STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. COMPLAINT # NJ 2704937 Based on observation, interview, and review of pertinent documents, the facility failed to ensure that the method for filing a grievance was consistent with the facility's practice and policy. This deficient practice was identified for one 1 of four 1 residents (Resident #27) reviewed for grievances and was evidenced by the following: Refer to 684E and 676EOn 1/6/26 at 10:13 AM, two (2) surveyors interviewed Resident #27 regarding the care that they received. Resident #27 stated their name and was aware that they resided in a long-term care facility. Resident #27 also stated that they had anticipated a medical appointment related to follow-up brain surgery that was scheduled on 12/29/25, and Resident #27 shared that they were eager to see their physician because of the persistent deep pain they felt in their head. Resident #27 added that nobody from the facility came to get them dressed and ready for their appointment on the morning of 12/29/25. Resident #27 confirmed that they did not refuse the appointment. The resident stated that they felt dizzy, had cramping pain and a headache, and then the resident used their finger to indicate the pain went from the back base of their neck, radiated to the back of their head and then removed their head scarf to show the pain radiated from their right hemi craniotomy (an area where part of the skull was removed to create space for a swollen brain). On 1/6/26 at 10:35 AM, during an interview with the surveyor, the Social Services Director (SSD) stated she was the grievance officer and tracked the grievances referred to her by the residents and staff. At that time the SSD provided the grievance log for October 2025, November 2025 and December 2025. Further review of the Grievance Log (GL) and Grievance Report (GR) revealed there were no grievances logged and a grievance report was not initiated for Resident #27. On 1/6/26 at 11:01 AM, during an interview with the surveyor, the Licensed Practical Nurse/Charge Nurse (LPN/CN) stated the unit clerk (UC) handled the scheduling and was not at work that day. The LPN/CN stated she also scheduled appointments for the residents and was written on the white board and progress notes. According to the LPN/CN the December 2025 scheduled appointments were not kept on record. The LPN/CN stated that any appointments missed for any reason such as transportation, refusals or family member cancellation would be documented in the resident's progress notes. On 1/6/26 at 11:21 AM, the surveyor reviewed the medical record for Resident #27 which revealed the following: According to the resident's admission Record (AR; or face sheet; admission summary) reflected the resident was admitted to the facility with diagnoses that included but not limited to; hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect arms, legs and facial muscles) following cerebral infarction (stroke due to disrupted blood flow to the brain) affecting left non-dominant side and epilepsy. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/11/25 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated the resident had a severely impaired cognition. Section E -Behavior reflected the Resident #27 did not exhibit behaviors such as rejection of care. Section GG (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Functional Abilities reflected Resident #27 was dependent (helper does all the effort) for upper and lower body dressing. On 1/6/26 at 1:42 PM, during an interview with the surveyor, the Certified Nurse Aide (CNA) stated she would learn from the Charge Nurse, or the Assistant Director of Nursing (ADON), or the Director of Nursing (DON) when a resident had an appointment so that she could get the resident ready for an appointment. The CNA stated she recalled Resident #27 had a missed an appointment last week and stated that she was not informed by anyone to get the resident ready for that appointment. The CNA also stated she did not recall the resident's name on the appointment list which was written on the white board. The CNA stated that the Resident Representative (RR) came into the facility visibly upset about the appointment that was missed and that the ADON and the DON had both been aware. On 1/6/26 at 1:50 PM, during an interview with the surveyor, the ADON stated she recalled Resident #27 missed their appointment last week, was in the hallway with the DON passing trays when the RR arrived visibly upset and was yelling in the hallway. The ADON recalled the resident refused to go to the appointment and confirmed she did not speak with the resident, or their family regarding the incident. At that time the ADON stated I don't think a grievance was made. On 1/6/26 at 1:56 PM, the surveyor and the ADON reviewed the progress notes (PN) for Resident #27 together. The ADON acknowledged and confirmed that the PN did not reflect that the resident refused to go to their appointment, a follow-up appointment was also not made, and that the physician was not made aware that Resident #27 had missed their appointment. On 1/6/26 at 2:01 PM, the DON confirmed that she was not made aware that the resident had an appointment on 12/29/25, and only learned of the missed appointment when the RR arrived. The DON stated the RR made her aware of the missed appointment and they were very angry. The DON informed the RR that she would investigate the matter and stated she did not start a grievance, but started an investigation. At that time, the DON stated a grievance was important to ensure issues were resolved, tracked, trended and brought back for discussion during the Quality Assurance and Performance Improvement (QAPI) meetings. A review of the investigation file provided by the DON contained one signed witness statement from the Licensed Practical Nurse (LPN) assigned to Resident #27 on 12/29/25. The