STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. BUILDING _____ B. WING _____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	18 W LAUREL ROAD STRATFORD, NJ 08084

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F 000	INITIAL COMMENTS Survey Date: 02/09/2022 Census: 91 Sample: 19 + 3 Closed Records 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.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		2/17/22

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

Electronically Signed | 02/17/2022

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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F 761	Continued From page 1 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to properly store medications within acceptable temperature ranges in accordance with manufacturer's guidelines. This deficient practice was identified for 1 of 2 medication rooms ([redacted]) reviewed as part of the medication storage and labeling task and was evidenced by the following: On 02/08/22 at 10:46 AM, the surveyors observed that the [redacted] Unit medication storage refrigerator had a temperature reading of 42 degrees Fahrenheit (F). During an interview with the surveyors on 02/08/22 at 10:50 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that the morning-shift nurse noticed the refrigerator was unplugged earlier today. He further stated that she removed all medications from the refrigerator and stored them in the neighboring unit's medication refrigerator, until the affected refrigerator returned to an acceptable temperature range. He stated he was unsure for how long the refrigerator was unplugged and that he thought the highest temperature reached by the refrigerator was 45 F. According to the LPN/UM, none of the medications stored in this refrigerator were used except [redacted] milligrams (mg)/[redacted] milliliters (ml) Solution for Resident #64. [redacted] is a medication that is used to supplement the treatment [redacted] but may also be used to treat [redacted]	F 761	F761 1) The identified medication stored in lower willow medication fridge has been discarded and replaced by the pharmacy under stat order. The Family and Medical Doctor where advised immediately of this finding. Vitals where ordered for identified resident every 6 hours for 48 hours. The nurses at Laurel Manor have been educated on the process by which to manage any compromise of the medication storage in refrigerators, which as required by the manufacturer guidelines must store medications within acceptable temperature ranges. A. Acceptable storage range is 36-46 degrees. B. Monitor and document temperatures daily, should the temperature fall outside of the acceptable range, and the duration of the temperature loss cannot be confirmed all medication must be discarded immediately. C. Report any mechanical malfunction to maintenance promptly D. Call the pharmacy to replace any affected medication request STAT delivery E. Call the medical practitioner regarding any missed doses should they occur, document any follow-up recommendations. If there are changes in orders it is mandatory to notify the resident□s responsible party. F. Daily monitoring of refrigerator temperatures will be completed daily by	

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F 761	Continued From page 2 During an interview with the surveyors on 02/08/22 at 10:55 AM, the Licensed Practical Nurse (LPN) stated she noticed the refrigerator was unplugged when she came into work at 7:00 AM this morning. She checked the temperature at that time and recorded a reading of 80 F. The LPN moved the medications from the affected refrigerator to the neighboring unit's refrigerator until 9:33 AM, when the temperature of the previously unplugged refrigerator was deemed to be within acceptable storage range. The LPN clarified she did not know how long the refrigerator was unplugged or for how long it remained at the recorded temperature of 80 F. When asked by the surveyors, she stated that the medication can expire if it is out of its required storage temperature and acknowledged that the medication involved should probably not have been put back into the refrigerator for continued use. The LPN also advised the surveyors that she could find out the exact process for what should have been done in such a circumstance. When asked, she stated this incident was reported to LPN/UM earlier this morning, but she was not given any further instruction, aside from how she proceeded, as described. The surveyors reviewed the facility documentation titled, "Medication Refridgerator [Refrigerator]" to verify the recorded temperature of 80 F on "12/8" at 7:00 AM, with a noted temperature of 41 F as of 9:33 AM on the same day. During a follow-up interview with the surveyors on 02/08/22 at 11:10 AM, the LPN/UM confirmed	F 761	unit nurses and will be overseen by the Unit Manager or designee. Any abnormality will be reported promptly and included on daily report. 2) All residents with refrigerated medication can be affected by Laurel Manor failing to store medication at the acceptable temperature ranges. Should the temperature of a medication storage refrigerator temperature be outside of the acceptable range (36-46 degrees) for any reason, the nurse is instructed to do the following as the stability or viability of the medication cannot equivocally be determined. 3) All nurses are in-serviced on how to manage and process when medication that are stored in refrigerators are observed outside of safe range when monitoring temperatures ranges. A. Acceptable storage range is 36-46 degrees. B. Monitor and document temperatures daily, should the temperature fall outside of the acceptable range, and the duration of the temperature loss cannot be confirmed all medication must be discarded immediately. C. Report any mechanical malfunction to maintenance promptly D. Call the pharmacy to replace any affected medication request STAT delivery E. Call the medical practitioner regarding any missed doses should they	

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F 761	Continued From page 3 that Resident #64 received [redacted] mg[redacted] ml Solution as ordered this morning and there were no other medications given out of the affected refrigerator. The LPN/UM described the process that should occur in the referenced situation was as follows: obtain the medications from the affected refrigerator, remove them, and store them in another refrigerator; then, try to determine how long the medications were out of appropriate temperature range, if possible. The LPN/UM stated that the LPN advised him that this process was completed earlier this morning. However, the LPN/UM acknowledged that he was unaware that the affected refrigerator temperature reached 80 F and that he must have misunderstood the situation earlier this morning, clarifying that he thought the temperature did not increase above 48 F at any point in time. He further acknowledged that he did not know how long the temperature remained at 80 F. The LPN/UM further stated that if the LPN noticed that the affected medications were warm, she should have removed them and repeated that he did not know how long the temperature of the affected refrigerator remained at 80 F, when asked by the surveyor. During an interview with the surveyor on 02/08/22 at 11:20 AM, the Director of Nursing (DON) addressed the process for dealing with deviations in medication refrigerator storage. She stated the medication should be removed from the affected refrigerator and stored in another refrigerator, until the affected refrigerator temperature returns to an acceptable range. She further stated there is no way of telling what the temperature was at any point in time, or for how long of a period it	F 761	occur, document any follow-up recommendations. If there are changes in orders it is mandatory to notify the resident□s responsible party. F. Daily monitoring of refrigerator temperatures will be completed daily by unit nurses and will be overseen by the Unit Manager or designee. Any abnormality will be reported promptly and included on daily report. 4) Daily Temperature logs will be audited weekly X 4, then monthly X 2, then Quarterly X 3. All audit results and any possible discrepancy will be presented to our monthly QAPI meetings.	

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F 761	Continued From page 4	F 761		

remained at a given temperature without seeing it, meaning there is no remote monitoring of medication refrigerator temperatures.

As a result, the DON stated it was important to immediately look at all items in the refrigerator and review the required temperatures and any permissible deviations of temperature for each of the items. If there is any uncertainty as to the viability of the medication(s) involved, it is necessary to discard them, and obtain new supplies from the pharmacy.

The process involved multiple staff members, including the LPN, LPN/UM, Assistant Director of Nursing (ADON), DON, and pharmacy staff. Finally, the DON acknowledged that if the process broke down, this would be a problem because the security (clarified as viability for use) of medication, cannot be determined and the affected medications may not be appropriate for use.

During a follow-up interview with the survey team on 02/08/22 at 12:17 PM, the DON confirmed that all the medications in the refrigerator were discarded and in the process of being replaced by the pharmacy. She reiterated that this procedure was completed because there is no way of knowing how long the medications were out of the temperature range, there is no remote monitoring of refrigerator temperatures, and the affected medications were possibly deteriorated.

A review of the Admission Record (Face Sheet) for Resident #64 did reveal diagnoses that included unspecified [redacted]

A review of the resident's current [redacted] physician

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F 761	Continued From page 5 orders revealed an order for [redacted] Solution [redacted] mg[redacted] ml, give [redacted] mg) orally three times a day for [redacted]. Further review of the physician's orders revealed Resident #64 was taking another medication for the treatment of [redacted], which was not affected by the referenced incident. A review of the Medication Administration Record revealed the [redacted] mg[redacted] ml was given as ordered on [redacted] at 9:00 AM. During an interview with the survey team on 02/09/22 at 11:04 AM, the DON and Administrator clarified the date on the refrigerator log, where the temperature of the affected refrigerator was recorded as 80 F. The referenced staff members advised the correct date was [redacted]" of the current year, not [redacted]" as documented. A review of the facility's "Policy & Procedure: Medication Refridgeration [Refrigerator] Storage" confirmed the storage of medication is a highly regulated and important subject, with the goal being safety of residents and the need for temperatures to be maintained at appropriate levels. The policy indicated a need to keep the refrigerator at temperatures between 36-46 F by checking the thermometer, which must be present, daily. A review of the manufacturer's guidelines for the storage of [redacted] mg/ml Solution revealed that it should be stored in a refrigerator, with a temperature range between 36 F to 46 F. NJAC 8:39-29.4(h)	F 761		
F 880 SS=F	Infection Prevention & Control	F 880		3/17/22

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F 880	Continued From page 6 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 7 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to implement personal protective equipment (PPE) according to the New Jersey Department of Health (NJ DOH) and Centers for Disease Control and Prevention (CDC) guidelines to minimize the potential spread of infection to residents on [redacted] units ([redacted]), b) ensure that staff wore proper PPE when caring	F 880	F880 1) Designated Infection Control Practitioner whose responsibility is to establish an infection prevention and control program that will ensure we provide a safe, sanitary, and comfortable environment that works to prevent the development and transmission of infections or communicable diseases.	

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F 880	Continued From page 8 for newly admitted residents who were under observation for sign/symptoms of [redacted], and c) minimize the potential spread of infection during [redacted] treatment for 1 of 1 nurses observed during [redacted] treatment observation on [redacted] units ([redacted]). This deficient practice was evidenced by the following: 1. On 02/02/22 at 11:50 AM, Surveyor #1 observed Certified Nursing Assistant (CNA) #4 making Resident #332's bed. Resident #332 was seated in a wheelchair next to the bed and the CNA handed the resident part of the bed sheet to assist in making the bed. CNA #4's PPE consisted of an N95 mask with a surgical mask over it. The CNA was not wearing eye protection. During an interview with Surveyor #1 on 02/03/22 at 10:28 AM, CNA #4 stated the required PPE on her assignment was an N95 mask with the option to wear a surgical mask over it and gloves during resident contact. The CNA further stated it was important to wear the correct PPE for infection control purposes. On 02/03/22 at 10:50 AM, Surveyor #1 observed CNA #5 enter Resident #26's room and ask the resident if he/she needed assistance going to the bathroom. The CNA and resident then entered the resident's bathroom together. CNA #5's PPE consisted of an N95 mask. The CNA was not wearing eye protection. During an interview with Surveyor #1 on 02/03/22 at 10:54 AM, CNA #5 stated the required PPE on her assignment was an N95 mask, eye protection, and gloves during resident contact.	F 880	A) Educate and supervise the facility regarding outbreaks, persons under investigation, resolutions of diseases or viruses, tracking infections and antibiotic stewardship and use surveillance and conduct route cause analysis as necessary. B) The IPCP will ensure there is an acceptable standard of practice and care in the execution of care and treatment among the staff to prevent the spread of infections. C)Handwashing, PPE usage which includes donning and doffing according to the correct standards. D) Education will reflect the most current guidelines as recommended by the CDC and NJDOH related Covid 19 management and guidance. The practitioner will monitor and institute infection control execution information to all staff. A LTC Infection Control Policy was conducted 2/20/2022. With a DPOC initiated 2/15/2022. A Root Cause analysis was completed identifying the breach by staff due to discrepancy in CDC timely notification of updated recommendations for covid precautions in effect 2/2/22. As well, routing education with monitoring needed to ensure staff remain compliant with requirements. 2) All residents can be affected by the facility failing to maintain a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all	

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F 880	Continued From page 9 The CNA then stated that she had goggles but left them at the nurses' station when she answered Resident #24's call light to assist with toileting. The CNA further stated that it was important to wear the correct PPE "because of the virus and other infectious things." On 02/03/22 at 10:59 AM, Surveyor #1 observed CNA #6 open the door to Resident #24's room and was bagging up trash and soiled linen. The CNA then assisted the resident with putting on his/her shoe. CNA #6's PPE consisted of an N95 mask with a surgical mask over it and gloves. The CNA was not wearing eye protection. During an interview with Surveyor #1 on 02/03/22 at 11:02 AM, CNA #6 stated the required PPE for her assignment was an N95 mask and gloves during resident contact. The CNA further stated that it was important to wear the correct PPE to "prevent contact with germs." On 02/03/22 at 12:15 PM, Surveyor #2 observed CNA #1 was wearing an N95 mask with a surgical mask over it. The CNA was not wearing eye protection. During an interview with the surveyor at this time, CNA #1 stated she wears an N95 mask with a surgical mask over it. She stated it is important to do so to avoid the spread of germs, during contact with residents. On 02/03/22 at 12:16 PM, Surveyor #3 observed the Registered Nurse/Unit Manager (RN/UM) assisting Resident #236 with the lunch meal near the nursing station. Surveyor #2 further observed that the RN/UM's PPE consisted of an N95 mask covered by a surgical mask. The RN/UM did not have on eye protection.	F 880	residents, staff, volunteers, visitors, and others providing care at Laurel Manor. 3) The Infection Control Practitioner or designee whose responsibility it is to review the latest guidelines and recommendations associated with infection control practices in nursing homes as directed by Centers for Disease Control and NJDOH. The infection prevention and control program (IPCP) practitioner's responsibility to review and update the Policy and Procedure Manual as changes occur. Auditing of proper PPE, [redacted] treatment, and handwashing to be completed weekly x8 then monthly x10. The results will be reported to QAPI committee and update ICP plan accordingly. A) Educate and supervise the facility regarding outbreaks, persons under investigation, resolutions of diseases or viruses, tracking infections and antibiotic stewardship and use surveillance. Mandatory in-services and video training with competency conducted. B) The IPCP will ensure there is an acceptable standard of practice and care in the execution of care and treatment among the staff to prevent the spread of infections. C) Handwashing, PPE usage which includes donning and doffing according to the correct standards. D) that will reflect the most current guidelines as recommended by the [redacted] guidance. The practitioner will monitor and institute infection control	

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F 880	Continued From page 10 On 02/03/22 at 12:18 PM, Surveyor #4 observed the Licensed Practical Nurse/Unit Manager (LPN/UM) sitting next to Resident #12 while [redacted] the resident in the [redacted] Unit dining room. The LPN/UM was wearing an N95 mask with no eye protection. On 02/03/22 at 12:22 PM, Surveyor #2 observed CNA #2 wearing an N95 mask and eyeglasses, but no eye protection. The CNA was feeding Resident #64 during this time. During an interview with the surveyor at this time, CNA #2 stated she wears an N95 mask. Sometimes they are provided with gowns and PPE, when it is necessary for COVID-19 protection. On 02/03/22 at 12:22 PM, Surveyor #4 observed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) sitting next to Resident # 13 while feeding the resident in the [redacted] Unit dining room. The ADON/IP was wearing a N95 mask with no eye protection During an interview with Surveyor #4 on 02/03/22 at 12:46 PM, the LPN/UM stated the required PPE for the [redacted] was an N95 mask and to wear gloves and a face shield when performing direct resident care. During an interview with the survey team on 02/03/22 at 1:13 PM, the ADON/IP stated the required PPE throughout the facility was an N95 mask. The ADON/IP then stated the COVID-19 Activity Level Index (CALI) score was "high" for the southwest region where the facility is located. When asked what the current transmission rate for Camden County (where the facility is located) was, the ADON/IP stated she was unsure how to obtain that information. The ADON/IP further	F 880	execution information to all staff. E) Auditing of proper PPE, [redacted] treatment, and handwashing to be completed weekly x8 then monthly x10. The results will be reported to QAPI committee and update ICP plan accordingly. 3A) A Root Cause analysis was completed identifying the breach by staff due to discrepancy in CDC timely notification of updated recommendations for covid precautions in effect 2/2/22. As well, routing education with monitoring needed to ensure staff remain compliant with requirements. The following inservice videos have been watched by both top line staff and all lines staff in each department. Keep Covid-19 Out! https://www.youtube.com/watch?v=7srwrF9MGdw&ab_channel=CentersforDiseaseControlandPrevention%28CDC%29 Closely Monitor Residents https://www.youtube.com/watch?v=1ZbT1Njv6xA&ab_channel=CentersforDiseaseControlandPrevention%28CDC%29 Use PPE Correctly for COVID-19 https://www.youtube.com/watch?v=YYTATw9yav4&ab_channel=CentersforDiseaseControlandPrevention%28CDC%29 Clean Hands https://www.youtube.com/watch?v=xmYMUly7qiE The following Modules was used for education to all staff employed by Laurel Manor. https://www.train.org/main/course/1081350/ Module 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. BUILDING _____ B. WING _____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11 stated that it was important for staff to wear the correct PPE because they give direct care to the residents and the correct PPE "prevents exposure to the residents and staff." Review of the current CALI report for the southwest region of NJ, provided by the ADON/IP on 02/03/22 at 1:46 PM, indicated the activity level was "high." Review of the current CDC COVID Data Tracker for Camden County, provided by the ADON/IP on 02/03/22 at 2:09 PM, indicated the transmission rate was "high." Review of the NJ DOH Executive Directive 20-026 included, "Facilities shall implement universal eye protection, in addition to source control and other infection prevention and control measures, for all staff and for compassionate care or essential caregiver visitors unable to maintain social distancing when the NJDOH CALI Level is Very High/High or Moderate." Review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidelines, revised 02/02/22, revealed the "Implement Universal Use of Personal Protective Equipment" section was last updated on 02/10/21 and included, "If SARS-coV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP [healthcare professionals] working in facilities located in counties with substantial or high transmission should also use PPE as described below: ... Eye protection (i.e. goggles or a face shield that covers the front and sides of the face) should be	F 880	https://www.train.org/main/course/1081802/ Module 4 https://www.train.org/main/course/1081803/ Module 5 https://www.train.org/main/course/1081804/ Module 6A https://www.train.org/main/course/1081805/ Module 6B https://www.train.org/main/course/1081806/ Module 7 https://www.train.org/main/course/1081815 Module 11B 4) The Administrator/DON or designee to audit and review ICP practices monthly or as changes occur and include monthly audit results to our QAPI meeting which occur monthly and mandated meeting quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. BUILDING _____ B. WING _____	02/09/2022

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F 880	Continued From page 12	F 880		

worn during all patient care encounters."

2. On 02/02/22 at 2:59 PM, Surveyor #3 observed a staff member in a resident's room while on the persons under investigation for COVID-19 (PUI) unit. The surveyor observed a yellow sticker tab next to the room number (yellow tab), a bin containing PPE next to the doorway and signage posted indicating the room was a PUI room. Surveyor #3 further observed the staff member sitting next to the resident's bed within six feet of the resident. The staff member's PPE consisted of an N95 mask and gown. Surveyor #3 further observed that the staff member did not don on eye protection or gloves prior to entering the PUI room.

Upon exiting the PUI room at 3:16 PM, Surveyor #3 conducted an interview with the staff member, who identified herself as the Director of Social Services (DSS). The DSS stated that the yellow tab indicated the residents were recently admitted and considered PUI. The DDS stated the required PPE to enter a PUI room was a gown, an N95 mask, and goggles over glasses. When asked why she did not don on eye protection prior to entering a PUI room, the DDS acknowledge that she did not have on goggles over her glasses and responded, that she just happened to step in the resident's room quickly.

During an interview with Surveyor #3 on 02/03/22 at 12:29 PM, the RN/UM stated they followed a color code system to determine the required PPE needed to enter a resident's room. The RN/UM stated that green-tabbed rooms required standard precautions and N95 masks; yellow- and red-tabbed rooms required full PPE which

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	315008	A. BUILDING _____ B. WING _____	02/09/2022

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F 880	Continued From page 13	F 880		

included goggles, N95 masks, gowns and gloves. The RN/UM further stated it was important to wear the proper PPE for infection control and to protect from getting COVID-19.

During an interview with Surveyor #3 on 02/04/22 at 10:55 AM, the ADON/IP stated she expected staff to don the appropriate PPE when entering PUI rooms. The ADON/IP further stated the required PPE for PUI room was a gown, gloves, an N95 mask, goggles, or face shield.

On 02/07/22 at 12:13 PM, Surveyor #3 observed a staff member in a resident's room on the PUI unit. Surveyor #3 observed a yellow tab next to the room number, a bin containing PPE next to the doorway and signage posted indicating the room was a PUI room. The staff member was within six feet of the residents and was observed touching the curtains while in the resident's room. The staff member's PPE consisted of an N95 mask and goggles. The staff did not have on a gown or gloves while assisting the residents in the PUI room.

Upon exiting the PUI room at 12:16 PM, Surveyor #3 conducted an interview with the staff member, who identified herself as a CNA (CNA #7). CNA #7 stated the required PPE for PUI rooms was an N95 mask, gown, gloves, and face shield or goggles. CNA #7 further stated it was important to wear proper PPE in PUI rooms for contact precautions.

A review of the facility's undated "Prevention and Control of COVID-19" policy, revealed that infection prevention and control recommendations for PUI included to adhere to standard, contact, droplet, and airborne

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. BUILDING _____ B. WING _____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	18 W LAUREL ROAD STRATFORD, NJ 08084

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F 880	Continued From page 14 precautions, including the use of eye protection. 3. On 02/02/22 at 3:10 PM, Surveyor #3 observed Resident #15 in bed with the head of bed slightly elevated. Resident #15 was alert and able to verbalize simple needs. At which time, the resident granted Surveyor #3 permission to observe the [redacted] treatment. On 02/08/22 at 10:15 AM, Surveyor #3 observed the Licensed Practical Nurse (LPN), with the assistance of the RN/UM, complete the [redacted] dressing change for Resident #15. The RN/UM assisted the LPN to reposition the resident onto his/her left side. During the dressing change, Surveyor #3 observe the LPN cleanse the [redacted] with gauze, ball the soiled gauze into a ball, touched the overbed table and curtain, then placed the soiled gauze into a plastic trash bag that was taped to the side of the overbed table. Surveyor #3 did not observe the LPN remove her gloves or perform hand hygiene after touching the overbed table and the curtain. The LPN continued the treatment and picked up a pair of scissors, opened an alcohol pad, wiped down the scissors, and opened/cut a piece of [redacted] Surveyor #3 observed the LPN touched the curtain as she placed the wrappers into the plastic trash bag. Surveyor #3 did not observe the LPN remove her gloves or perform hand hygiene after touching the curtain. The LPN continued the treatment and applied the	F 880		

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F 880	Continued From page 15	F 880		

calcium alginate to the resident's [redacted] and covered it with border gauze.

After the completing the [redacted] dressing change, the LPN removed her gloves and washed her hands. Surveyor #3 observed the LPN applied friction for five seconds outside the stream of water. When interviewed at that time, Surveyor #3 interviewed the LPN regarding her normal process for hand washing. The LPN stated the proper procedure for hand washing was to apply friction for 20 seconds outside the stream of water. The LPN further stated that she forgot to sing the "Happy Birthday Song."

During a follow up interview with Surveyor #3 on 02/08/22 at 10:29 AM, the RN/UM stated that she expected staff to apply friction for 20 seconds outside the stream of water.

During an interview with Surveyor #3 on 02/08/22 at 12:23 PM, the Director of Nursing (DON) stated that she expected staff to turn on the water, wet hands, apply soap, and wash hands for 20 seconds of friction outside the stream of water. The DON further stated that proper hand washing was important for infection control and was the number one way to prevent the spread of infections.

A review of the facility's undated "[redacted] Care" policy indicated that the licensed nurse would provide[redacted] care using aseptic technique (using practices and procedures to prevent contamination from pathogens). The policy further indicated to use universal precautions on every resident to prevent cross-contamination.

A review of the facility's undated

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 880	Continued From page 16 "Handwashing/Hand Hygiene" policy indicated to create friction to all surfaces for 20 seconds under a moderate stream of running water. The CDC (Centers For Disease Control) Guideline for Hand Hygiene in Healthcare Settings recommends "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet." NJAC 8:39-19.4	F 880		

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	060405	A. BUILDING: _____ B. WING _____	02/09/2022

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 14 of 14-day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	S560 1) The staffing coordinator was educated on the required minimum direct care staff-to- resident ratios as mandated by the state of New Jersey. The facility will continue to reach out to existing staff to see if they want to pick up overtime shifts and continue to try and staff accordingly 2) All residents have the ability to be affected by the facility failing to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey.	2/17/22

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

Electronically Signed | 02/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060405	A. BUILDING: _____ B. WING _____	02/09/2022

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. Review of Certified Nursing Assistant (CNA) assignment sheet for the Upper Willow and Lower Willow Units revealed there were five CNAs assigned on the 7:00 AM-3:00 PM day shift for 02/03/22. Review of the Midnight Census Report, printed by the facility on 02/03/22 at 12:28 PM, revealed there was currently 32 residents on the Upper Willow Unit and 33 residents on the Lower Willow Unit, for a total of 65 residents assigned to five CNAs (1 CNA to 13 residents). Further review of the CNA assignment sheet and Midnight Census Report for the Upper and Lower Willow Units revealed CNA #4 was assigned to 11 residents, CNA #5 was assigned to 13 residents, and CNA #6 was assigned to 14 residents. During an interview with Surveyor #1 on 02/03/22 at 10:54 AM, CNA #5 stated that she was assigned to 13 residents and that she typically	S 560	3) The facility will continue to post job openings on job sites to promote CNA openings The facility is offering a sign on bonus The facility has contracted with agency to assist with our staffing needs The administrator/designee will review the daily staffing sheets weekly x 4 then monthly for 3 months and quarterly thereafter. 4) The Administrator/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits.	

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	060405	A. BUILDING: _____ B. WING _____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2	S 560		

had nine to 10 residents on her assignment. The CNA further stated that she will not have enough time to get her work done if there are less than five CNAs assigned to the Upper and Lower Willow Units.

During an interview with Surveyor #1 on 02/03/22 at 11:02 AM, CNA #6 stated that she was assigned to 11 residents and that she typically had eight residents on her assignment.

During an interview with Surveyor #1 on 02/03/22 at 11:11 AM, CNA #4 stated she was assigned to 12 residents and that she typically had 12 residents on her assignment. The CNA further stated that she can get her work done, but "not at the timely manner that the residents want."

During an interview with the Surveyor #3 on 02/03/22 12:15 at PM, CNA #1 stated that she had 16 residents on her assignment and there are usually 12-20 residents on her assignment. She stated that she can get her work done, but it often requires missing breaks.

During an interview with the Surveyor #3 on 02/03/22 at 12:22 PM, CNA #2 stated that she has 14 residents on her assignment and there are usually 12-15 residents on her assignment. She stated she can get her work done, but it requires working very hard.

A review of the CNA Assignment Sheet revealed that CNA #1 had 15 residents on her assignment and CNA #2 had 14 residents on her assignment.

During an interview with the Surveyor #2 on 02/03/22 at 12:16 PM, CNA #3 stated he had 9 residents on his assignment. CNA #3 further stated that they normally would have three CNAs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060405	A. BUILDING: _____ B. WING _____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 on this unit (Redwood). CNA #3 further stated that if you have too many residents on your assignment, it makes it hard to get things done. A review of the CNA assignment sheet for the Redwood Unit revealed two CNAs were assigned nine residents and one CNA was assigned 10 residents for the day shift for 02/03/22. The surveyor requested staffing for weeks of 01/16/22 and 01/29/22. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -01/16/22 had 7 CNAs for 89 residents on the day shift, required 12 CNAs. -01/17/22 had 9 CNAs for 87 residents on the day shift, required 11 CNAs. -01/18/22 had 9 CNAs for 86 residents on the day shift, required 11 CNAs. -01/19/22 had 8 CNAs for 86 residents on the day shift, required 11 CNAs. -01/20/22 had 9 CNAs for 86 residents on the day shift, required 11 CNAs. -01/21/22 had 7 CNAs for 86 residents on the day shift, required 11 CNAs. -01/22/22 had 8 CNAs for 90 residents on the day shift, required 12 CNAs. -01/23/22 had 8 CNAs for 90 residents on the day shift, required 12 CNAs. -01/24/22 had 8 CNAs for 90 residents on the day shift, required 12 CNAs. -01/25/22 had 6 CNAs for 90 residents on the day shift, required 12 CNAs. -01/26/22 had 8 CNAs for 90 residents on the day shift, required 12 CNAs.	S 560		

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S 560	Continued From page 4 -01/27/22 had 9 CNAs for 90 residents on the day shift, required 12 CNAs. -01/28/22 had 9 CNAs for 90 residents on the day shift, required 12 CNAs. -01/29/22 had 7 CNAs for 90 residents on the day shift, required 12 CNAs. During an interview with Surveyor #4 on 02/08/22 at 09:46 AM, the Staffing Coordinator stated that she was unsure of the mandated staffing ratios. During an interview with Surveyor #4 on 02/08/22 at 11:44 AM, the Administrator stated that he was aware of the mandated staffing ratios. He further stated that he's been trying to meet these ratios as much as possible and implemented programs such as bonuses, referrals, and retention programs. NJAC 8:39-5.1(a)	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. BUILDING **02** B. WING _____	**02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	**18 W LAUREL ROAD** **STRATFORD, NJ 08084**

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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 2/07/2022 and Laurel Manor Healthcare and Rehabilitation Center 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 Occupancies. Laurel Manor Healthcare and Rehabilitation Center is a two (2) story, Type I Protected building that was built in January 1969. The facility is divided into 7 smoke zones.	K 000		
K 241 SS=F	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by:	K 241		3/14/22

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

Electronically Signed | 03/16/2022

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
	315008	A. BUILDING **02** B. WING _____	**02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	**18 W LAUREL ROAD** **STRATFORD, NJ 08084**

(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 241	Continued From page 1 Based on observation and review of pertinent facility documentation on 02/07/2022, in the presence of facility management, it was determined that the facility failed to provide at least two exits, remote from each other, for each floor or fire section of the building. This deficient practice was evidenced by the following: At 9:28 AM, a request was made to the facility's Administrator and Corporate Director of Facilities (CDOF) to provide a copy of the facility layout which identifies the various rooms in the facility for the first and second floors. The surveyor also asked if the facility had any waivers for the facility. The Administrator said, "Yes, a time limited waiver for the second floor." Starting at 9:31 AM, in the presence of the facility's CDOF and Maintenance Staff (MS), an inspection of the building was conducted. During this inspection at 1:20 PM, the surveyor, Administrator and CDOF observed that there were only one means of egress from the 2nd floor. This exit consisted of a single stairway to the 1st floor. During an interview, at the time, the Administrator stated the 2nd floor is an administration area only, is fully sprinklered, and has a heat detection/fire alarm system. The only door to the 2nd floor remains locked at all times from resident access by an electronic key-coded lock with an additional push-button release behind the reception desk. The Administrator was informed of the finding at	K 241	Requesting a time limited waiver to construct a 2nd exit for the 2nd story. anticipated completion for the second stairwell date of 12/31/2025. Please note, the spoken second story compartment is restricted access with a keypad and only designated select employees can enter that location. Please note, Monthly fire checks are conducted, and will be increased to 2x monthly. Education will be provided quarterly regarding this specific area. Please note any discrepancies will be brought to the attention of the QAPI team Which meets Monthly.	

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K 241	Continued From page 2 the Life Safety Code exit conference on 02/07/2022.	K 241		
K 363 SS=D	NJAC 8:39 - 31.2(e) Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		3/16/22

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	315008	A. BUILDING **02** B. WING _____	**02/09/2022**

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K 363	Continued From page 3 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on interview and observation on 02/07/2022, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of room doors with penetrations restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 2 of 65 resident room/office corridor doors and was evidenced by the following: Starting at 9:31 AM in the presence of the facility's Corporate Director of Facility (CDOF) and Maintenance Staff (MS) an inspection of the building was conducted. During this inspection the surveyor observed two (2) corridors that had penetrations through the door in the following locations: 1. At 12:51 PM, the surveyor observed the corridor door leading into the Physical Therapy room had three (3) holes drilled through the door. The surveyor measured and recorded one hole was 1" in diameter and two holes were 1/2" in diameter. 2. At 12:53 PM, the surveyor observed the corridor door leading into the Trash and Soiled Linen closet had three (3) holes drilled through	K 363	S363 1)The Maintenance Director and assistant was educated on the importance and requirements of fire safety as well, the importance of ensuring there are no door penetrations. Both the trash room door and therapy room door have metal plate covering the holes. 2)All residents have the ability to be effected by this practice of fire doors with penetrations. 3)The Maintenance Director or Designee will audit all doors. As well, any closet doors to ensure there are no penetration's to ensure the maximum safety. 4)The Maintenance Director or Designee will audit all doors as well, any closet doors to ensure there are no penetration's to ensure the maximum safety, weekly x 4 then monthly x 2 then quarterly x 3. As well, any closet doors to ensure there are no penetration's to ensure the maximum safety. The Administrator or Designee will audit the above in intervals weekly x4 monthly x2 quarterly x3. All finding will be addressed immediately and reported to	

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K 363	Continued From page 4 the door. The surveyor measured and recorded one hole was 1" in diameter and two holes were 1/4" in diameter. Both corridor doors appeared to have the door knob hardware removed and replaced with combination door locks that were installed on the doors. The CDOF and MS confirmed the findings at the time of observations. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The Administrator was informed of the finding at the Life Safety Code exit conference on 02/07/2022. NJAC 8:39-31.1(c), 31.2(e)	K 363	QAPI committee which meets monthly.	