vinegar, and mayonnaise. R1 was served two meals containing allergens. Serving residents foods to which they are allergic has the potential to lead to serious harm, injury, or death.The failure to follow its policy titled Allergies to ensure R1 was not served a food to which the resident was allergic placed this resident and all residents with food allergies at risk of serious harm, injury, or death. Immediate Jeopardy was identified on 03/03/26 at 12:20 PM when R1 was served mayonnaise and offered ketchup at the lunch meal. The Administrator was notified of the Immediate Jeopardy on 03/03/26 at 5:50 PM. The facility provided an acceptable removal plan on 03/04/26 at 5:33 PM.The removal plan included an audit of all resident diet orders and staff education on checking meal tickets and on not providing food items to residents to which they are allergic. The survey team validated implementation of the facility's IJ Removal Plan, and the IJ was lifted on 03/04/26 at 5:33 PM. Findings include:Review of R1's Census tab of the electronic medical record (EMR) revealed R1 was admitted to the facility with diagnoses included in the Diagnoses tab of bipolar disorder, gastroesophageal reflux, and anxiety.Review of the R1's Allergy tab in the EMR revealed they were allergic to dill, dill oil, mushrooms, ketchup, lactose, radishes, acetic acid (vinegar), and mayonnaise.Review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/25 and located in the MDS tab of the EMR, revealed R1's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating R1 was cognitively intact.Review of R1's Care Plan, dated 12/18/25, revealed a focus problem of allergies to acetic acid (vinegar), dill, mushroom, ketchup, lactose, mayonnaise, and radishes. The goal was for the resident to have no allergic reaction over the next 90 days.Review of R1's Orders tab of the EMR revealed that allergies were listed as acetic acid, dill, mushroom, ketchup, lactose, and radishes.Review of the Diet Type report provided by the facility revealed that R1 was listed as having allergies to acetic acid, dill, dill oil, ketchup, mayonnaise, mushrooms, and radishes. Review of R1's tray card, provided by the facility, listed the same allergies.During an interview on 03/03/26 at 11:30 AM, R1 confirmed the food allergies, specifically to mayonnaise. R1 states they had talked with the Dietary Manager (DM) multiple times and continued to be served foods containing allergens. R1 stated that their mouth and tongue would swell when they consumed the allergens.During an observation of the noon meal service in the dining room on 03/03/26 at 12:20 PM, R1 was served the alternate menu items of a cheeseburger and potatoes. On the meal tray was a sealed packet of mayonnaise. Certified Nursing Assistant (CNA) 1 offered R1 ketchup, and the resident refused.During an interview on 03/03/26 at 12:15 PM, CNA1 confirmed she served R1's tray, confirmed she asked the resident if they wanted ketchup, and confirmed a mayonnaise packet was served with R1's meal. CNA 1 attempted to locate the tray card for R1 but was unable to do so.During an interview on 03/03/26 at 12:25 PM, the Dietary Manager (DM) stated she visited with R1 at least twice a week and was unaware that R1 had been served mayonnaise with her meal. The DM confirmed that R1 was allergic to ketchup and mayonnaise, and that the mayonnaise should not have been on the plate, and that CNA1 should not have offered the resident ketchup.During an interview on 03/03/26 at 2:30 PM, the Administrator confirmed the allergies listed on R1's EMR and confirmed that food allergies were listed on the diet ticket taken from physician orders, which the kitchen used to prepare resident meal trays. The Administrator confirmed R1's food allergies were noted on their tray slip, which dietary staff failed to utilize to ensure the resident did not receive and ingest food to which they were allergic.During an observation and interview in the dining room on 03/03/26 at 5:20 PM, R1 was served the evening meal prepared by the facility. R1 was served a cheeseburger, creamy coleslaw, cubed potatoes, and cookies. The coleslaw was not served in its own container and came into contact with the other foods on the (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	plate.A review of the facility-made creamy coleslaw recipe provided by the facility revealed that mayonnaise and vinegar were used as ingredients. During an interview on 03/04/26 at 10:30 AM, the Registered Dietitian (RD) stated that allergies were in Meal Tracker and food items with the allergens did not appear on the resident's tray slip. The RD confirmed R1 received mayonnaise and creamy cole slaw on her tray last evening and that it was an error for R1 to receive those items.Review of the facility policy titled Allergies dated 03/03/26 directs staff some residents have allergies that can cause the residents to have an adverse reaction to said allergies. It is vital to the residents' safety that all meal tickets are checked for allergies by the dining department as well as the nursing department to ensure resident safety.NJAC 8:39-17.4(a)(1)(e)