statement documented that Resident #27 refused to go to their appointment after transport arrived and the facility staff cleaned the resident. The LPN also documented that she had encouraged the resident to go. There was no witness statements from the CNA who cared for the resident on 12/29/25, from the resident, or from the RR who staff, including the DON confirmed verbalized their concerns. A review of the provided trip order #[redacted] reflected the pick-up was for Resident #27 was on 12/29/25 at 8:55 AM and was then cancelled by the same LPN who documented the single signed statement. The reason for cancelling the transportation was documented as due to appointment cancelled. On 1/9/26 at 12:02 PM, the surveyor discussed the concern regarding the missed appointment voiced by the resident, and the RR, with the survey team present, the Licensed Nursing Home Administrator and the DON. The facility was unable to provide a resolution for Resident #27 and there was no grievance initiated. A review of the provided facility policy titled; Grievance/ Complaints, Filing included that residents and their representative have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated. The administrator and staff would make prompt efforts to resolve grievances.The resident or person filing the grievance and/or complaint and/or complain on behalf of the resident will be informed verbally and in writing of the findings of the investigation and the actions that will be taken to correct any identified problems. No further information was provided. NJAC 8:39-4.1(a)(35);13.2(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** COMPLAINT #2704937 Based on observation, interview, and record review, it was determined that the facility failed to provide a communication device for a resident identified as having language barrier. This deficient practice was identified for one (1) of one (1) resident (Resident #27) reviewed for language and communication deficits and was evidenced by the following: Refer to 684EA review of the Complaint #2704937 reflected an alleged event date on 12/29/25 at 8:15 AM showed the family representative arrived at the hospital on that day at 8:00 AM that day, to meet the resident and was told that the facility cancelled the appointment. The family representative then arrived at the facility at 8:15 AM and spoke with Resident # 27 who spoke minimal English. On 1/5/26 at 10:44 AM, the Certified Nursing Assistant (CNA #1) assigned to the resident that day entered Resident #27's room with the surveyor. At that time, the CNA #1 could not locate a communication device and confirmed that a communication board was no communication board inside the resident's room. The surveyor reviewed the medical record for Resident #27. According to the resident's admission Record (AR; or face sheet; admission summary) reflected the resident was admitted to the facility with diagnoses that included but not limited to; hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect arms, legs and facial muscles) following cerebral infarction (stroke due to disrupted blood flow to the brain) affecting left non-dominant side and epilepsy. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/11/25 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated the resident had a severely impaired cognition. Section A1100. Language reflected Resident #27's preferred language was [dialect redacted] and needed an interpreter. A review of the individualized comprehensive care plan included a focus on communication that was initiated/revised on 8/22/25. The interventions were dated/ revised on 8/22/25, included that there were staff that spoke the same dialect and were able to translate. The family of Resident #27 was also available via phone to translate, and the resident had a communication board in their room. On 1/6/26 at 1:42 PM, during an interview with the surveyor, CNA #2 stated that the family arrived on 12/29/25 to go with the resident in the transport to help with translation, the resident doesn't speak English, you know. On 1/6/26 at 2:45 PM, during an interview with the surveyor, the Medical Doctor/ Director (MD) stated he could not speak the same language as Resident #27 and communicated with the resident by speaking slowly and by looking at the resident. The MD confirmed that he did not use a translation device or service, nor did the facility provide those services. On 1/7/26 at 11:03 AM, during an interview with the surveyor, the Licensed Practical Nurse/ Charge Nurse (LPN/CN) stated that they did not have a translation or ancillary communication device in the facility. On 1/7/26 at 11:07 AM, in the presence of the DON and the surveyor, the LPN/CN provided binders to the surveyor that had words with corresponding images. The LPN/CN informed the surveyor that she found the binders for translation was found underneath the bedside table. At that time, the surveyor discussed the concern with the communication device that the staff was not aware of and could not be located prior to surveyor inquiry. On 1/9/26 at 12:02 PM, during a meeting with the survey team the Licensed Nursing [NAME] Administrator and the Director of Nursing, the surveyor discussed the concern with the communication device that the staff was not aware of. A review of the provided facility policy titled; Translation Services dated/revised on 1/2020 included that the facility maintained a contracted relationship with a translation service for language and sign language. Family members and friends shall not be relied upon to provide interpretation services fir the resident unless explicitly requested by the resident. Family and friends used to interpret must have (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a written consent for disclosure of protected health information. No further information was provided. NJAC 8:39-27.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Complaint # NJ 2704937Based on observation, interviews, and record review, it was determined that the facility failed to ensure that a system was developed and implemented that enabled residents to attend outside physician appointments in accordance with resident needs, goals for care, and professional stands of practice. This deficient practice was identified for one (1) of one (1) resident (Resident# 27) reviewed for Activities of Daily Living (ADL) and was evidenced by the following: On 1/5/26 at 10:51 AM, Resident #27 was observed asleep in the activities room and appeared well dressed and groomed. The surveyor reviewed the medical record for Resident #27. According to the resident's admission Record (AR; or face sheet; admission summary) reflected the resident was admitted to the facility with diagnoses that included but not limited to; hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect arms, legs and facial muscles) following cerebral infarction (stroke due to disrupted blood flow to the brain) affecting left non-dominant side and epilepsy. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/11/25 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated the resident had a severely impaired cognition. Section A1100. Language reflected Resident #27's preferred language was [dialect redacted] and needed an interpreter. Further review of the MDS under, Section E -Behavior reflected the Resident #27 did not exhibit behaviors such as rejection of care. Section GG Functional Abilities reflected Resident #27 was dependent (helper does all the effort) for upper and lower body dressing. A review of the physician's progress notes (PN) revealed two entries made by the provider in the resident's electronic medical record (eMR) which were on 9/8/24 and 11/25/24 and reflected the following:The Physician PN dated 9/24/24 was the comprehensive overview of Resident #27's heath status and indicated the resident underwent a right hemi craniotomy (temporarily removing part of the skull to create space for a swollen brain) after a stroke that caused swelling in one side of the brain.The Physician PN dated 11/25/24, included that the resident had left sided weakness and to follow-up with Neurology.No Physician PN were found for 2025 and 2026.On 1/6/26 at 10:13 AM, during an interview with two (2) surveyors, Resident #27 stated their name and was aware that they resided in a long-term care facility. Resident #27 also stated that they had anticipated their appointment the night before 12/29/25 and was eager to see their physician because of the persistent deep pain they felt in their head. Resident #27 added that nobody came to get them dressed and ready for their appointment on the morning of 12/29/25 and did not refuse the appointment. The resident stated that they felt dizzy, had cramping pain and headache, the resident used their finger to indicate the pain was from the back base of their neck, radiated to the back of their head and removed their head scarf to show the pain radiated from their right hemi craniotomy (temporarily removing part of the skull to create space for a swollen brain).On 1/6/26 at 2:45 PM, during a meeting with three surveyors, the Medical Director (MD) stated that he had his own eMR where he documented the resident's PN and transferred into the facility's eMR. The MD also stated that his office copied then pasted the information into the facility's eMR and that there must have been something that went wrong that occurred with transcribing the 2025 PNs. The MD stated he would look into the matter. At that time, the physician could not recall if he was informed by the facility of the missed appointment on 12/29/25. The MD also stated that the resident's headache could be related to the hemi craniotomy and could be related to the reason why he referred the resident to the Neurologist. The MD stated he would upload and forward the information to the surveyor. A review of the provided Physician PN that was uploaded into the facility's eMR reflected the following: On 4/15/25 at 3:39 PM, (late entry) the Physician PN included the resident had left sided weakness, recommended (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	continuation of fall safety precautions, experienced headache, received Fioricet as needed (headache pain reliever) and recommended a follow-up with Neurosurgery/Neurology; On 8/12/25 at 3:25 PM, (late entry) the Physician PN included the resident had left sided weakness, recommended continuation of fall safety precautions, experienced headache, received Fioricet as needed (headache pain reliever) and recommended a follow-up with Neurosurgery/Neurology; On 1/6/25 at 4:01PM, (late entry) the Physician PN included that the resident was seen as a follow-up of the missed appointment [after surveyor inquiry]. Resident #27 complained of dizziness and the physician recommended a follow-up with Neurology. On 1/7/26 at 11:07 AM, during a meeting with the Director of Nursing (DON), the surveyor inquired if the DON was aware that there were no Physician PN on record prior to surveyor inquiry and discussed the concern that ancillary health care staff were not able to view the physician notes.On 1/7/26 at 2:07 PM, a follow up interview was held at the DON in which she confirmed that Resident #27 did not refuse to the physician appointment on 12/29/25.On 1/6/26 at 10:27 AM, during an interview with the surveyor, the Assistant Director of Nursing stated that appointments were scheduled and then documented in the resident's progress note.On 1/6/26 at 11:01 AM, during an interview with the surveyor, the Licensed Practical Nurse/Charge Nurse (LPN/CN) stated the unit clerk (UC) handled the scheduling and was not at work that day. The LPN/CN stated she also scheduled appointments for the residents and then it was written on the white bulletin board and in progress notes. According to the LPN/CN the December 2025 scheduled appointments were not kept for the record and had no additional information to provide. The LPN/CN stated that any appointments missed for any reason such as transportation, refusals or family member cancellation would be documented under the resident's progress notes. On 1/6/26 at 1:42 PM, during an interview with the surveyor, the Certified Nursing Assistant (CNA) stated she learned from the Charge Nurse, or the Assistant Director of Nursing (ADON), or the Director of Nursing (DON) when a resident had an appointment so that she could get the resident ready for an appointment. The CNA recalled Resident #27 had missed an appointment last week and stated that she was not informed by anybody to get the resident ready for that appointment. The CNA also did not recall the resident's name being listed on the appointment/white board. On 1/6/26 at 1:56 PM, the surveyor and the ADON reviewed the Resident #27's PN together. At that time, the ADON confirmed that there were no documented notes made by facility staff that the resident refused to attend their appointment. The ADON also confirmed that the PN did not reflect the physician was made aware of the missed appointment, a rescheduled follow-up appointment with the Neurologist was not found prior to surveyor inquiry. On 1/9/26 at 12:02 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA), and the DON, the surveyor discussed the concern regarding with Resident #27 who had communication deficits, was dependent on staff for upper and lower body dressing, was not assisted, and prepared by staff to attend their Neurosurgeon/Neurologist appointment that was recommended by the Medical Director since November 2024. Additionally, the surveyor discussed the concern that the facility failed to reschedule the appointment prior to surveyor inquiry and failed to inform the physician that the appointment he recommended was missed. A review of the facility provided policy titled; Charting and Documentation included the following information to be documented in the resident medical record: objective observation, treatment and services performed, events, incidents or accidents involving the resident.whether the resident refused the procedure/treatment, notification of family, physician, or other staff.The facility was unable to provide any policy regarding scheduling of resident appointments.NJAC 8:39-11.2(b); 27.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2704937; 414412 Based on observation, interview, and record review, it was determined that the facility failed to ensure a) adequate supervision was provided to a cognitively impaired resident (Resident #7) identified as being at high risk for falls, impulsive, and required supervision. Resident #7 sustained 13 falls including three falls with injury that required transfer to the emergency room on 8/10/25, for a contusion and laceration to the left supraorbital and frontal scalp; on 10/28/25, for a large intramuscular hematoma to the right thigh, and on 11/14/25, for a closed head injury and laceration to the forehead which required sutures; b) ensure each fall was thoroughly investigated to prevent additional falls; and c.) consistently initiate and implement new fall prevention interventions in response to falls to prevent further falls. This deficient practice identified for 3 of 3 residents reviewed for falls (Resident #7, #27, and #70) and was evidenced by the following: A review of the facility's policy titled Managing Falls and Fall Risk, dated/revised 3/2018, included the staff would identify interventions related to the resident's specific risks and causes to prevent the resident from falling and minimize complications from falling.Under Resident-Centered Approaches to Managing Falls and Fall Risk included; that the staff with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls.the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather many at once). When a fall reoccurred despite initial interventions, the staff would implement additional or different interventions or indicate why the current approach remained relevant. If underlying causes could not be readily identified or corrected, staff would try various interventions, based on assessment of the nature or category of falling, until reduced or stopped, or until the reason for the continuation was identified as unavoidable. Under Monitoring of Subsequent Falls and Fall Risk included that the staff would monitor and document each resident's fall response to interventions intended to reduce falling or the risks of falling. For continued falls the staff would re-evaluate the situation and the appropriateness to continue or change current interventions and the attending physician would help the staff reconsider possible causes that may not have been identified. A review of the facility's Falls- Clinical Protocol Policy, revised September 2012, and the Falls Risk Assessment Policy, revised March 2018, were also reviewed. All three policies did not include supervision related to falls. 1. On 1/05/26 at 10:00 AM, the surveyor toured the nursing unit and observed Resident #7 seated in a wheelchair in the dayroom (room [ROOM NUMBER]). The resident had a peg board on the table and was trying to play with the board. The resident could not communicate with the surveyor. The resident appeared restless and confused and there was no staff in attendance. On 1/05/26 at 11:00 AM, the surveyor observed Resident #7 in the dayroom (room [ROOM NUMBER]) seated at a table alone, along with seven other residents. There was no staff observed in attendance. At 11:20 AM, the surveyor observed a staff member coming from the other room (staff identified it as the Purple Room), and the staff member identified herself as the Activity Aid (AA). The AA informed the surveyor she had to provide activities and monitor both rooms by herself, and she stated she didn't have any help. The AA informed the surveyor that the facility used two dayrooms where the Certified Nurse Aides (CNAs) brought the residents to after providing morning care, and the residents could attend activities in either room [ROOM NUMBER] or the Purple Room. According to the AA, the facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0689 Level of Harm - Actual harm Residents Affected - Some	assigned only one staff member to cover both activity rooms. There was no staff observed in the first room to supervise the residents, while the AA had to monitor the residents in the Purple Room. On 1/06/26 at 11:15 AM, the surveyor observed Resident #7 seated alone at a table in room [ROOM NUMBER]. The resident appeared restless and was observed attempting to stand, moving back and forth in the wheelchair. The AA was in the Purple Room and there was no clear, unobstructed path to visualize what was happening in room [ROOM NUMBER]. The surveyor interviewed the AA and inquired who was responsible to supervise and provide activities to room [ROOM NUMBER] while she was attending to the residents in the Purple Room. The AA stated that currently she had no help, and at times she had to transport some of the residents to the hairdresser, so she had to ask the nursing staff to keep an eye on both rooms. The AA stated there were no staff physically assigned to monitor the activity area if she had to step out. The AA asked the surveyor what the ratio should be for activities as she was aware that she could not provide activities and supervise both rooms. The surveyor referred her to the Licensed Nursing Home Administrator (LNHA). The surveyor then asked the AA if she discussed her concerns with the Activity Director, and she stated, yes. On 1/06/26 at 11:35 AM, the surveyor interviewed the CNA who cared for Resident #7. The CNA stated that Resident #7 required extensive assistance with care, was very confused, and required supervision to prevent falls. The CNA further stated that the resident was usually transferred to the dayroom after care for activities. On 1/06/26 at 11:45 AM, the surveyor interviewed Resident #7's Charge Nurse regarding resident falls. The Charge Nurse stated that all the falls were reviewed during morning meetings and the Director of Nursing (DON) updated the care plan. On 1/06/26 at 11:55 AM, the surveyor requested all of Resident #7's fall investigations, their fall risk assessments, and a timeline of their falls from the DON. On 1/07/26 at 10:11 AM, the surveyor observed Resident #7 in room [ROOM NUMBER] with six other residents and there was no staff in attendance. Resident #7 was observed attempting to stand from the wheelchair and another resident (unsampled) asked the resident to sit down. There was no staff in attendance. The surveyor walked to the next room, the Purple Room, and observed the AA in the back of the Purple Room with her back facing the entrance door to the room, looking through papers. The AA was unable to visualize the residents in room [ROOM NUMBER] that was divided by a wall. At that time, the residents in room [ROOM NUMBER] were left unattended. At 10:18 AM, the surveyor was about to exit the door, when the AA came into the room and stated to the surveyor that she had to get something from the Purple Room. On 1/07/26 at 11:30 AM, the surveyor reviewed Resident #7's medical record which revealed the following: A review of the admission Face Sheet (an admission summary), reflected that Resident #7 was admitted to the facility with diagnoses which included but were not limited to; aphasia following cerebral infarction (loss or impairment of language ability due to brain injury following a stroke), muscle weakness, bipolar disorder, current episode hypomanic (elevated mood), repeated falls, traumatic subdural hemorrhage with loss of consciousness (blood collects under the brain's outer layer due to head injury), adult failure to thrive. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 11/12/25, reflected that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0689 Level of Harm - Actual harm Residents Affected - Some	Resident #7 had a Brief Interview for Mental Status (BIMS) score of 3 out 15, which indicated a severely impaired cognition. A review of Resident #7's Comprehensive Care Plan provided by the facility on 1/07/26, included a focus area initiated 4/11/25, that Resident #7 was at risk for falls. The goal was that Resident #7 will be free from falls related injuries through the next review date: 10/15/25, with a target date of 3/24/26. The interventions included:Keep items of importance within reach, initiated 4/14/25. The resident had a special scoop mattress to the bed to facilitate proper positioning and to deter them from rolling off the bed, initiated 4/14/25.The resident was impulsive and has poor safety awareness and requires prompt response to all requests for assistance, initiated 4/14/25.Maintain the bed in the lowest position, initiated 4/18/25.Evaluate the environment at the time of the resident's fall and identify any factors that may have contributed to the fall, initiated 4/22/25. Therapy to screen/evaluate and/or treat as indicated, initiated 4/22/25. The resident was to be in the common area when out of bed, and do not leave the resident alone in the room in the wheelchair, initiated 4/28/25. Staff to bring resident out of the room after morning care to participate in activities of their choice, initiated 4/28/25. The resident needs supervised activities that minimize the potential for falls while providing diversion and distraction, initiated 10/29/25. On 1/07/26 at 11:40 AM, the following Fall Risk Evaluations were provided by the DON: -Fall Risk Evaluation dated 1/16/25, reflected Resident #7 scored a 20, which indicated a high fall risk. (10 or above = high risk for falls).-Fall Risk Evaluation dated 4/16/25, reflected that the facility identified Resident #7 as a high fall risk. Resident #7 received a score of 24. -Fall Risk Evaluation dated 4/24/25, reflected that the facility identified Resident #7 as a high fall risk. Resident #7 received a score of 24. -Fall Risk Evaluation dated 7/23/25, reflected that the facility identified Resident #7 as a high fall risk. Resident #7 received a score of 21.-Fall Risk Evaluation dated 10/24/25, reflected that the facility identified Resident #7 as a high fall risk. Resident #7 scored a 22. The following incidents and Fall Evaluations were documented in the electronic Medical Record, and/or provided by the DON, and revealed the following:-On 11/11/24 at 1:03 PM, a Nursing Progress Note revealed Resident #7 was found on the floor by the housekeeping staff between the bathroom and the bed. There was no fall investigation provided by the facility. -On 11/27/24 at 12:30 PM, a Nursing Progress Note revealed that the writer was called to room by the CNA, and they observed the resident laying on the floor in the room, next to the wheelchair on their right side. The resident was incontinent, and Resident #7 was provided with incontinence care and taken to the common area. There was no fall investigation provided by the facility. -On 11/29/24 at 7:40 PM, a Nursing Progress Note revealed the resident fell in the room and sustained a skin tear. There was no fall investigation provided by the facility. -On 12/09/24 at 2:20 PM, a Nursing Progress Note revealed the resident found on the floor in the activity room. No investigation was provided for this fall. The facility did not identify who was responsible to monitor the resident in the dayroom. -On 12/14/24 at 8:06 PM, a Nursing Progress Note revealed that the resident was found on the floor in the doorway of the room and sustained a skin tear to the right elbow. There was no fall investigation provided by the facility. -On 3/31/25 at 7:00 PM, a Nursing Progress Note revealed that the resident was found on the floor in the room, and upon assessment, Resident #7 was noted with redness to the left arm. A review of the corresponding Unwitnessed Fall report dated 3/31/25, did not include a causal factor for the fall. The Interdisciplinary Care (IDC) team indicated that, The resident has been identified as high risk for falls. All current interventions remain appropriate and in place. Additional interventions are not appropriate at this time. The goal for the resident is to prevent injury from falls.- On 4/09/25 at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0689 Level of Harm - Actual harm Residents Affected - Some	9:06 AM, a Nursing Progress Note revealed that the resident was found on the floor in the room, and that the CNA found the resident on the floor in the room, on their back leaning against the bed. The resident was assisted to bed with no injury noted. Neurological checks were initiated. The corresponding Unwitnessed Fall investigation dated 4/09/25, revealed the aide reported the resident on floor. 4/10/25, the IDC team reviewed the fall. The resident fell from bed, the resident was impulsive and does not recognize limits.No revised interventions added to the Care Plan.-On 4/17/25 at 10:15 PM, an Incident report dated 4/17/25, reflected that Resident #7 was found in the room between the bed and the bathroom's door. The recommendation was to maintain their bed in the lowest position. According to the staff, the resident was attempting to go the bathroom. The IDC team notes dated 4/18/25, documented the resident remains impulsive and with poor safety awareness. Bed in lowest position. -On 8/10/25 at 9:11 PM, an Incident Report revealed Resident #7 sustained a fall in the hallway during transfer. The progress notes revealed that the resident was observed lying on the floor in the hallway with swelling and blood dripping from left side of their head. The resident stated, I fell and hit my head. The CNA assisted the resident into the wheelchair and the resident fell forward. The resident was transferred to the Emergency Department (ED) and was diagnosed with soft tissue injury to left supraorbital and frontal scalp, contusion and laceration (skin tear and bruising in the area above the eye). The IDC team's recommendations were to educate staff on safely repositioning in the wheelchair. During the transfer to the room, there was no leg rest in use. According to the CNA's statement, the resident's legs got caught underneath, the resident fell and hit their head. -On 10/06/25 at 2:00 AM, an Incident Report revealed during rounds, a CNA found the resident on the floor. The bed was low, and the IDC team met on the same day to discuss the fall and there was no causal factor indicated for the fall per the resident's care plan intervention, and the care plan interventions were not reviewed or revised.-On 10/28/25 at 11:30 AM, an Incident Report revealed that a CNA alerted the nurse that Resident #7 was found on the floor in the activity room with the wheelchair behind them. On 10/29/25, the IDC team reviewed the fall, and it was determined that Resident #7 would stand and sit repetitively even when there would be a puzzle or activity in front of them. During the fall, Resident #7 stood up and went to sit down and missed the chair and sat on the floor. The resident needs supervised activities that minimize the potential for falls while providing diversion and distraction. - On 11/4/25 at 7:42 AM, following the fall of 10/28/25, the CNA reported to the nurse that Resident #7 had right leg bruising and was swollen and was warm to the touch. The resident was transferred to the ED for evaluation and treatment. A review of the hospital records revealed a history of fall and trauma. A computed tomography (CT) scan (diagnostic imaging that uses a combination of X-rays and computer technology to produce images of any part of the body) of the right lower extremity was performed on 11/04/25, which revealed a large intramuscular hematoma (bruise) to the right leg, measuring 28 centimeters (cm) by (x) 6.5 cm x 4.3 cm. Resident #7 remained at the hospital from [DATE] to 11/08/25. The resident was also diagnosed with bandemia (large amount of immature white blood cells (band cells) released by bone marrow to fight infection or inflammation. Common causes are severe pain or stress, tissue damage.) There was no acute fracture. -On 11/14/25 at 4:03 PM, a late entry Incident Note revealed that Activity Saff reported that the resident was found on the floor in the activity room. The resident was actively bleeding from the right side of their forehead with injury above their eyebrow with a 3-centimeter cut noted and discoloration on their nose bridge noted. The resident was transferred to the emergency room for facial/head injury. The resident sustained a laceration above the right eye, bruises to the bridge of nose, open area to the right side of the head. The resident was diagnosed with closed head injury and facial laceration (skin tear) that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0689 Level of Harm - Actual harm Residents Affected - Some	required sutures (stitches). The Incident Report dated 11/14/25, revealed that on 11/17/25, the IDC team reviewed the fall and determined that Resident #7 attempted to ambulate and fell and All current interventions remain appropriate and in place. Additional interventions are not appropriate at this time. The goal for the resident is to prevent injury from falls. The IDC team did not address the failure to supervise the resident after it was documented post fall on 10/28/25, that the resident required supervision while in activities. A review of the therapy Screen/Referral Form dated 9/30/25, revealed the following: After speaking with nursing staff and CNA, as well as observation of [the resident], [the resident] may at times demonstrate unsafe behavior (stands up with I to participate in [activities of daily living (ADLs)], however this is [the resident's] typical behavior. There has been no decline in ADLs or transfer. No [occupational therapy] indicated. The facility did not indicate what measures were put in place to address the unsafe behavior. On 1/08/26 at 9:53 AM, the surveyor interviewed the DON regarding Resident #7's multiple falls at the facility including the falls with injuries. The DON stated that the staff should have followed the care plan. When asked if Resident #7 had behaviors, the DON stated, No. The DON added that Resident #7 was easily redirected, and Resident #7 attempted to stand up all the time as this is their ritual, someone has to remind them to sit. On 1/09/26 at 11:39 AM, the surveyor interviewed and shared the above concerns with the Activity Director (AD) regarding staffing. The AD stated, the activity needs to be re-evaluated, currently staffing is lacking, and stated her expectations were to re-evaluate and provide a safe environment to all residents. When asked if her expectations were being met/considered, she stated that she was aware of the staffing issue, that the activity staff had to oversee residents in both rooms, and she did not have a plan yet to resolve the staffing issues and ensure the residents' needs were met. A review of the Activity Director Position Description revealed the following: The activity director is responsible for the development, implementation, and supervision of the full scope of the facility's recreation services. This includes providing an ongoing inclusive program that uses purposeful activities to improve and maintain the quality of life for residents. The Activity Director was to uphold and safeguard resident's rights, advocates for and on behalf of residents. 2. The surveyor reviewed the electronic medical record (EMR) which revealed a comprehensive Minimum Data Set (MDS), an assessment tool dated 8/05/24, which indicated Resident #70 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated an intact cognitive function. a further review of the MDS revealed Resident #70 required maximum assistance for transfers and had diagnoses that included but were not limited to; Alzheimer's disease, anxiety, and diabetes. A review of the individual comprehensive care plan (ICCP) included a focus area dated 7/29/24, for high risk for falls. The focus area was updated to include a fall with no injury on 8/03/24, a fall with no injury on 8/06/24, a fall with no injury on 8/11/24, a fall with no injury on 8/14/24, a fall with no injury on 8/30/24, and an actual fall with skin tear to their left hand and elbow on 10/18/24. Interventions dated 7/29/24, included to review information on past falls and attempt to determine cause of falls; record possible root causes; after remove any potential causes if possible; anticipate and meet the resident's needs; be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; the resident needs prompt response to all requests for assistance; educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; ensure that the resident is wearing appropriate footwear; follow facility fall protocol; maintain bed in lowest position while in bed; offer and provide toileting assistance before and after meals, at bedtime and as needed. An intervention dated 8/06/24, was physical therapy (PT) and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0689 Level of Harm - Actual harm Residents Affected - Some	occupational therapy (OT) evaluate and treat as ordered or as needed (PRN). An Intervention dated 8/11/24, was to encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Interventions dated 8/14/24, were to continue as risk plan and offer activities that minimize the potential for falls while providing diversion and distraction. An intervention dated 10/21/24, was the resident currently needs new glasses and will be seen by the optometrist on 10/23/24. Monitor closely at this time until new glasses are received. According to documentation reviewed, there were no new interventions for the falls that occurred on 8/30/24. A review of the facility provided Accident/Incident reports did not indicate when the resident was last seen or toileted, footwear at time of the incident, position of bed (if applicable), or if resident had participated in activities as per ICCP interventions. Effectiveness of interventions were not evaluated and a root cause of falls not identified. A review of the facility provided Fall Risk Evaluation dated 7/29/24, indicated that Resident #70 scored a 22 (above 10 indicates high risk for falls). No additional fall risk evaluations provided. On 1/09/26 at 10:55 AM, the survey team interviewed the Director of Nursing (DON), who stated that when there was a fall, the nurse on duty did the incident report. The DON continued that the Interdisciplinary care team (IDCT) met the next morning to look for the root cause of the fall, and interventions were put into place immediately, before investigation was complete. The DON stated as a team, the fall was reviewed to look at what happened, and the care plan was updated with intervention(s) to prevent further falls. The DON stated they contacted whoever was needed for the intervention (i.e. therapy if PT or OT was indicated). The DON stated when the investigation was complete, we changed the interventions if needed. A review of the facility provided policy Falls - Clinical Protocol, dated revised March 2018, which included:Assessment and Recognition .2. In addition, the nurse shall assess and document/report the following .h. Precipitating factors, details on how the fall occurred .5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations, etc .Cause Identification: 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall .2. If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes .Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation . 3. On 1/05/25 at 10:44 AM, the surveyor observed Resident #27 in the activities room, seated in a high back wheelchair, well dressed, groomed, asleep and was not awakened by the surveyor's voice. The surveyor reviewed the medical record for Resident #27. According to the resident's admission Record, Resident #27 was admitted to the facility with diagnoses that included but not limited to; hemiplegia and hemiparesis (muscle weakness or partial (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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 0689 Level of Harm - Actual harm Residents Affected - Some	paralysis on one side of the body that can affect arms, legs and facial muscles) following cerebral infarction (stroke due to disrupted blood flow to the brain) affecting left non-dominant side and epilepsy. A review of the most recent quarterly MDS dated [DATE], reflected the resident had a BIMS score of 2 out of 15, which indicated the resident had a severely impaired cognition. Section E -Behavior reflected the Resident #27 did not exhibit behaviors related to the rejection of care. Section GG, Functional Abilities, reflected Resident #27 was dependent (helper does all the effort) for upper and lower body dressing and toileting (adjust clothes before and after voiding or bowel movements). A further review of the MDS under Section J1800 Falls revealed the resident had a fall that resulted in an injury (skin tears, abrasion, laceration, superficial bruises, hematomas and sprain; or any fall -related injury that caused the resident to complain of pain). A review of the facility Risk Management Report (RMR) dated 8/12/25 at 6:45 PM, revealed Resident #27 had fallen while being turned on their right side, by the Certified Nursing Assistant (CNA). The report was prepared by the Licensed Practical Nurse (LPN) who was alerted by the CNA. The LPN also documented that the Resident #27's leg hit the floor while their body remained on the bed. The RMR did not include Resident #27's signed statement but was described as aware of who they were and the situation. Further review of the RMR reflected that on 8/13/25, the interdisciplinary (IDCP) team met to discuss Resident #27's fall and resulted in staff education of positioning the resident in the center of the bed before turning to one side or the other. A review if the individualized comprehensive care plan (CP) for Resident #27 under falls did not include the incident that occurred on 8/13/25, and the CP was not updated after that fall, including that the fall occurred and the intervention discussed of proper positioning Resident #27 required prior to being turned to one side or the other. On 1/09/26 at 10:15 AM, during an interview with the surveyor, the Licensed Practical Nurse/Charge Nurse stated that the Director of Nursing (DON) was responsible for updating the resident's CP. On 1/09/26 at 10:49 AM, during an interview with the surveyor, the DON stated that the Assistant Director of Nursing (ADON) was responsible for collecting the data for all incidents and accidents reported and that she as the DON reviewed the information the ADON collected. The DON stated that after a fall, the interdisciplinary team (included the DON, ADON, social services, rehabilitation services and activities) met as a team to review and placed interventions prior to the completion of investigation to prevent further falls. On 1/09/26 at 12:02 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the DON, the surveyor discussed the concerns regarding Resident #27's CP was not updated to include the intervention discussed during the IDCP meeting on 8/13/25, to prevent falls. A review of the provided policy titled; Managing Falls and Fall Risk included that the staff would monitor and document each resident's response to interventions intended to reduce falling or risk of falling. No further information was provided. N.J.A.C. 8:39-27.1(a)