STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 Complaint #s: NJ172327, NJ172547, NJ173349, NJ180343, Survey Date: 1/31/25 Census: 62 Sample: 16 + 3 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		2/28/25

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

Electronically Signed | 02/21/2025

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
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and review of other pertinent documentation, it was determined that the facility failed to treat all residents in a dignified manner by failing to provide a resident with respect and dignity during wound care. This deficient practice was identified 1 of 16 residents reviewed (Resident #231). The deficient practice was evidenced by the following: On 1/27/25 at 11:12 AM, the surveyor observed Resident #213 in their room. The resident was observed with a NJ Ex Order 26.4b1 . During the interview the resident stated they had NJ Ex Order 26.4b1 prior to coming into the facility. Resident #231 was	F 550	1. On 1/28/25, the Director of Nursing (DON) spoke with resident #231 regarding the nurse writing the date on NJ Ex Order 26.4b1 that was affixed to the resident's NJ Ex Order 26.4b1 after the treatment was completed. The DON asked if the treatment can be redone, but resident #231 refused and stated that it has already been completed. The DON met with the Registered Nurse #1 and educated her regarding her deficient practice of writing the date and her initials on NJ Ex Order 26.4b1 that is already affixed on the resident's NJ Ex Order 26.4b1. 2. All residents have the potential to be affected, especially those residents who require wound care and were treated by the registered nurse #1 on the same date. The DON and designee reviewed the list	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 550	Continued From page 2 agreeable to allow the surveyor to observe the NJ Ex Order 26.4b1 . A review of Resident #231 medical record revealed that the resident had diagnosis that included but were not limited NJ Ex Order 26.4b1 A review of the admission MDS, (an assessment tool used to facilitate the management of care) with an assessment reference date of NJ Ex Order 26.4b, revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated the resident is NJ Ex Order 26.4b1. A review of the NJ Ex Order 26.4b1 Physician Orders Sheet (POS) revealed an order NJ Ex Order 26.4b1. The PO was dated NJ Ex Order 26.4b1 On 1/28/25 at 11:51 AM, the surveyor observed the Registered Nurse (RN#1) NJ Ex Order 26.4b1 on Resident #231's NJ Ex Order 26.4b1. The surveyor then observed RN #1 write a date and her initials with a pen directly on the resident's NJ Ex Order 26.4b1 which had already been placed on the residents NJ Ex Order 26.4b1). Surveyor asked RN #1 if writing the date and her initials on NJ Ex Order 26.4b1 while on the resident provided the resident dignity and respect? RN #1 stated, she should have written the date and her initials on a separate NJ Ex Order 26.4b1 and then place that on the resident's NJ Ex Order 26.4b1.	F 550	of residents who were treated by the registered nurse, on the same date. Four residents were noted to have the date and the registered nurse #1 initials on the tape on the wound site, the DON offered to re-do the treatments on those residents. All the residents declined to have their dressings to be re-done. 3. The DON provided education to all the licensed nurses on how to appropriately document the date of treatment. The date and initials must be written on the label prior to application. The nurses were educated on F550- Residents Rights/Exercise of Rights. 4. The DON, and/or designee, will conduct 4 treatment audits weekly x 4, monthly x 3 and quarterly x 2 with the licensed nurses to assure that the licensed nursing staff are documenting the date of treatment appropriately by dating and initialing the label prior to application. The DON will report the findings of the audits during the QAPI meetings. The QAPI committee will determine if it requires continuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 550	Continued From page 3 On 1/29/25 at 9:50 AM, the US FOIA (b)(6) provided the surveyor with a facility policy titled, Quality of Life - Dignity with a revised date of 1/24/24. Under the procedure section of the policy it states, "1. Resident shall be always treated with dignity and respect. 2. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth ...11. Demeaning practices and standards of care that compromise dignity are prohibited." On 1/29/25 at 12:32 PM, the US FOIA (b)(6)) and US FOIA (b) met with the survey team to review concerns found during the survey. The US FOIA (b)(6) stated RN #1 did not follow the correct procedure for initialing and dating for a resident's NJ Ex Order 26.4 and would in-service the staff. No further comments provided. On 1/30/25 at 2:00 PM, the survey team met with the US FOIA (b)(6) for the exit conference. The facility did not provide any further pertinent information.	F 550		
F 582 SS=B	NJAC 8:39-4.1(a)(12)(28), 17.3(c), 17.4(d) Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the	F 582		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 582	Continued From page 4 facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 582	Continued From page 5 behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to issue the required Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) for 2 of 3 residents (Resident #8 and Resident #41) reviewed. The SNF ABN provides information to beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. If the SNF provides the beneficiary with the SNF ABN, the facility has met its obligation to inform the beneficiary of his or her potential financial liability and related standard claim appeal rights. On 1/27/25 at 10:51 AM, the facility provided the surveyor with a list of residents who were discharged from the facility within the [NJ Ex Order 2] [redacted] and should have received the SNF ABN form. The surveyor reviewed Resident #8 and Resident #41 who were listed discharged from Medicare Part A coverage stay and were documented that they remained in the facility. 1. Resident #8 was admitted to the facility on [NJ Ex Order 28.4b1]. The last documented covered day from Medicare Part A service was [NJ Ex Order 26.4b]. A review of the form titled, "SNF Beneficiary Notification Review" that was filled out by the facility's [US FOIA (b)(6)] [redacted] indicated the SNF ABN was not provided to the resident. There was no additional documentation about the	F 582	1. The Director of Social Service filled out and provided copies of the completed SNF ABN to residents #8 and #41. 2. All residents have the potential to be affected by this deficiency, particularly residents who have been discharged from the Medicare A services and into long term care in the facility, or another facility. The Administrator and the Director of Social Service reviewed the list of discharged residents, and those who stayed in the facility for long term care were reviewed. The residents without SNF ABN were provided with a complete document by the Director of Social Services. 3. The Administrator provided education to the [US FOIA (b)(6)] [redacted] about the importance of completing the SNF ABN and its purpose. 4. The Director of Social Service will provide the list of discharged residents and copies of their SNF ABN to the administrator once weekly. The Director of Social Services will report the information during the QAPI meetings weekly x4, monthly x3, then quarterly x2. The QAPI committee will determine if it requires continuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 582	Continued From page 6 communication of these forms to the resident or the resident's representative. 2. Resident #41 was admitted to the facility on [NJ Ex Order 26.4b]. The last documented covered day from Medicare Part A service was [NJ Ex Order 26.4b]. A review of the form titled, "SNF Beneficiary Notification Review" that was filled out by the facility's [US FOIA (b)] indicated the SNF ABN was not provided to the resident. There was no additional documentation about the communication of these forms to the resident or the resident's representative. On 1/30/24 at 1:31 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated to the surveyor the SNF ABN form did not have to be issued when residents remain in the facility after Medicare A's last covered day service. The [US FOIA] stated she was responsible to send the notices of Medicare non-coverage forms and the have them signed and the ABN forms. She further stated that she should have sent the ABN forms to the residents and or the families. She further stated that she was aware that there were new ABN forms, and she needed to review them. On 1/29/25 at 12:33 PM, the surveyor discussed the above concerns with the facility's [US FOIA (b)(6)] and the [US FOIA (b)(6)] and [US FOIA (b)(6)]. There was no additional information provided.	F 582		
F 657 SS=E	NJAC 8:39-4.1(a)(8) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 657	Continued From page 7 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise the comprehensive care plans (CP) for 2 of 15 residents reviewed (Resident #35 and #13). This deficient practice was evidenced by the following: 1. On 1/27/25 at 11:00 AM, the surveyor observed Resident #35 sitting in the wheelchair inside the recreation room, NJ Ex Order 26.4b1 the surveyor's inquiry.	F 657	1. Resident# 35's care plan was reviewed and amended to reflect the discontinuation of the use of NJ Ex Order 26.4b1 [redacted]. The care plan was also updated to reflect that the resident is currently on NJ Ex Order 26.4b1 that started on NJ Ex Order 26 [redacted]. The cup of water found in resident #13's room was removed immediately. The unit manager in-serviced the nursing staff in ensuring that residents NJ Ex Order 26.4b1 do not have access to extra water/ liquid	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

(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 657	Continued From page 8 On 1/27/25 at 1:25 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #35, which revealed the following: A review of the Face Sheet (FS; an admission summary) reflected that Resident #35 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4b1 [redacted]. A review of the recent quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care) dated NJ Ex Order 26.4b indicated that the facility assessed the residents' cognitive status, with a Brief Interview for Mental Status (BIMS) score NJ Ex Order 26.4b of 15, indicating that the resident had NJ Ex Order 26.4b1 cognition. A further review of the Q/MDS revealed that the resident received NJ Ex Order 26.4b1 medications on a routine basis. A review of the most recent Physician Order Sheet (POS) reflected a physician's order of the following medications: 1. NJ Ex Order 26.4b1 daily with an order date of NJ Ex Order 26.4b and discontinued on NJ Ex Order 26.4b1 2.NJ Ex Order 26.4b1. by mouth daily with an order date of NJ Ex Order 26.4b1. A review of the resident's individualized person-centered care plan (CP) with an effective date of NJ Ex Order 26.4b1 reflected under problems that "I am at risk for complications related to the use of NJ Ex Order 26.4b1. I am NJ Ex Order 26.4b1." The goal reflected that the	F 657	in their rooms . The registered dietitian educated the resident's on 1/30/2025 regarding their NJ Ex Order 26.4b1. Resident #13 expressed not wanting to be NJ Ex Order 26.4b [redacted]. Unit Manager called resident's physician and physician agreed to discontinue NJ Ex Order 26.4b1, and to allow the resident to self-limit NJ Ex Order 26.4b1 [redacted] The care plan was amended to reflect the resident's preference to no longer be NJ Ex Order 26.4b1 2. All residents have the potential to be affected by this deficient practice. The Director of Nursing (DON) and Unit Managers reviewed care plans for all residents who are currently in the facility to ensure that the care plans reflect all the appropriate changes in the residents medication orders and preference changes. 3.The DON in-serviced the licensed nursing staff to amend care plans when needed, specifically in changes in medications and resident's preferences, to ensure that the deficient practice no longer recur. The DON also in-serviced the licensed nursing staff in listening and advocating to the resident's preferences and needs and to communicate it with the resident's physician/provider. 4. The DON, and/or designee, will conduct care plan audits weekly x 4, monthly x 3 and then quarterly x 2. In addition, the DON will audit residents with dietary restrictions, particularly residents on fluid restrictions. The DON will report	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 657	Continued From page 9 resident would have no complications related to the use of NJ Ex Order 26.4b1 in the next 90 days. Further review of the CP does not reflect the discontinued use of NJ Ex Order 26.4b1 and the use of the NJ Ex Order 26.4b1, with a start order of NJ Ex Order 26. On 1/29/25 at 11:30 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the above concern but did not provide further information. 2. On 1/27/25 at 11:35 AM, the surveyor observed Resident #13 lying in bed, alert and awake. The surveyor observed that the resident had a cup of water on the table. Resident #13 stated they have NJ Ex Order 26.4b1 Tuesday, Thursday, and Saturday pick-up at 10:00 am. On 01/30/25 at 09:05 AM, the surveyor observed Resident #13 awake and had just finished breakfast. The surveyor observed that the resident had a 16-ounce cup of water on the table. The resident was aware that they were NJ Ex Order 26.4b1 and added that they were NJ Ex Order 26.4b1 with the NJ Ex Order 26.4b1 On 1/29/25 at 1:18 PM, the surveyor reviewed the hybrid medical record of Resident #13, which revealed the following: A review of the FS reflected that Resident #13 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4b1).	F 657	the information during the QAPI meetings weekly x4, monthly x3, then quarterly x2. The QAPI committee will determine if it requires continuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 657	Continued From page 10 A review of the recent Q/MDS, dated NJ Ex Order 26.4b, indicated that the facility assessed the residents' cognitive status using a BIMS score NJ Ex Order 26.4b1 of 15, which indicated that the resident had NJ Ex Order 3 A review of the most recent POS reflected a physician's order of NJ Ex Order 26.4b1 hours with an order date of NJ Ex Order 26.4b1. A review of the resident's individualized person-centered CP with an effective date of NJ Ex Order 26.4 to present reflected under problems, NJ Ex Order 26.4b1 on Tuesday, Thursday, and Saturday." Further review of the CP does not indicate that the residents are NJ Ex Order 26.4b1. On 1/30/25 at 9:10 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the above concern. The US FOIA (b) stated that he knew the resident was NJ Ex Order 26.4b1 and would give the resident the NJ Ex Order 26.4b1. He added that the resident would ask for NJ Ex Order 26.4b1, and he felt bad about it. The US FOIA (b) revealed that the resident had been NJ Ex Order 26.4b1 since entering the facility. On 1/30/25 at 10:31 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the above concern. The US FOIA (b) stated that the resident has a history of NJ Ex Order 26.4b1 A review of the facility policy titled "Resident Care Plan" with the revised date of October 2024 stated under Procedure: The resident care plan will reflect the resident's expressed wishes	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 657	Continued From page 11 regarding care and treatment goals. The resident has the right to refuse to participate in the development of his/her care plan and medical nursing treatments. When such refusal are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies. 1. Resident care plan will be developed for all care planning issues including but not limited to: c. Resident's risk factors...d. Resident's needs..." NJAC-8:39 11.1 NJAC 8:39-27.1(a)	F 657		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 758	Continued From page 12 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to consistently monitor, document, and evaluate the ongoing benefits of continued use of NJ Ex Order 26.4b1 for 3 of 5 residents reviewed for unnecessary medications (Resident #3, #4, and #35). This deficient practice was evidenced by the following: 1. On 1/27/25 at 10:43 AM, the surveyor	F 758	1. Resident #3 medical record was reviewed by the Director of Nursing (DON) and Unit Manager. The order for NJ Ex Order 26.4b1 by mouth daily and NJ Ex Order 26.4b1 was changed to include the resident□s NJ Ex Order 26 . The DON and Unit Manager reviewed and amended the care plan for resident #3 to include NJ Ex Order 26.4b1 to decrease NJ Ex Order 26.4b1 symptoms associated with the resident□s diagnosis	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 758	Continued From page 13 observed Resident #3 out of bed to the wheelchair inside the activity room, [redacted] the surveyor's inquiry. On 1/29/25 at 11:33 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #3, which revealed the following: A review of the Face Sheet (an admission summary) reflected that Resident #3 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4b1 [redacted]. A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) dated [redacted] indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score [redacted] out of 15, which indicated that the resident had NJ Ex Order 26.4b1. A further review of the A/MDS revealed that the resident received NJ Ex Order 26.4b1 [redacted] on a routine basis. A review of the most recent Physician Order Sheet (POS) with the start date of [redacted] reflected a physician order of the following: 1. NJ Ex Order 26.4b1 [redacted] one time daily, and the order was discontinued on [redacted] and increase the dosage to NJ Ex Order 26.4b1 [redacted] one time daily for NJ Ex Order 26.4b1 [redacted] and 2. NJ Ex Order 26.4b1 is given one tablet by mouth for [redacted] There was no further documentation to reflect	F 758	of [redacted] Resident #4 medical record was reviewed by the DON and Unit Manager. The order for NJ Ex Order 26.4b1 was amended to include the NJ Ex Order 26.4b1. The care plan was changed to reflect the specific [redacted] and non-pharmacological interventions to decrease symptoms associated with the resident□s diagnosis of NJ Ex Order 26.4b1 Resident #35 medical record was reviewed amended to include [redacted] daily, NJ Ex Order 26.4b1 [redacted] and as needed. The care plan was changed to reflect the residents□ NJ Ex Order 26.4b1 and non-pharmacological interventions. 2. All residents have the potential to be affected by this deficient practice, particularly those who receive psychotropic medications. The DON and Unit Managers reviewed all the medical records of the residents with orders for psychotropic medications. The orders were changed to include target behavior for the specific resident and non-pharmacological interventions 3. The DON and designee in-serviced the licensed nursing staff on the importance of including the resident specific target behavior for all psychotropic medications. The licensed staff were also in-serviced to make sure that the care plan of each resident includes the target behavior and non-pharmacological interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 758	Continued From page 14 that the resident was being monitored routinely with the use NJ Ex Order 26.4b1 after the increase of dosage of NJ Ex Order 26.4b1 from NJ Ex Order 26.4b1 . A review of the NJ Ex Order 26.4b1 Medication Administration Record (MAR) revealed that the nurses signed that Resident #3 was administered NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 at 8:00 PM and NJ Ex Order 26.4b1 daily for NJ Ex Order 26.4b1 at 9:00 PM. The NJ Ex Order 26.4b1 MAR did not reflect the NJ Ex Order 26.4b1 and potential side effects of the NJ Ex Order 26.4b1 . A review of the recent NJ Ex Order 26.4b1 Progress Note dated NJ Ex Order 26.4b1 revealed under assessment/plan to continue to NJ Ex Order 26.4b1 for changes. A review of the resident's individualized person-centered care plan (CP) with an effective date of NJ Ex Order 26.4b1 to present reflected under problems that the resident is NJ Ex Order 26.4b1 for complications related to the NJ Ex Order 26.4b1 medication used. The goal reflected that the resident would have no complications for 90 days. The interventions included administering the medications as ordered by the physician, monitoring for adverse reactions, and monitoring NJ Ex Order 26.4b1 every shift. The CP did not reflect specific NJ Ex Order 26.4b1 for the use of NJ Ex Order 26.4b1 medication and non-pharmacological interventions to NJ Ex Order 26.4b1 associated with NJ Ex Order 26.4b1 of the resident. On 1/29/25 at 11:30 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the above concern. The US FOIA (b)(6) revealed that the nurses documented the NJ Ex Orde	F 758	4. The DON, or designee, will conduct 5 audits of residents receiving psychotropic medication weekly x 4, monthly x 3 and quarterly x 2, to make sure that the target behavior for the specific resident is included in the orders and in the care plan, including the non-pharmacological interventions. The DON will report the information during the QAPI meetings. The QAPI committee will determine if it requires continuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 758		F 758		

Continued From page 15

effects only if the resident had a side effect but did not provide documentation of the NJ Ex Order 26.4b1 [redacted].

2. On 1/27/25 at 10:01 AM, the surveyor observed Resident #4 sitting in the wheelchair inside the room, NJ Ex Order 26.4b1 the surveyor's inquiry.

On 1/27/25 at 11:29 AM, the surveyor reviewed the hybrid medical record of Resident #4, which revealed the following:

A review of the FS reflected that Resident #4 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4b1 [redacted]).

A review of the recent quarterly Minimum Data Set (Q/MDS) dated NJ Ex Order 26.4b1 indicated that the facility assessed the residents' cognitive status, with a BIMS score NJ Ex Order out of 15, indicating that the resident had NJ Ex Order 26.4b1. A further review of the Q/MDS revealed that the resident received NJ Ex Order 26.4b1 on a routine basis.

A review of the most recent POS with the start date of NJ Ex Order 26.4b reflected a physician's order of NJ Ex Order 26.4b1 to give one tablet by mouth NJ Ex Order 26.4b1.
A review of the NJ Ex Order 26.4b1 MAR revealed that the nurses signed that Resident #4 was administered NJ Ex Order 26.4b1 tablet by mouth daily for NJ Ex Order 26.4b1 at 7:00 PM. The NJ Ex Order 26.4b1 MAR did not indicate the NJ Ex Order 26 and potential side effects of the NJ Ex Order 26.4b1 medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 758	Continued From page 16	F 758		

A review of the resident's individualized person-centered CP with an effective date of [redacted] to present reflected under problems that the resident is [redacted] for complications related to the [redacted] medication used. The goal reflected that the resident would have no complications for 90 days. The interventions included administering the medications as ordered by the physician, [redacted] every shift, and monitoring for adverse reactions, side effects, and changes in [redacted]. The CP did not reflect specific [redacted] for the use of [redacted] medication and non-pharmacological interventions to [redacted] associated with [redacted] of the resident.

3. On 1/27/25 at 11:00 AM, the surveyor observed Resident #35 sitting in the wheelchair inside the recreation room, [redacted] the surveyor's inquiry.

On 1/27/25 at 1:25 PM, the surveyor reviewed the hybrid medical record of Resident #35, which revealed the following:

A review of the FS reflected that Resident #35 was admitted with diagnoses that included but were not limited to [redacted]

A review of the recent Q/MDS dated [redacted] indicated that the facility assessed the residents' cognitive status, with a BIMS score [redacted] out of 15, indicating that the resident had [redacted] ognition. A further review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 758	Continued From page 17 Q/MDS revealed that the resident received NJ Ex Order 26.4b1 medications on a routine basis. A review of the most recent POS reflected a physician's order of the following medications: 1. NJ Ex Order 26.4b1 with an order date of NJ Ex Order 26.4b. 2. NJ Ex Order 26.4b1 with an order date of NJ Ex Order 26.4b 3. NJ Ex Order 26.4b1 with an order date of NJ Ex Order 26.4b1 4. NJ Ex Order 26.4b1 with an order date of NJ Ex Order 26.4b 5. NJ Ex Order 26.4b1 as needed with an order date of NJ Ex Order 26.4b The NJ Ex Order 26.4b1 MAR revealed that the nurses signed the above medications for Resident #35. There was no further documentation to reflect that the resident was being monitored and evaluated routinely with the use of the above NJ Ex Order 26.4b1 medications between the period of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 A review of the resident's individualized person-centered CP with an effective date of NJ Ex Order 26.4b1 reflected under problems that the resident is NJ Ex Order 26.4 for complications related to the NJ Ex Order 26.4b1 medication used. The goal reflected that the resident would have no complications for 90 days. The interventions included administering the medications as ordered by the physician, NJ Ex Order 26.4b1 every shift, and monitoring for NJ Ex Order 26.4b1, side effects, and changes in NJ Ex Order 26.4b1. The CP did not reflect specific NJ Ex Order 26.4b1 for the use of NJ Ex Order 26.4b1 medication and non-pharmacological interventions to decrease	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 758	Continued From page 18 symptoms associated with the resident's [NJ Ex Order 26.4b1] A review of the [NJ Ex Order 26.4b1] medication changes provided by the [US FOIA (b)] does not reflect a consistent monitoring of [NJ Ex Order 26.4b1], potential side effects and evaluate the ongoing benefits of continued use of [NJ Ex Order 26.4b1] medications. On 1/29/25 at 11:30 AM, the surveyor interviewed the [US FOIA (b)(6)]) regarding the above concern. The [US FOIA (b)(6)] revealed that the nurses documented the side effects only if the resident had a side effect but did not provide further information regarding the [NJ Ex Order 26.4b1]. On 1/29/25 at 12:47 PM, the team of surveyors met with the [US FOIA (b)(6)]) and [US FOIA (b)(6)] regarding the above concern. The [US FOIA (b)] stated that the nurses documented if there was a side effect noted to the resident with the use of [NJ Ex Order 26.4b1] medications, and if there was no side effect, there was no documentation. The [US FOIA (b)(6)] did not provide further information. A review of the facility policy with the revised date 5/11/23 titled "Behavioral Symptoms," under the "Procedure: 11: f. iv Monitoring is necessary as long as the drug is being used to identify side effects and to identify opportunities to reduce the drug dosage or discontinue the use of the drug." NJAC 8:39-29.3(a); 29.8; 33.2(a)	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 761	Continued From page 19	F 761		
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 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Repeat deficiency Based on observation, interview, and record review of other facility documentation, it was determined that the facility failed secure medications within the medication cart. This deficient practice was observed during wound care observation and was evidenced by the following:	F 761	1.Registered Nurse #1 was immediately educated in making sure that the treatment carts/ medication carts are locked when the nurse walks away from the cart. 2.All residents have the potential to be affected by the deficient practice. The DON checked all medication carts and	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 761	Continued From page 20 On 1/28/25 at 11:51 AM, the surveyor observed Registered Nurse (RN#1) provide NJ Ex Order 26.4b1 on Resident #213. RN#1 was observed gathering medication from the medication cart outside of Residents #213's room. Once RN#1 gathered all medications and supplies from the medication cart, the surveyor observed RN#1 close the drawer to the medication cart and walk away. Surveyor asked RN#1 if they had locked the medication cart. RN#1 went back to the medication cart and stated, "I forgot to lock the cart. That was a mistake on my part" On 1/29/25 at 9:50 AM, the US FOIA (b)(6) provided the surveyor with a facility policy titled, Storage of medications with a revised date on 5/1/2017. Under the procedure section of the policy it states, "7. Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others." On 1/29/25 at 12:32 PM, the survey team met with the US FOIA (b)(6) to review concerns found during the survey. The US FOIA (b) stated the medication carts should always be locked whenever the nurse is stepping away from the cart. No further comments provided. On 1/30/25 at 2:00 PM, the survey team met with the US FOIA (b)(6) for the exit conference. The facility did not provide any further pertinent information.	F 761	treatments carts on all units, all were locked when the nurse was away from the cart. 3.To ensure that the deficient practice does not recur, all licensed nurses were educated on ensuring their medication/treatment carts are locked when they are not in their line of sight. 4. The pharmacy consultant, DON and/or designee will conduct 10 audits of medication/ treatment carts weekly x 4, monthly x 3 and quarterly x 2, to make sure that the carts are locked before the nurse steps away. The QAPI committee will determine if it requires continuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 761	Continued From page 21 NJAC 8:39- 29.4(a) (d)(h), 29.7(a)	F 761		
F 812 SS=F	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: Repeat deficiency Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 1/27/25 at 9:55 AM, while on the 4th floor in the kitchenette the surveyor observed the	F 812	1. The Director of Nursing (DON), Infection Preventionist, Director of Housekeeping, and Unit Managers went to the refrigerator #1and freezer #2 on the fourth floor upon being informed of the finding on 1/27/25. The cheesecake without cover and missing a use by date, the open jar of molasses without an open/use by date, both without labels, and a frozen brown substance not dated without a use by date were all removed and thrown out immediately. On the second floor, the DON, Infection	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 812	Continued From page 22 following: in refrigerator #1 had an individual cheesecake without a cover and missing a use by date, an open jar of molasses without an open/use by label, and in freezer #2 a paper cup with a brown frozen substance not dated and without a use by label. On 1/27/25 at 10:15 AM, while on the 2nd floor in the kitchenette the surveyor observed the following in refrigerator #1: a zip lock bag of sliced pickles and red cup with oatmeal-like substance both missing labels and use by dates. On 1/27/25 at 10:20 AM, the surveyor interviewed the US FOIA (b)(6)), who stated all items in the refrigerator and freezers should be covered as well as have a label with an open and use by date. The US FOIA further stated the kitchenette areas are checked by the nurses and certified nursing assistants, but unable to explain why those items had not been labeled. On 1/29/25 at 12:00 PM, the US FOIA (b)(6) provided the surveyor with a facility policy titled, Food Storage with reviewed date of 10/2024. Under the policy section it states, "All leftovers are labeled, dated, and used within three days and then discarded. If there is any question about a product's storage or expiration, discard the product." On 1/29/25 at 12:32 PM, the survey team met with the US FOIA (b)(6)) to review concerns. The US FOIA (b) stated all the refrigerator and freezers in the three kitchenettes have been checked and any foods that did not have a label have been discarded. On 1/30/25 at 2:00 PM, the survey team met with	F 812	Preventionist, Director of Housekeeping, and Unit Manager went to refrigerator #1 and removed the lock bag of pickles and red cup with oatmeal-like substance and threw it out in the garbage. 2. All residents have the potential to be affected by this deficient practice. The DON, Infection Preventionist, Director of Housekeeping, and Unit Managers checked all the refrigerators and freezers in the facility, including the third floor. There were no other uncovered, undated, unlabeled with use by, items found. 3. To make sure that the deficient practice does not recur, the DON and Infection Preventionist, and Director of Housekeeping in-serviced the nursing and housekeeping staff in making sure that any food or food container that is not labeled, uncovered, or does not have a use by date must be disposed immediately, without exception. 4. The Director of Housekeeping will conduct 4 audits weekly x 4, monthly x 3 and quarterly x 2. The findings will be reported during the QAPI meetings. The QAPI committee will determine if it requires continuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

(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 812	Continued From page 23 the US FOIA (b)(6) for the exit conference. The facility did not provide any further pertinent information. 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315329 Y1	A. Building B. Wing Y2	3/4/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

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 F0550	Correction	ID Prefix F0582	Correction	ID Prefix F0657	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	02/28/2025	LSC	02/28/2025	LSC	02/28/2025
ID Prefix F0758	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	02/28/2025	LSC	02/28/2025	LSC	02/28/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
1/31/2025	☐ 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
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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
E 000	Initial Comments The Oaks at Denville 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 from 01/29/2025 to 01/31/2025 and The Oaks at Denville 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The Oaks at Denville is a Four-story building that was built in 1993. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The Natural Gas generator located on the roof powers approximately 80% of the building per the Maintenance Director. The current occupied beds were 62 of 84.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced	K 211		1/31/25

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

Electronically Signed | 02/21/2025

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
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 211	Continued From page 1 by: Based on observations and interview on 01/29/2025 in the presence of the [US FOIA (b)(6)] [redacted], 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 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 had the potential to affect all 62 residents and was evidenced by the following: An observation at 10:13 AM in the presence of the [US FOIA (b)(6)] revealed one set of glass sliding doors located at the front entrance of the facility had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The [US FOI] tested the doors by locking and pushed it to open, but he could not open the door. In an interview at the time, the [US FOIA (b)(6)] confirmed the observation. The [US FOIA (b)(6)] was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM. N.J.A.C. 8:39-31.2(e).	K 211	1. The lockset hook type deadbolt on the glass doors by the front entrance was removed by the locksmith vendor contracted by the facility. 2. All residents have the potential to affected by the deficient practice. The Facility Service Manager (FSM) and his designee conducted an inspection in all the doors in the facility. No other issues regarding the use of deadbolts were noted. 3. The FSM and/or his designee will conduct daily door inspections for 4 weeks and thereafter ongoing weekly inspection. 4. Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the	K 223		1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 223	Continued From page 2 closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 01/29/2025 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that a door with a self-closing device was kept in the closed position in accordance with NFPA 101:2012 Edition, Sections 7.2.1.8 and 19.2.2.2.7. This deficient practice had the potential to affect 18 of 62 residents and was evidenced by the following: An observation at 10:31 AM revealed that the door between the front corridor to the reception office with self-closing device was held opened with a door wedge. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM. N.J.A.C 8:39-31.2(e)	K 223	1.The door wedge was removed immediately by the Facility Service Manager (FSM). 2.All residents have the potential to be affected by the deficient practice. The FSM and designee made rounds in the facility and did not see any other door that was propped open with a wedge or other item to have the door in an open position. 3.The FSM and/or designee will conduct daily rounds for 4 weeks to make sure that doors are not propped open with a wedge or something the same. The FSM will educate the staff regarding not propping doors open with wedges. 4.Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance.	
K 225 SS=F	Stairways and Smokeproof Enclosures	K 225		2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 225	Continued From page 3 CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview from 01/29/2025 to 01/31/2025 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that exit stair landings and exit stair handrails were marked in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3, 7.2.2.5.5.2 and 7.2.2.5.5.3. This deficient practice had the potential to affect all 62 residents and was evidenced by the following: Observations during the tour between 9:15 AM to 3:45 PM in the presence of the US FOIA (b)(6), revealed 2 of 2 exit stairways had no marking stripes on the steps and the upper surface of the handrails were not marked as required by the Code. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM. NJAC 8:39 31.2 (e)	K 225	1. Two of two stairwells that were noted in the survey were addressed immediately by the Facility Service Manager (FSM). The stairways were painted with yellow stripes and the surface of the handrails were marked as required by code. 2. All residents have the potential to be affected. There are only 2 stairwells and both were addressed. 3. The FSM and designee will be continue to make sure that the stripes on the steps remain intact and surface of the handrails are marked as required by the code. 4. Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 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 observations and interviews from 01/29/2025 to 01/31/2025 in the presence of the US 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, Section 19.2.8 and 7.8.1.3* (2). This deficient practice was observed in 3 of 3 occupied areas, had the potential to affect 62 residents, and was evidenced by the following: 1. An observation on 01/29/25 at 10:50 AM, revealed in the Second-floor occupied dining room that 2 sets of wall switches shut-off 6 of 6 ceiling light fixtures. 2. Observations at 12:22 PM, revealed in the Third -floor occupied dining room that 2 sets of wall switches shut-off 6 of 6 ceiling light fixtures. In an interview at the time, the US FOIA (b)(6) confirmed the observation. 3. An observation on 01/30/25 at 9:50 AM, revealed in the Fourth-floor occupied dining room that 2 sets of wall switches shut-off 6 of 6 ceiling	K 281	1. The FSM contacted the contracted vendor for the facility and installed three emergency back up lights in the 2nd, 3rd, and 4th floor dining areas. 2. All residents have the potential to be affected. The FSM did rounds in the facility and did not note and other rooms with means of egress that required to have an emergency illumination. 3. The FSM added all three emergency lights in the preventative maintenance schedule to be tested monthly to ensure that it is proper working order. 4. Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance.	2/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 281	Continued From page 5 light fixtures. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM.	K 281		
K 291 SS=F	NJAC 8:39-31.2(e) Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview from 01/29/2025 to 01/31/2025 in the presence of the US FOIA (b)(6) it was determined that the facility failed to conduct functional testing of emergency lighting system in accordance with NFPA 101: 2012 Edition, Sections 19.2.9.1 and 7.9. This deficient practice had the potential to affect all 62 residents and was evidence by the following: An observation with the US FOIA (b)(6) on 01/29/2025, revealed battery backup emergency lighting was provided in various locations of the facility. A documentation review on 01/30/2025, revealed no records on annual and monthly emergency lighting functional testing.	K 291	1. The Facility Service Manager (FSM) tested the test for the emergency lighting system immediately. There were no issues noted. 2. All residents have the potential to be affected by the deficient practice. The FSM/designee completed the 30 minute and 90-minute test of the emergency lighting system. 3. The FSM immediately added the 30 minute and 90 minutes test to the generator log sheet and will be tested, then recorded on the log, monthly. 4. Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the	1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 291	Continued From page 6 During an interview on 01/31/2025 at 12:10 PM, the US FOIA (b)(6) confirmed the facility did not have any documented evidence that the emergency lighting system was tested monthly and annually. The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference at 2:15 PM.	K 291	audit results/compliance.	
K 321 SS=F	NJAC 8:39-31.1(c), 31.2(e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K 321		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 321	Continued From page 7 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 01/29/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2, 19.3.2.1.3, 8.4 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all 62 residents and was evidenced by the following: Observations with the US FOIA (b)(6) from 8:45 AM to 3:41 PM, revealed the following: At 11:07 AM, Room #220 measured over 120-square feet and was being used to store combustibles and had no self-closing device installed on the door. At 11:29 AM, Room #215 measured over 120-square feet and was being used to store combustibles and had no self-closing device installed on the door. At 1:48 PM, Room #210 measured over 120-square feet and was being used to store combustibles and had no self-closing device installed on the door. At 2:35 PM, the Third floor Nurse's Educator office measured over 50-square feet and was being used to store combustibles and had no	K 321	1. A self-closing mechanism for the door in room #220 was installed on 1/30/25, A self- closing mechanism for the door in room #215 was installed on 1/30/25, A self-closing mechanism for the door in room #210 was installed on 1/30/25, A self- closing mechanism for the door in the educator's office on the 3rd floor was installed on 1/30/25. 2. All residents have the potential to be affected by the deficient practice. The FSM and/or designee inspected the other rooms and noted that no other rooms required to have a self-closing door. 3. The FSM in-serviced the staff regarding having self-closing doors in rooms that have hazardous equipment/ materials. 4. The FSM will check the rooms every month for 12 months to make sure that the rooms are properly addressed with regards the need for self-closing doors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 321	Continued From page 8 self-closing device installed on the door In an interview at the time, the [US FOIA (b)(6)] confirmed the observations. The [US FOIA (b)(6)] was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM. N.J.A.C 8:39-31.2(e)	K 321		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 01/30/2025 in the presence of the [US FOIA (b)(6)] and [US FOIA (b)(6)], it was determined that	K 353	1. The ceiling tile in the sprinkler control valve room was immediately put back in place by the Facilities Service Manager (FSM).	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 353	Continued From page 9 the facility failed to ensure the ceiling level was smoke resisting in accordance with NFPA 101:2012 Edition, Section 9.7.5 and NFPA 25: 2011 Edition, Section 5.2.1.1. This deficient practice had the potential to affect all 62 residents and was evidenced by the following: An observation at 10:02 AM revealed 2-foot by 4-foot ceiling tile was not in place in the fire sprinkler control valve room. An observation at 11:36 AM revealed a 1-foot by 1-foot and a 3-inch by 4-inch hole in ceiling in the closet at the second floor nurse's station. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	The hole in the ceiling on the closet at the second-floor nurses' station was repaired by the FSM. 2. All residents have the potential to be affected by the deficient practice. The FSM/designee made rounds and corrected other areas with missing tiles or holes in the ceiling area. 3. The FSM in serviced staff to inform the maintenance department when they note a missing tile or hole in the ceiling. 4. Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance.	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code.	K 362		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 362	Continued From page 10 Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interview from 01/29/2025 to 01/31/2025 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that corridor walls were constructed to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6.2 and 19.3.2.7. This deficient practice had the potential to affect 62 residents and was evidenced by the following: 1. An observation on 01/29/2025 at 10:27 AM with the US FOIA (b)(6), revealed a hole in the wall above the set of doors between the Oncology unit and the Health Care section in the ceiling. 2. An observation at 10:57 AM, revealed a hole in the wall above the set of doors in the ceiling next to room #222. In an interview at the time, the US FOIA (b)(6) confirmed the observation. 3. An observation on 01/30/25 at 12:19 PM, revealed wall above the set of doors next to room #327 had a hole in the ceiling.	K 362	1. The hole above the set of doors between the Oncology unit and the Health Care section was sealed with caulking material immediately by the FSM. The hole in the wall above room #222 was sealed with caulking material by the FSM. The hole above the door next to room #327 was sealed with caulking by the FSM. 2. All residents have the potential to be affected. The FSM/ Designee went on rounds and inspected the rooms and doorways, and addressed the affected areas with caulking seal. 3. The FSM in serviced staff to inform the maintenance department when they note a missing tile or hole in the ceiling. 4. Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 362	Continued From page 11 In an interview at the time, the US FOIA (b)(6) confirmed the observation. The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM.	K 362		
K 363 SS=D	N.J.A.C. 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	K 363		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 363	Continued From page 12 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. 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 observations and interview on 01/30/2025 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Sections 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect 13 of 62 residents and was evidenced by the following: An observation at12:24 PM, revealed the third floor dining room set of doors had a gap between the meeting edges when tested by [redacted]. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	1. The third-floor dining room set of doors with a gap between the meeting edges was addressed by the Facility Service Manager (FSM) by installing new astragals. 2. All residents have the potential to be affected. The FSM made rounds with his designee and addressed any gaps found between double doors. 3. The FSM and/or designee in-serviced staff about reporting any gaps found to the maintenance department. 4. Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance.	
K 521 SS=E	HVAC CFR(s): NFPA 101	K 521		1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 521	Continued From page 13 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 01/29/2025 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that residents room air conditioner (AC) units were maintained in safe operating condition in accordance with the National Fire Protection Association (NFPA) 90 A. This deficient practice was identified for 4 of 65 rooms observed and was evidenced by the following: During the tour between 9:15 AM and 2 :29 PM in the presence of the US FOIA (b)(6) , the surveyor observed resident room #206, #208, #210 and #306 AC unit filters were clogged and dirty. In an interview at the time, the US FOIA (b)(6) confirmed the observations. The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM. N.J.A.C 8:39-31.2(e)	K 521	1.The air conditioning filters for rooms #206, #208, #210, #306 were all cleaned and unclogged by the Facility Service Manager (FSM). 2.All residents have the potential to be affected. The FSM/designee made rounds and inspected the air conditioning filters in the facility and cleaned them. 3.The FSM/designee will conduct monthly rounds to check the air conditioning filters in the residents' rooms. 4.Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 911	Continued From page 14	K 911		
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 01/30/2025, it was determined that the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99: 2012 Edition Chapter 6 and NFPA 110: 2010 Edition, Section 5.1.4. for 1 of 1 generator. This deficient practice had the potential to affect all 62 residents and was evidenced by the following: A documentation review at 2:41 PM with US FOIA (b)(6) [redacted] revealed the facility had a natural gas generator. The facility could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption.	K 911	1. Facility Service Manager (FSM) reached out to New Jersey Natural Gas (NJNG)and received a Reliability letter on February 19, 2025. This letter is regarding Natural Gas Standby Generator (see attached). The letter contains all required elements. 2. All residents have the potential to be affected by the deficient practice. 3. The FSM will review the letter with the Administrator annually to ensure that we continue to have communication with NJNG to ensure there are no changes. 4. The FSM will notify the administrator and NJNG if there are any changes in the generator and obtain another letter if any changes occur. This will be reviewed annually. (Attachment sent via email)	2/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 911	Continued From page 15 5. The signature of technical personnel from the natural gas vendor. The finding was verified by the [US FOIA (b)(6)] at the time of the observation. The [US FOIA (b)(6)] was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM.	K 911		
K 912 SS=E	NJAC 8:39-31.2(e), 31.2(g) Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/30/2025 in the presence of the [US FOIA (b)(6)] it was determined that the facility failed to ensure that 2 of 7 electrical outlets located next to a water source were equipped with a Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 and 99. This deficient practice had the potential to affect 15 of 58 residents and was evidenced by the following:	K 912	1. The second-floor fish tank and the Hydrocollator on the second floor (Rehab) were replaced by ground fault outlet devices on 1/29/2025 by Fino Electric. 2. 15 residents have the potential to be affected by the deficient practice. 3. All healthcare floors were inspected to ensure that Ground Fault Outlets are in place where required. All staff will be	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 912	Continued From page 16 An observation at 10:42 AM with the [redacted] revealed the Second-floor dining room fish tank was plugged into brown household grade power cord and then into extension cord on the floor to a duplex wall outlet, not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. An observation at 2:02 PM with the [redacted] revealed in the Physical Therapy room that a Hydrocollator was plugged into a duplex wall outlet, not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. In an interview at the time, the US FOIA (b)(6) confirmed the observations. The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM. NJAC 8:39 -31.2 (e) NFPA 70, 99	K 912	in-serviced in reference to the prohibited use of electrical extension cords in all licensed areas. 4. Monthly. And ongoing for 12 months the FSM /Designee will review and report to the Administrator/QAPI Committee the audit results/compliance.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 920	Continued From page 17 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/30/2025 in the presence of the[US FOIA (b)(6) redacted] it was determined that the facility failed to prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with NFPA 101: 2012 LSC Edition, Sections 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70: 2011 LSC Edition, Sections 400.8 and 590.3 (D). NFPA 99: 2012 LSC Edition, Sections 10.2.3.6 and 10.2.4. This deficient practice was identified for 1 of 3 electrical wires observed, had the potential to affect 15 of 62 residents and was evidenced by the following: An observation at 10:42 AM with the [redacted] revealed the Second-floor dining room Fish tank was plugged into brown household grade power cord, into extension cord on the floor, to a regulator duplex wall outlet. In an interview at the time, the [US FOIA (b)(6) redacted] confirmed the observation and policy for	K 920	1. The extension cord found on the 2nd floor dining room fish tank was removed immediately by the Facility Service Manager (FSM). 2. All residents have the potential to be affected. The FSM/designee made round in the facility and found no other extension cords. 3. The FSM in-serviced staff about not using any extension cords in the facility and notify the maintenance department if one is needed. 4. Monthly, and ongoing for 12 months the FSM/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 920	Continued From page 18 extension and power cord was requested. On 01/31/2025 at 2:10 PM, Policy for Extension Cords was provided by [US FOIA (b)(6)] that stated, "Extension cord are not permitted to be used in the healthcare Center". The [US FOIA (b)(6)] was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM.	K 920		
K 921 SS=E	NJAC 8:39-31.2(e) Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements 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	K 921		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 19 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 from 01/29/2025 to 01/31/2025 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to provide safety electrical labels or tags for all the patient care related electrical equipment (PCREE), conduct inspection for all electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 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 5 of 62 residents and was evidenced by the following: Observations on 01/30/2025 from 8:15 AM to 3:25 PM, revealed residents electric recliner chairs in Rooms 219, 221, 315 and 412 were not provided with PCREE safety inspection stickers. In an interview at the time, the US FOIA (b)(6) confirmed the observation, and the surveyor requested the facility policy on PCREE at 3:31 PM. On 01/31/2025 at 2:10 PM, the policy provided by the [redacted] stated, "All tested electrical equipment must be tagged with a safety label indicating vendor name and date of inspection/ testing".	K 921	1. The electric recliners in rooms #219, #221, #315, #412 were inspected by the Facility Service Manager and found that all were in proper working order. 2. All residents have the potential to be affected. Especially the ones who have electric recliners that were leased and delivered to the facility. The FSM/designee made rounds in the facility and did not see any other recliner that did not have the vendor's name and date of inspection. 3. The FSM will in-service staff to make sure that electric equipment brought into the facility are labeled with the vendor's name and date of inspection. 4. All electrical equipment recliners, etc. at the time of delivery, if not tagged in compliance with Patient Care Related to Electrical Equipment regulations, the delivery will be denied at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD** **DENVILLE, NJ 07834**

(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 20 The US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 01/31/2025 at 2:15 PM. NJAC 8:39-31.2(e) NFPA 99	K 921		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315329 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/4/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	01/31/2025	LSC K0223	01/31/2025	LSC K0225	02/07/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	02/06/2025	LSC K0291	01/31/2025	LSC K0321	02/28/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	02/28/2025	LSC K0362	02/28/2025	LSC K0363	02/28/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	01/31/2025	LSC K0911	02/19/2025	LSC K0912	02/28/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0920	02/28/2025	LSC K0921	02/28/2025	LSC	

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	
1/31/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO