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	03/05/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. COMPLAINT # 2792802 and 2795965 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that facility staff members failed to a.) ensure control measures were implemented, maintained and monitored to prevent the growth of Legionella in accordance with the facility Water Management Program (WMP)(a risk management plan for the prevention and control of legionellosis associated with the building water systems) and in accordance with accepted national standards, Centers for Disease Control and Prevention (CDC) guidelines and American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Guideline 12, when there was a positive Legionella report in December 2024 and February 2025, by maintaining and changing filters in the shower heads and ice machine; b.) including the Infection Preventionist (IP) in the control measures to minimize the risk of Legionella exposure to all residents; and c.) update the WMP to include current responsible identified program team members. The deficient practice had the potential to affect all residents and was evidenced by the following: Reference: CDC guidelines for Legionella Control dated March 15, 2024, indicates to follow a successful remediation procedure, clean and maintain water system components regularly in accordance with manufacturer recommendations and ice machines are cleaned regularly and replace filters per manufacturer recommendations. In addition, implement Legionella control measures for devices that use water per ASHRAE Guideline 12. On 03/05/2026 between 10:19 AM and 11:00 AM, the survey team, accompanied by the Campus Maintenance Director (CMD) and the New Jersey Department of Health (NJDOH) Communicable Disease Services (CDS) Research Scientist/Water Systems Analyst (Water Scientist), and a Local Health Department (LHD) representative, toured the skilled nursing section of the building and observed the following: On 03/05/2026 at 10:44 AM, the surveyor, in the presence of the CMD, observed three (3) shower heads in the shower room. The CMD stated two (2) of the three (3) shower heads were in use. The CMD acknowledged one of the two (2) shower heads had a filter. The CMD explained the Certified Nursing Aides (CNAs) may have removed the filter to get better flow. The CMD added that the filters were checked by the maintenance department every three (3) months. The CMD also added there would be a log indicating the filters were checked/replaced and would provide the log. On 03/05/2026 at 10:49 AM, the surveyor, in the presence of the CMD, observed an ice machine in the dining room/pantry area with an inspection sheet that indicated on 11/18/2025, the ice machine was cleaned and sanitized by the Heating, Ventilation and Air Conditioning Mechanic (HVACM). In addition, there was a filtration device attached to the wall connected to the water line for the ice machine with a date of 02/04/2025, handwritten on the device. The CMD stated 02/04/2025, may have been the date of installation and was unsure if the filter had been changed after that date. The CMD could not speak to the manufacturer's specifications as to when the filter device should have been changed. The CMD added he would provide a log when the ice machine filter was checked/replaced. On 03/05/2026 at 11:05 AM, the survey team interviewed the Licensed Nursing Home Administrator (LNHA), who stated he became the LNHA in October 2025. The LNHA also stated he was aware the filters required to be checked and changed and would have to check with maintenance for the schedule. On 03/05/2026 at 11:10 AM, the surveyor interviewed the Director of Nursing (DON), who stated water for the residents was supplied from water coolers and no water for (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	consumption was obtained from the faucets. The DON added that the ice machine was used on a regular basis for the residents and any filters were done by maintenance. In addition, the DON was unaware of any water pressure issues with the shower heads. The DON added the residents used the shower room and there were four (4) rooms with private showers. The DON provided a shower schedule for all residents. On 03/05/2026 at 11:27 AM, the surveyor interviewed the IP/Licensed Practical Nurse (IP/LPN), who stated she had been the IP for approximately a year. The IP/LPN stated she had no knowledge of any issue with Legionella and upper management, and maintenance were involved in handling Legionella. The IP/LPN added she was told to provide education regarding Legionella approximately a year ago to the staff as to what the disease was, how you get the disease and where it was found. The IP/LPN also added she was unaware of any issues currently with Legionella in the building. The IP/LPN stated the water for consumption for the residents was obtained from water coolers and ice was in the ice machine and used on a regular basis for meals, devices, and medications. The IP/LPN explained residents on nectar thick liquids could not receive ice and thought maintenance was responsible for the filter. The IP/LPN also stated the CNAs were responsible for following the shower schedule for all residents and remembered shower head filters being put in by the previous LNHA but was unable to remember when that was. The IP/LPN added she thought maintenance checked the filters. The IP/LPN also added there were no complaints by staff about low water pressure from the shower heads. On 03/05/2026 at 12:27 PM, the surveyor interviewed the LNHA, who stated the IP/LPN was responsible for educating the staff on Legionella but was currently not involved in remediation. The LNHA added he would involve the IP/LPN if there were any cases of Legionella. The LNHA confirmed the IP/LPN had not been included in any discussions since becoming LNHA regarding Legionella but had planned on including her. On 03/05/2026 at 12:35 PM, the surveyor observed LPN #1 at the medication cart with a water pitcher approximately three-fourths empty with water and ice melting. LPN #1 stated she filled the pitcher with water from the cooler and ice from the ice machine before going out to administer medications to the residents and the ice was melting but the water was still cold. LPN #1 added that was her usual procedure. On 03/05/2026 at 12:39 AM, the surveyor observed CNA #1 carrying a resident's meal tray. The surveyor interviewed CNA #1, who stated he was bringing a meal tray to a resident and used the water dispenser to fill the cup on the tray with water and ice from the ice machine in the dining room. On 03/05/2026 at 12:41 PM, the surveyor observed an unsampled resident with two (2) cups on their overbed table. The surveyor interviewed the unsampled resident who confirmed the two (2) cups contained water with ice and received showers in the shower room approximately twice a week. On 03/05/2026 at 12:45 PM, the surveyor observed CNA #2 in the dining room filling a cup with ice and pouring juice in the cup and placed the cup on a meal tray for a resident. The surveyor interviewed CNA #2, who stated that was her regular routine to fill the cups with ice and add juice or water from the cooler for the resident's meal tray. On 03/05/2026 at 12:46 PM, the surveyor interviewed CNA #3 and CNA #4, who stated neither had an issue with low pressure from the shower heads in the shower room. CNA #4 added he had given a resident a shower in their room that morning because they had a private shower in their room and had no issues with pressure. CNA #3 and CNA #4 both acknowledged their usual routine every day was to provide each resident with a cup of water from the cooler and ice from the ice machine in the morning and then whenever needed during their shift. On 03/05/2026 at 2:03 PM, the surveyor interviewed the HVACM in the dining room at the ice machine. The HVACM confirmed he signed the inspection record and explained on 11/18/2025, he disassembled, sanitized, soaked parts and re-installed all parts of the ice machine. The HVACM stated he normally would change the cartridge to the filter but in November 2025, there was a different filter device and had he not changed the filter device. The HVACM added the filter device should have been changed. The HVACM also stated he knew the device had a date of 02/04/2025, written on it because he was told by the CMD that morning and thought the date of 02/04/2025, was when the device was installed but he was unsure. The HVACM added he would be changing the filter device, but the device had to be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ordered. The HVACM added he did not do the ordering and thought the Maintenance Supervisor (MS) was responsible for ordering the filter device, but the MS was terminated last month. On 03/05/2026 at 2:29 PM, the surveyor interviewed the CMD, who stated he could not provide logs of when the shower head filters, or ice machine filter was checked or changed. The CMD had no ordering schedule or receipt of order because vendors were changing frequently and there were too many hands involved. The CMD explained the MS was terminated for multiple reasons which included one of the reasons was audits not being completed and completed properly. The CMD provided a SNF Community Shower Room log which indicated 08/10/2025, was Date New Filter Was Installed. The CMD could not speak to what the log meant. The CMD added that it was the only record he had. On 03/05/2026 at 3:09 PM, the surveyor interviewed the LNHA, who stated he thought the audits for the shower heads and filters were being done. The LNHA added he was unaware the filters were not changed as per manufacturer's specifications. The LNHA explained the administrative team was new and there was a change in ownership. The LNHA also stated he was aware when he became the LNHA in October 2025, there was a history of a Legionella issue but was unaware of the magnitude and was unaware where in the process of mitigation the facility was. The LNHA then acknowledged he had been in contact with the NJDOH CDS regarding Legionella remediation since becoming the LNHA in 10/2025. The LNHA stated he thought he was following all recommendations made by the NJDOH CDS for remediation. The LNHA added he had a third-party consultant come in 02/19/2026, for sampling and received a preliminary report that there was one positive sample for Legionella and had not retained a mechanical engineer yet due to conflicting schedules. The LNHA confirmed the 02/19/2026, was the only sampling report completed and thought he was following the facility WMP. The LNHA was unable to provide documentation as to the NJDOH CDS recommendations that were completed before 02/19/2026. At that time, the LNHA reviewed the facility policies provided to the surveyors regarding Legionella Water Management Program and stated that was not the facility WMP and would provide the WMP. A review of the facility WMP titled Water Management Plan dated 07/15/2025, provided by the LNHA, revealed the program team members included the current CMD and an Executive Director and Administrator who no longer were employed at the facility. In addition, the WMP revealed ice machines, medical devices, shower heads and hoses were specific devices at risk for Legionella contamination. The WMP further explained ice machines required a control measure of regular cleaning and changing filters according to manufacturer's specifications and documented. In addition, the WMP included but not limited to instructions; showerheads and hoses required regular cleaning, replacing or dismantling, disinfecting, and eliminating all deposits of scale from shower heads, hoses, aerators or flow restrictors. The WMP indicated If Legionella-positive sample is found outside of the control limits, more frequent samples may be required as part of the review of the system operation, in order to establish the source of the contamination and determine when the system is back within control limits as specified in the WMP. A review of the facility policy titled Legionella Water Management Program with a revision date of 9/2022, provided by the DON, revealed the facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella. In addition, the water management team consisted of at least the infection preventionist, administrator, medical director, director of maintenance and director of environmental services. NJAC 8:39-19.4 (b), 19.6(d)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Complaint #: 2792802 and 2795965 Based on observations, interviews, and review of pertinent facility documentation on 03/05/2026, in the presence of the facility's Campus Maintenance Director (CMD), it was determined that the facility failed to provide 0.2-micron biological point-of-use filters on resident showerheads and change water filters on ice machines to ensure control measures were implemented to mitigate the growth of legionella. This deficient practice had the potential to affect all residents and was evidenced by the following:A review of facility provided documentation from the New Jersey Department of Health (NJDOH) Communicable Disease Service (CDS) to the facility, dated 01/21/2025, included:Immediate Control Measures: 1. Immediately install 0.2-micro biological point-of-use filters on any shower heads intended for use or restrict showers and use sponge baths instead. Filters must comply with the requirements of ASTM F838.a. Access the facility for the potential installation of additional point-of-use filters at water fixtures where the risk of exposure to aerosolized water is elevated, such as salon sinks used for hair washing and other sinks accessed by residents at higher risk for Legionnaires disease. b. Understand point-of-use filters manufacturers recommendations regarding the temperature, pressure, chemical levels that filters can withstand, and suggested frequency for replacement.2. Provide bottled drinking water for residents who are at risk of aspiration (i.e., swallowing difficulties). Do not provide tap water to residents at risk of aspiration, including use of ice from the facility's ice machines in their beverages and use tap water used in dilution/hydration of meals for patients on a soft diet. Consider providing bottled water to other susceptible patients. On 03/05/2026 at 10:19 AM, the surveyor, accompanied by the CMD, the Research Scientist/Water Systems Analyst (Water Scientist) from the NJDOH CDS, and a Local Health Department (LHD) Representative observed the following: At approximately 10:45 AM, an inspection inside the Resident Shower Room revealed when the showerhead was opened, there was no evidence of a 0.2-micron biological point-of-use filter. At that time, the CMD told the surveyor that sometimes the Certified Nursing Aides (CNA) removed the filter if the water flow was low. The CMD added that the filters were checked by the maintenance department every three (3) months. The DM also added there would be a log indicating the filters were checked/replaced and would provide the log. At approximately 11:05 AM, an inspection of the ice machine in the service area adjacent to the resident dining area, revealed the filter was installed on 02/04/2025. The CMD stated 02/04/2025, may have been the date of installation and was unsure if the filter had been changed after that date. The CMD could not speak to the manufacturer's specifications as to when the filter device should have been changed. The CMM added he would provide a log when the ice machine filter was checked/replaced. At that time, the Water Scientist informed the CMD that those filters needed to be changed every six months. On 03/05/2026 at 11:05 AM, the survey team interviewed the Licensed Nursing Home Administrator (LNHA), who stated he became the LNHA in October 2025. The LNHA also stated he was aware the filters required to be checked and changed and would have to check with maintenance for the schedule. On 3/5/26 at 2:03 PM, the surveyor interviewed the Heating Ventilation Air Conditioning Mechanic (HVACM) in the dining room at the ice machine. The HVACM confirmed he signed the inspection record and explained on 11/18/2025, he disassembled, sanitized, soaked parts and re-installed all parts of the ice machine. The HVACM stated he normally would change the cartridge to the filter but in November 2025, there was a different filter device and had he not changed the filter device. The HVACM added the filter device should have been changed. The HVACM also stated he knew the device had a date of 02/04/2025, written on it because he was told by the CMD that morning and thought the date of 02/04/2025, was when the device was installed but he was unsure. The HVACM added he would be changing the filter device, but the device had to be ordered. The HVACM added he did not do the ordering and thought the Maintenance Supervisor (MS) was responsible for ordering the filter device, but the MS was terminated last month. On 03/05/2026 at 2:29 PM, the surveyor interviewed the CMD, who stated he could not provide logs of when the (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	shower head filters, or ice machine filter was checked or changed. The CMD had no ordering schedule or receipt of order because vendors were changing frequently and there were too many hands involved. The CMD explained the MS was terminated for multiple reasons which included one of the reasons was audits not being completed and completed properly. The CMD provided a SNF Community Shower Room log which indicated 08/10/2025, was Date New Filter Was Installed. The CMD could not speak to what the log meant. The CMD added that it was the only record he had. On 03/05/2026 at 3:09 PM, the surveyor interviewed the LNHA, who stated he thought the audits for the shower heads and filters were being done. The LNHA added he was unaware the filters were not changed as per manufacturer's specifications. The LNHA explained the administrative team was new and there was a change in ownership. The LNHA also stated he was aware when he became the LNHA in October 2025, there was a history of a Legionella issue but was unaware of the magnitude and was unaware where in the process of mitigation the facility was. The LNHA then acknowledged he had been in contact with the NJDOH CDS regarding Legionella remediation since becoming the LNHA in 10/2025. The LNHA stated he thought he was following all recommendations made by the NJDOH CDS for remediation. The LNHA added he had a third-party consultant come in 02/19/2026, for sampling and received a preliminary report that there was one positive sample for Legionella and had not retained a mechanical engineer yet due to conflicting schedules. The LNHA confirmed the 02/19/2026, was the only sampling report completed and thought he was following the facility WMP. The LNHA was unable to provide documentation as to the NJDOH CDS recommendations that were completed before 02/19/2026. No additional information was provided. A review of the facility's policy titled Water Management Plan (WMP) dated 07/15/2025, provided by the LNHA, revealed the program team members included the current CMD and an Executive Director and Administrator who no longer were employed at the facility. In addition, the WMP revealed ice machines, medical devices, shower heads and hoses were specific devices at risk for Legionella contamination. The WMP further explained ice machines required a control measure of regular cleaning and changing filters according to manufacturer's specifications and documented. In addition, the WMP included but not limited to instructions; showerheads and hoses required regular cleaning, replacing or dismantling, disinfecting, and eliminating all deposits of scale from shower heads, hoses, aerators or flow restrictors. The WMP indicated If Legionella-positive sample is found outside of the control limits, more frequent samples may be required as part of the review of the system operation, in order to establish the source of the contamination and determine when the system is back within control limits as specified in the WMP. NJAC 8:39-31.2(e)