STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING ______ B. WING ______	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD ABSECON, NJ 08201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 12/23/2024 Census: 152 Sample: 30 + 2 closed records Complaint #'s NJ 169201, 169245, 170494 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. Census: 152 Sample Size: 30 + 2 closed records Complaint #'s NJ 169201, 169245, 170494	F 000		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must--	F 577		1/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/10/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING ______ B. WING ______	C 12/23/2024

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PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD ABSECON, NJ 08201**

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F 577	Continued From page 1 (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to make survey results readily accessible to residents and visitors. This deficient practice was evidenced by the following: 1. On 12/18/0224 from 10:07 to 10:49 AM the surveyor conducted the resident council task with five (5) facility long-term resident's, with 4 of 5 residents that regularly attend resident council meetings. When asked if the residents were made aware of the location of the most recent state survey results, 5 out 5 residents (Resident #33, #35, #51, #113, and #127) responded that they were not aware of where the most recent survey results were located. 2. On 12/18/2024 at 10:57 AM, the surveyor interviewed the U.S. FOIA (b)(6) survey results. When asked where the survey results	F 577	F577 SS – D Element #1 – The recent state survey results were immediately made readily accessible by the U.S. FOIA (b)(6) on 12/18/2024, to residents and visitors by the reception area and on all 3 units. A notice of the availability of such reports is posted in areas of the facility that are prominent and accessible to the public. Element #2 - This cited deficient practice has the potential to affect all residents and visitors. Element #3 – U.S. FOIA (b)(6) were re-in serviced on 12/23/24 by facility educator on having the survey results readily accessible. The U.S. FOIA (b)(6) was reeducated on 12/23/24 by facility educator to make residents aware of the location of survey results biyearly during	

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	315244	A. BUILDING ______ B. WING ______	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

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F 577

Continued From page 2

were located the [NJ Exec Order 26.4b1] told the surveyor that the survey results were located behind the [U.S. FOIA (b)(6)] desk and on the table in the lobby. The [U.S. FOIA (b)(6)] also said that they were also available on the first and second floor and [NJ Exec Order 26.4b1] nursing stations. The surveyor then asked the [U.S. FOIA (b)(6)] and [U.S. FOIA (b)(6)] to provide the surveyor with the most recent survey results book to observe. The [U.S. FOIA (b)(6)] and [redacted] walked around the reception area/lobby and stated that they are "usually" here but could not produce the results book for the surveyor. The [U.S. FOIA (b)(6)] then asked the [U.S. FOIA (b)(6)] where the survey results book was located and the [U.S. FOIA (b)(6)] and [U.S. FOIA (b)(6)] produced a pink binder from behind the [U.S. FOIA (b)(6)] desk. The binder was not accessible to residents and visitors without having to ask. Surveyor #2 then searched for the survey results on the [NJ Exec Order 26.4b1] unit. The results were accessible to the surveyor on her tippy toes. The results would not have been accessible to residents in wheelchairs and was located within the nurse's station that residents on the unit do not have access to because there are wooden locked doors on either side of the nurse's station. Surveyor #2 interviewed RN/UM #1 on the [NJ Exec Order 26.4b1] unit. Surveyor #2 asked if the survey results were always kept on the shelf behind the nurse's station and RN/UM #1 replied, "Yes." Observation of the survey results by Surveyor #2 revealed that the last available results for the state survey on [NJ Exec Order 26.4b1] were dated 2009.

3. On 12/18/2024 at 11:16 AM the surveyor went to the 1st floor nurses station and requested to see the state survey results book. The staff stated let me get [staff name]. The Registered Nurse/Unit manager (RN/UM #2). RN/UM #2 approached the surveyor and stated hold on. RN/UM #2 looked around the nurse's station then

F 577

the monthly resident council meeting.

Element #4 – Bi-Weekly audit x 3 months and then monthly x 3 months will be conducted by the Administrator/designee to ensure the survey results are always easily accessible to residents and visitors. Any negative findings will be corrected immediately through one-on-one re-education by facility educator and disciplinary measures as appropriate. Results of audits will be reported to the quarterly QA committee.

Completion Date: 1/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING ______ B. WING ______	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD ABSECON, NJ 08201**

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F 577	Continued From page 3 proceeded to go into her office across the hallway and make a telephone call. RN/UM #2 told the surveyor she was unable to locate the state survey book but told the surveyor it was usually at the nurse's station on a shelf. 4. On 12/18/2024 at 01:05 PM RN/UM #2 approached the surveyor in the hallway and explained that they now have a copy of the survey results available at the first floor nursing station. N.J.A.C. 8:39-9.4(b)	F 577		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		2/14/25

PRINTED: 07/01/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING ______ B. WING ______	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 4 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean, safe, and sanitary environment for 2 of 3 units (NJ Exec O floor and NJ Exec Order 26.4b1). This deficient practice was evidenced by the following: On 12/17/2024 at 12:17 PM, Surveyor #1 observed the following on NJ Exec Order 26.4b1: Medication Cart #2 had hair tangled in the wheels, and a mechanical lift also had hair wrapped around its wheels. A clean linen cart on the low hall showed a blue stain on the top shelf, along with tan and brown stains on the left side of the vertical support. Additionally, the covers for the clean linen carts on both the low and high halls were in poor condition with rips. On 12/17/2024 at 10:30 AM, Surveyor #2	F 584	F584 SS - E Element #1 □ Hair and debris were immediately removed by U.S. FOIA (b)(6) from the wheels on Medication cart #2 and mechanical lift on NJ Exec Order 26.4b1 on 12/20/2024. Hair, debris, and stains were immediately removed by U.S. FOIA (b)(6) from the wheels on team #2 medication cart, treatment carts and mechanical lift on the second floor on 12/20/2024. All the linen carts were entirely cleaned by U.S. FOIA from stains on 12/20/2024. New linen cart covers were ordered by NJ Exec O on 12/23/2024 and were placed the carts on 2/14/2025. U.S. FOIA (b)(6) conducted a random check of residents immediate environment on 12/20/2024 to assure floors are clean and free from visible debris and hairs.	

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F 584	Continued From page 5 observed the following on the 2nd floor: Team #2's Medication and Treatment Carts had hair tangled in the wheels, and the medication cart had a yellow substance on the wheels along with brown stains on the front. Additionally, the mechanical lift's wheels had pieces of plastic and hair caught in them. During an interview with the surveyors on 12/20/2024 at 1:01 PM, the U.S. FOIA (b)(6) were made aware of the identified environmental concerns. The U.S. FOIA (b)(6) said that environmental services are responsible for cleaning the medication carts and mechanical lifts according to a monthly schedule. She emphasized that hair and plastic should not be found in the medication carts or mechanical lifts. Additionally, she highlighted that clean linen cart shelves must be free of stains and inspected by all staff, and that the clean linen carts cover should not have any rips. The facility was unable to provide a policy outlining the cleaning procedures for medication carts, mechanical lifts, and clean linen carts. 8:39-31.4 (a)FACILITY	F 584	Element #2 - This cited deficient practice has the potential to affect all residents. Element #3 □ Facility educator initiated re-in-service on 12/20/2024 to nursing and EVS staff to observe and immediately report any accumulation of hair and debris seen on wheels of nursing equipment to the EVS Director and/or Nurse Unit Manager. In-service is ongoing. Facility educator initiated re-in-service on 12/20/2024 to Nursing and EVS staff on maintaining cleanliness on their respective linens carts and to report to the EVS Director and/or Nurse Unit Manager any stains/soilage, need for cleaning and any damaged carts or Lids. In-service is ongoing. These in-services will be given during orientation for newly hired staff, annually and as deemed necessary. The EVS Director placed new linen cart covers on the carts on 2/14/2025. Element #4 □ Weekly equipment audits of 5 items across all units x 4 weeks and then monthly x 3 months will be conducted by the Housekeeping Director/designee to ensure that wheels of equipment are free from hair and debris. Weekly clean linen cart audits of 3 carts across all units x 4 weeks and then monthly x 3 months will be conducted by the Housekeeping Director/designee to ensure that linen carts are free of stains and covers are free of rips/tears. Any negative findings will be corrected immediately through one-on-one re-educations by facility educator and disciplinary measures as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 6	F 584	Results of audits will be reported to the quarterly QA committee for 2 quarters. Completion Date: 2/14/2025	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 12/17/2024 at 11:09 AM, the surveyor, accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM #1), observed the	F 812	F812 SS=D Element #1 – Unit manager removed and disposed of all food products from the refrigerator and freezer immediately, and the microwave was removed by the maintenance director. Maintenance director inspected the Refrigerator and freezer, it was working properly and the temperatures were within appropriate	1/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING ______ B. WING ______	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

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F 812	Continued From page 7 following on the 2nd Floor resident pantry: Upon entry to the pantry the surveyor reviewed the temperature log for the resident refrigerator and freezer. A review of the resident refrigerator and freezer temperature log revealed that temperatures had not been recorded for the refrigerator or freezer for 12/17/2024 at the time of observation. A review of freezer temperatures for 12/1/through 12/16/2024 revealed a temperature range of -1 to 5 degrees Fahrenheit (F). A review of the refrigerator temperatures from 12/1 to 12/16/2024 revealed a temperature range of 32 to 40 degrees F. The surveyor then proceeded to open the freezer door and observed that the internal temperature of the freezer was 42 F according to the internal thermometer. The surveyor observed an opened box of Cherry Italian Ice. The box contained 5 containers of Italian ice. The 5 containers were in a liquid state when handled by the surveyor. In addition, there were 2 vanilla ice creams that were also determined to be soft to the touch and not frozen. The surveyor then proceeded to open the refrigerator and observed an internal temperature of 52 F. There were approximately 6-8 bagged sandwiches, several 8oz cartons of milk and several plastic cups of pudding in the refrigerator. The surveyor then told LPN/UM #1 that there were concerns with the resident freezer and refrigerator temperatures. LPN/UM #1 told the surveyor that somebody probably unplugged the refrigerator. The surveyor and LPN/UM #1 went back into the pantry and observed that the resident refrigerator/freezer had been unplugged. LPN/UM #1 told the surveyor that sometimes staff unplug it to use the microwave, which needed to be plugged in. LPN/UM#1 then proceeded to remove all food products from the freezer and	F 812	ranges. Element #2 - This cited deficient practice has the potential to affect all residents on the second floor. Element #3 – Facility educator initiated re-in-service to staff on 12/20/24 not to unplug any refrigerator/freezers and to immediately report any problems to the Unit Manager and/or Maintenance Director. In-serve is ongoing. Element #4 - Weekly audits x 4 weeks and then monthly x 3 months will be conducted by the maintenance director/designee on 3 refrigerator/freezers in the facility to ensure they are plugged in correctly and in working order. Any negative findings will be corrected immediately through one-on-one re-educations and disciplinary measures as appropriate. Results of all audits will be reported to the quarterly QA committee. Completion Date: 1/15/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 8 refrigerator and dispose of them. A review of the [facility name] Refrigerator/Freezer Temperature Log revealed the following Corrective Actions: A. Temperature turned up. Re-checked in 1 hour and returned to normal range. B. Temperature turned down. Re-checked in 1 hour and returned to normal range. C. Items removed from refrigerator and maintenance notified to malfunction. NJAC 8:39-17.2(g)	F 812		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315244	A. Building B. Wing	4/2/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0577 Reg. # 483.10(g)(10)(11) LSC	Correction Completed 01/15/2025	ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 02/14/2025	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/15/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING **01** B. WING ______	**12/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/18/24 and 12/23/24 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Preferred Care at Absecon is a two-story, Type II protected building that was built in 2010. The facility is divided into ten smoke compartments. The interior diesel generator powers 100% of the building per the U.S. FOIA (b)(6). The number of occupied beds was 150 out of 162 at the time of the survey. The facility has a 1st floor NJ Exec Order 26.4b1 l unit with a different license number called NJ Exec Order 26.4b1 that was included in the building tour for recertification. .	K 000		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as	K 131		2/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/10/2025

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.

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	315244	A. BUILDING **01** B. WING ______	**12/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

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K 131	Continued From page 1 other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/23/24 in the presence of the NJ Exec Order 26.4b1 [redacted], it was determined that the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with NFPA 101: 2012 Edition, Section 19.1.3.3* between the NJ Exec Order 26.4b1 and Long Term Care units (separate licenses). This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:11 AM with the U.S. FOIA (b)(6) [redacted] revealed the door that separated the NJ Exec Order 26.4b1 Unit and the Long Term Care unit on floor #1 of the facility did not have any label indicating the fire resistant rating of the door.	K 131	K131 SS □ F Element #1 □ The NJ Exec Order 26.4b1 immediately contacted a contracted vendor on 12/23/2024 and a fire label indicating the fire-resistant rating of the door was placed on the door that separates the NJ Exec Order 26.4b1 Unit and the Long-Term Care unit on floor #1 of the facility. Element #2 □ This cited deficient practice has the potential to affect all residents. Element #3 □ Maintenance staff were re-in serviced on 12/23/2024 by facility educator on the requirement of having	

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	315244	A. BUILDING 01 B. WING ______	12/23/2024

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K 131	Continued From page 2 The U.S. FOIA (b)(6) confirmed the findings during the observations. The U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 12/23/24 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e)	K 131	labels on the doors indicating the fire-resistant rating of the door. Element #4 □ The maintenance director/designee will audit monthly x 3 months, 4 doors on the [redacted] unit to ensure they have a label indicating the fire rating of the door. Any negative findings will be corrected immediately and will be reinspected by the maintenance director/designee. Results of audits will be reported to the quarterly QA committee for one quarter. Completion Date: 2/6/2025	
K 200 SS=E	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/23/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to provide guards at exit ramps in accordance with NFPA 101 Life Safety Code (2012 Edition) Section	K 200	K200 SS □ E Element #1 □ The U.S. FOIA (b)(6) immediately contacted a contracted vendor and guards were installed at exit ramp door #4 in accordance with Federal	1/20/25

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K 200	Continued From page 3 7.2.2.4.5. This deficient practice had the potential to affect 60 residents on floors 1 and 2 and was evidenced by the following. Observations at 10:20 AM, with the U.S. FOIA (b)(6) at exit/egress door #4 revealed that the concrete landing and ramp was not provided with any guards. The concrete landing and ramp were approximately 12-inches to 18-inches off the outer area grounds in that area. In an interview at the time, the U.S. FOIA (b)(6) both indicated a guard needs to be in place to protect residents from falling off the landing and ramp in the event of an emergency evacuation. The NJ Exec Order 26.4b1 was informed of the deficient practice at the Life Safety Code exit conference on 12/23/24 at 12:45 PM. NJAC 8:39-31.2(e)	K 200	and State requirements. Element #2 □ This cited deficient practice has the potential to affect anyone exiting door #4 in an emergency. Element #3 □ Maintenance staff were reeducated on 12/23/2024 by facility educator on the requirement to provide guards on exit ramps. Element #4 □ The Maintenance director/designee will audit the facility monthly x 3 months to ensure there are guards on all exit ramps. Any negative findings will be corrected immediately and will be reinspected by maintenance director/designee. Results of audits will be reported to the quarterly QA committee for one quarter. Completion Date: 1/20/2025	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of	K 222		1/15/25

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K 222	Continued From page 4 locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in	K 222		

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K 222	Continued From page 5 accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 12/18/24, in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was identified for 1 of 1 outer set of sliding doors and had the potential to affect all residents and was evidenced by the following: Observations on 12/18/24 at 9:15 AM at the main entrance with the U.S. FOIA (b)(6) revealed that the outer set of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the doors could restrict emergency use of the exit. The sliding doors had signs indicating push to open in an emergency, but with the thumb-latch locks engaged this procedure would not open the doors as stated on the signs. A review of the current evacuation plan revealed that the front doors were designated an exit/egress route. In an interview at the time the US FOIA stated that the lockset (hook type deadbolt) could restrict use of	K 222	K222 SS E Element #1 The lockset that engaged a hook-type deadbolt was immediately removed by the U.S. FOIA (b)(6) on 12/23/2024 from the outer set of sliding doors at the main entrance. Element #2 This cited deficient practice has the potential to affect all residents. Element #3 Maintenance staff were reeducated on 12/23/2024 by facility educator on ensuring that all exit/egress doors are readily accessible and free of all obstructions or impediments. Element #4 The maintenance director/designee will audit the outer set of sliding doors to ensure they are readily accessible and free of all obstructions or impediments monthly x 3 months. Any negative findings will be corrected immediately and will be reinspected by maintenance director/designee. Results of audits will be reported to the quarterly QA committee for one quarter. Completion Date: 1/15/2025	

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K 222	Continued From page 6 the exit from the egress-side in the event of an emergency. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 12/23/24 at 12:45 PM. NJAC 8:39-31.2(e)	K 222		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/23/24 in the presence of the U.S. FOIA (b)(6) , it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 4 of 4 areas, had the potential to affect all residents and was evidenced by the following: 1. Observations at 9:30 AM in the occupied second floor activities room, revealed that one (1) wall switch shutoff all eleven (11) ceiling light fixtures. 2. Observations at 9:40 AM in the occupied second floor activities room, revealed that seven	K 281	K281 SS □ F Element #1 □ On 12/24/2024 the second-floor activities room (1), Second floor activities room (2), NJ Exec Order 26.4b1 activities room, first floor activities room, were provided by the maintenance director with emergency illumination that would operate automatically along the means of egress, continuously in operation or capable of automatic operation without manual intervention. Element #2 □ This cited deficient practice has the potential to affect all residents. Element #3 □ Maintenance staff were reeducated on 12/23/2024 by facility	1/15/25

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K 281	Continued From page 7 (7) wall switch's shutoff all fourteen (14) ceiling light fixtures. 3. Observations at 9:52 AM in the floor #1 occupied activities room, revealed that two (2) wall switches shutoff all six (6) ceiling light fixtures. 4. Observations at 10:18 AM in the occupied NJ Exec Order 26.4b1 activities room that one (1) wall switch shutoff all four (4) ceiling light fixtures. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The U.S. FOIA (b)(6) both confirmed the findings at the time of observations. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code survey exit conference on 12/23/24 at 12:45 PM. NJAC 8:39-31.2(e)	K 281	educator on the requirement that illumination along the means of egress must be continuously in operation or capable of automatic operation without manual intervention. Element #4 □ Biweekly x 3 months and then monthly x 3 months audits will be conducted by the maintenance director/designee, ensuring emergency illumination that would operate automatically along the means of egress continuously in operation or capable of automatic operation without manual intervention. Any negative findings will be corrected immediately and will be reinspected by maintenance director/designee. Results of audits will be reported to the quarterly QA committee for 2 quarters. Completion Date: 1/15/2025	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K 324		1/15/25

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K 324	Continued From page 8 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/23/24 in the presence of the U.S. FOIA (b)(6) , it was determined that the facility failed to provide the required instructional signage above the Class K portable fire extinguisher to ensure all portable fire extinguishers were ready for use in accordance with NFPA 101: 2012 Edition, Sections 19.3.5.12 and 9.7.4.1 and NFPA 10: 2010 Edition, Section 5.5.5.3(a). This deficient practice had the potential to affect all residents in the facility and was evidenced by the following: An observation at 10:28 AM during the kitchen tour, revealed two (2) of two (2) K-type fire extinguishers, that did not have the required instructional placard indicating: "Warning in case of appliance fire, use this extinguisher only after fixed suppression system has been activated." In an interview at the time of observation, the U.S. FOIA	K 324	K324 SS F Element #1 On 12/23/2024 the U.S. FOIA (b)(6) immediately placed instructional signage above the 2 class K-type portable fire extinguishers in the kitchen, indicating "Warning in case of appliance fire, use this extinguisher only after fixed suppression system has been activated." Element #2 This cited deficient practice has the potential to affect all residents. Element #3 U.S. FOIA (b)(6) were reeducated on 12/23/2024 by facility educator on ensuring that proper instructional signage is placed in areas of need by fire extinguishers.	

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K 324	Continued From page 9 and U.S. FOIA (b)(6) both stated that they was unaware of this requirement. The U.S. FOIA (b)(6)r was informed of the finding at the Life Safety Code exit conference on 12/23/24 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 10	K 324	Element #4 □ The maintenance director/designee will audit 2 class K-type portable fire extinguishers ensuring that proper instructional signage is placed as per Federal and State regulations. Audits will be conducted Monthly x 3 months. Any negative findings will be corrected immediately and will be reinspected by maintenance director/designee. Results of audits will be reported to the quarterly QA committee for one quarter. Completion Date: 1/15/2025	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/18/24 and 12/23/24 in the presence of the U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that the fire doors were inspected annually by an	K 761	K761 SS □ F Element #1 □ The fire doors were inspected by a contracted vendor on 12/11/2024 as required by Federal and	1/15/25

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K 761	Continued From page 10 individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101: 2012 Edition, Section 7.2.1.15 and NFPA 80: 2010 Edition, Section 5.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: A document review on 12/18/24, revealed there were no documented annual fire door inspections provided by the facility. In an interview on at 09:30 AM, the U.S. FOIA stated that the facility had no documented inspections of the fire doors at this time. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 12/23/24 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	State regulations. Element #2 □ This cited deficient practice has the potential to affect all residents. Element #3 □ Maintenance staff were reeducated on 12/23/2024 by facility educator on ensuring the fire doors are inspected annually. Element #4 □ The maintenance director/designee will audit the facility fire doors monthly x 3 months to ensure the fire doors are inspected annually. Any negative findings will be corrected immediately and will be reinspected by maintenance director/designee. Results of audits will be reported to the quarterly QA committee for one quarter. Completion Date: 1/15/2025	
K 771 SS=F	Engineer Smoke Control Systems CFR(s): NFPA 101 Engineer Smoke Control Systems 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 12/23/24 in the presence of the U.S. FOIA (b)(6) ______, it was determined that the facility failed to ensure that	K 771	Request for Time-Limited Waiver We are requesting a time-limited waiver for Tag K771. Some of the smoke	3/1/26

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K 771	Continued From page 11 smoke control systems (smoke dampers) were maintained in a safe operating condition in accordance with NFPA 101:2012 Edition, Sections 8.4.6.2 and 19.7.7. This deficient practice was evidenced for 2 of 2 wall vents of the building and could affect all residents by the following: A review at 10:00 AM of the facility's inspection and testing reports for their internal fire/smoke extinguishing and detection equipment revealed that the building's smoke dampers were not currently being tested. Observations of the wall vents from floors 2 and floor 1, revealed an approximately 2' x 4' vent grill size. In an interview, the U.S. FOIA confirmed the observations and revealed there was no documentation on when the last inspection was conducted on the smoke dampers. The U.S. FOIA indicated the wall vent was provided with an internal damper, but did not have any information on when it was last inspected. The U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 12/23/24 at 12:45 PM. NJAC 8:39-31.2(e)	K 771	dampers were found to be old and need to be replaced. This will take an extended amount of time due to vendor availability and installation logistics. We are committed to restoring full functionality as soon as possible and will keep you informed throughout and once it is completed. Our sprinkler systems, fire alarms systems and fire extinguishers are all in working order. They will assist in the safety of the residents, staff, and visitors. The maintenance director and/or maintenance assistants are monitoring safety of the project by auditing the sprinkler systems, fire alarms systems and fire extinguishers monthly throughout the duration of the project, to ensure they are functioning properly. Any negative findings will immediately be reported to the administrator and to the QAPI committee, and will immediately be corrected. Facility educator is reeducating the maintenance staff quarterly throughout the duration of the project, on the life safety requirement that smoke control systems are maintained in a safe operating condition, inspected and records of the inspection are to be maintained in accordance with Federal and State requirements. The U.S. FOIA (b)(6) is reviewing life safety plans and evacuation plans with staff monthly, throughout the duration of the project. The quarterly QAPI committee will review the project until the project is completed.	

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PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 771	Continued From page 12	K 771	Once the project is completed, the maintenance director/designee will audit the facility smoke damper reports monthly x 3 months, to ensure smoke control systems are maintained in a safe operating condition, inspected and records of the inspection are to be maintained in accordance with Federal and State requirements. Any negative findings will be corrected immediately and will be re-in serviced by facility educator. Results of audits will be reported to the quarterly QA committee for one quarter. Timeline 12/23/2024 Contacted damper vendors to schedule testing and inspection of dampers 1/13/2025 Damper testing and inspection initiated 1/24/2025 Electrician came to diagnose and fix breakers for damper motors 2/10/2025 Damper vendor found some dampers that need to be replaced 3/15/2025 HVAC company is already scheduled to measure and order new dampers 7/1/2025 We plan to begin process of installing new dampers and testing to ensure compliance 3/1/2026 Completion date	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements	K 921		1/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING **01** B. WING ______	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 13 The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 12/23/24 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA	K 921	K921 SS □ F Element #1 □ Maintenance director initiated re-inspecting and initiated documenting resident room electric beds throughout the facility on 12/23/2024. Inspection stickers were applied on electrical beds. Inspection and documentation are ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING **01** B. WING ______	**12/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 14 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations from 9:35 AM to 12:15 PM revealed that all resident room electric beds had no inspection stickers throughout the facility. In an interview at the time, the U.S. FOIA (b)(6) both confirmed the findings. A documentation review revealed no policy on patient care related electric beds. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 12/23/24 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	Element #2 □ This cited deficient practice has the potential to affect all residents. Element #3 □ Maintenance staff were re-in serviced on 12/23/2024 by facility educator on conducting inspections, maintenance of electrical equipment and maintaining inspection documentation related to electrical equipment. Element #4 □ The Maintenance director/designee will audit 5 electric beds per week x 4 weeks and then monthly x 3 months to ensure they are inspected and documented. Any negative findings will be corrected immediately through one-on-one re-educations by facility educator and disciplinary measures as appropriate. Results of audits will be reported to the quarterly QA committee for one quarter. Completion Date: 1/15/2025	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315244	A. Building 01 - MAIN BUILDING 01 B. Wing	4/2/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0131	Correction Completed 02/06/2025	ID Prefix Reg. # NFPA 101 LSC K0200	Correction Completed 01/20/2025	ID Prefix Reg. # NFPA 101 LSC K0222	Correction Completed 01/15/2025
ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 01/15/2025	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 01/15/2025	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 01/15/2025
ID Prefix Reg. # NFPA 101 LSC K0771	Correction Completed 02/06/2025	ID Prefix Reg. # NFPA 101 LSC K0921	Correction Completed 01/15/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO