PRINTED: 05/01/2024 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDIN | PLE CONSTRUCTION G 01 | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|------------------------------|---|---|----------|----------------------------|
| | | 315234 | B. WING _ | | · · · · · · · · · · · · · · · · · · · | | 11/23/2022 |
| | ROVIDER OR SUPPLIER | I AND HEALTHCARE CENTER | | STREET ADDRES 261 TERHUNE I WAYNE, NJ 0 | | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EA | PROVIDER'S PLAN OF CORR ICH CORRECTIVE ACTION SI SS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| K 000 | New Jersey Departr | Survey was conducted by the nent of Health, Health Facility | K 0 | 00 | | | |
| | 11/23/22 and Arbor Healthcare Center v noncompliance with participation in Medi 483.90(a), Life Safe Edition of the Natior | the requirements for icare/Medicaid at 42 CFR ty from Fire, and the 2012 nal Fire Protection Association fety Code (LSC), Chapter 19 | | | | | |
| K 222 SS=D | is a three-story, Typ | litation and Healthcare Center e I Fire Resistant Protected ilt in June 1986. The facility oke zones. | К 2 | 22 | | | 12/19/22 |
| | equipped with a later use of a tool or key using one of the followarrangements: CLINICAL NEEDS (LOCKING) Where special locking clinical security need only one locking developed each door and proving rapid removal of occ | means of egress shall not be the or a lock that requires the from the egress side unless owing special locking OR SECURITY THREAT In garrangements for the ds of the patient are used, vice shall be permitted on sions shall be made for the cupants by: remote control of bocks or keys carried by staff at | | | | | |
| ADODATODY | all times; or other su to the staff at all time 18.2.2.2.5.1, 18.2.2. SPECIAL NEEDS L | ıch reliable means available | | | TITLE | | (X6) DATE |

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.

Electronically Signed

12/17/2022

| STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | FIPLE CONSTRUCTION NG 01 | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|-------------------------|--|--------------------------------------|-------------------------------|--|
| | | 315234 | B. WING _ | | | 11/23/2022 | |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | · | STREET ADDRESS, CITY, STATE, ZIP 261 TERHUNE DRIVE WAYNE, NJ 07470 | CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE | |
| K 222 | Where special locking safety needs of the policial or Security Lebeing met. In addition electrical locks that faupon loss of power to protected by a supersystem and the locked complete smoke deteconstantly monitored within the locked sparand detection system doors upon activation 18.2.2.2.5.2, 19.2.2.2 DELAYED-EGRESS ARRANGEMENTS Approved, listed delainstalled in accordance permitted on door as ordinary hazard contenting the detection system automatic sprinkler some 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROL ARRANGEMENTS Access-Controlled Eginstalled in accordance permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY IN ARRANGEMENTS Elevator lobby exit accordance with 7.2. door assemblies in buy an approved, supersome permited in buy an approved, supersome in the province of the p | g arrangements for the atient are used, all of the ocking requirements are now, the locks must be all safely so as to release to the device; the building is vised automatic sprinkler at dispace is protected by a section system (or is at an attended location ce); and both the sprinkler at an arranged to unlock the nower of the sare arranged to unlock the nower of the sembles serving low and the sembles s | K | 222 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION G 01 | 1, , | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|--|--|-------------------------------|--|
| | | 315234 | B. WING | | 11 | /23/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | STREET ADDRESS, CITY, STATE, ZIP CODE | • | | |
| ARBOR R | IDGE REHABILITATION | AND HEALTHCARE CENTER | | 261 TERHUNE DRIVE WAYNE, NJ 07470 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| K 222 | by: Based on observation facility documentation presence of facility metermined that the findischarge doors in prodeficient practice was doors (Stairwell F) and following: During the survey end of survey) at 9:41 AM Maintenance Director the facility layout white rooms and smoke contained and survey of the facility layout white rooms and smoke contained on 11/22/22 and continued on 11/22/22 and continued on 11/22/22 and continued on 11/22/22 and survey of the | It is not met as evidenced on, interview, and review of on on 11/22/22 in the nanagement, it was facility failed to maintain exit roper working condition. This is identified for 1 of 6 exit and was evidenced by the trance on 11/22/22 (day one of the surveyor requested the rope in the facility. It is provided to the various of the facility with a total of doors. at approximately 10:02 AM (23/22, in the presence of the Plant Operations (RDPO) building was conducted. Liveyor observed and sts of six exit discharge dyou outside of the building) | K 22 | 1. What corrective action(s) will be accomplished for those residents sto have been affected by the deficipractice. ~~ No residents were identified. 2. How the Facility will identify othe residents having the potential to be affected by the same stated deficie practice and what corrective action taken. ~~ All residents have the potential to laffected. 1)Exit Door #F was immediately oi rust was removed. 2)On 11/23/202 rust on Exit door and frame #F was sanded down and repainted, door opens easily with less than 15 pour pressure. 3)On 11/23/2022 all othe doors were inspected for any rust, any identified rust was removed. 3. What measures will be put into put what systemic changes will the fact make to ensure that the stated definition in the stated definition in the stated definition. | er ee ent oe ent oe ent oe ee ent oe | | |
| | surveyor made a req code on the keypad t discharge door and t release to open the c | proximately 12:04 PM, the uest to the MD to enter the for Stairwell "F" exit hen push on the manual door. When the MD entered I on the manual release, the | | 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggere facility's Maintenance/Safety work and task management software sy | d by the order | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|---|---|----------------------------------|----------------------------|
| | | 315234 | B. WING _ | | | 11/ | /23/2022 |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 261 TERHUNE DRIVE WAYNE, NJ 07470 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| K 222 | door did not open. To bottom of the door's it second attempt using door, which required pressure to open the Along the tour the su emergency evacuation various locations that discharge door as the exit discharge door of an emergency. The RDPO and MD of time of observation. During Life Safety Co | the door was caught on the frame. The MD performed a plant his full body weight and the more than 15 pounds of door. To reveyor observed three (3) on diagrams posted in identified Stairwell "F" exit is primary and/or secondary at of the building in the event exonfirmed the finding at the code exit conference on ately 12:05 PM, the surveyor distributions and the inding. | K2 | 2222 | he/she must thoroughly review the detailed step by step instructions for ea audit. 2)There is a task in the facility's Maintenance Software system that is comonthly for the Maintenance Director of designee to audit, that all doors open a close and seal properly when closed. A "Open/due task reports" are automatic sent by email weekly to the Regional Director of Operations, Regional Director of Plant Operations and the Facility Administrator to review and follow-up a necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1)Starting on 12/19/2022 the Administrator will audit 2 doors post Maintenance Director's inspection for 3 months. Each month a different 2 door 2)Results of the audits will be submitted to, and reviewed by the Quality Assurate Performance Improvement Committee monthly for the duration of the audits as | due or and All ally tor as as as | |
| K 281 SS=E | CFR(s): NFPA 101 Illumination of Means Illumination of means discharge, is arrange shall be either contin | · · | K 2 | 281 | the committee will make recommendations to the Administrator any further actions. | for | 1/23/23 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---------------------|-----|--|------------------|----------------------------|
| | | 315234 | B. WING _ | | | 11/ | 23/2022 |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | | 26 | TREET ADDRESS, CITY, STATE, ZIP CODE 61 TERHUNE DRIVE /AYNE, NJ 07470 | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| K 281 | by: Based on observation facility provided docupresence of facility metermined the facility emergency illumination automatically along the accordance with NFP 19.2.8 and 7.8. and N (NEC) 70. The deficiexit discharge paths the was evidence by the exit discharge paths the exit disch | is not met as evidenced n, interview, and review of mentation on 11/22/22 in the anagement, it was refailed to provide on that would operate he means of egress in A 101, 2012 Edition, Section hational Electrical Code ent practice affected 1 of 6 or each a public way and following: 00.16 Emergency hey Illumination shall include he gress lighting, illuminated her lights specified as required illumination. restems shall be designed he failure of any individual has the burning out of a light total darkness any space her illumination. rance on 11/22/22 (day one her, the surveyor requested the (MD) to provide a copy of the identified the various mpartments in the facility. reprovided layout identified (3) floors. The second floor ing rooms; the first floor had | K 2 | 281 | 1. What corrective action(s) will be accomplished for those residents state to have been affected by the deficient practice. ~~ No residents were identified. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will taken. ~~ All residents have the potential to be affected. 1) The facility will install a light that is operated automatically, to fully illuminate mentioned pathway. 2) The facility install a light illuminated keypad for visibility at night. The two installations noted above will be completed by 12/23/2022. 3. What measures will be put into place what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1) On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by facility is Maintenance/Safety work and | be te will | |
| | had offices, Kitchen, Commercial Laundry, | | | | facility's Maintenance/Safety work orde and task management software systen he/she must thoroughly review the | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 315234 B. WING 11/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 TERHUNE DRIVE** ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER **WAYNE, NJ 07470** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 5 K 281 Mechanical Room. detailed step by step instructions for each audit. 2)There is a task in the facility's Starting On 11/22/22 at approximately 10:02 AM, Maintenance Software system that is due the surveyor in the presence of the Regional weekly for the Maintenance Director to Director of Plant Operations (RDPO) and MD check illumination of exit lighting. All conducted a tour of the building. open/due task reports are automatically sent by email weekly to the Regional At approximately 11:37 AM, an inspection outside Director of Operations, the Regional a designated exit discharge door (illuminated exit Director of Plant Operations and the sign above door) near Resident Room #123 Facility Administrator to review and identified a gated residents' patio area. The follow-up as necessary. surveyor also observed no evidence of emergency lighting along the approximate 80 feet 4. How the corrective actions will be discharge path to reach the discharge gate. The surveyor observed no emergency lighting for the monitored to ensure the stated deficient "Key-Pad" to unlock the magnetic hold close practice will not recur, i.e. what QA device. program will be put into place. ~~ At this time the surveyor asked the MD do you 1)Starting on 1/23/2023 the Administrator have any lights here? The MD responded, "No". or designee will audit all exit illumination lighting monthly for 3 months. 2)The Along the tour the surveyor observed two (2) above mentioned audits will be reviewed emergency evacuation diagrams posted that by the Quality Assurance Performance identified the discharge door as the primary Improvement Committee at each monthly and/or secondary exit discharge out of the meeting for 3 months and the committee will make recommendations to the building. Administrator for any further actions. 3)An The RDPO and MD confirmed the finding at the audit report of all open tasks will be ran time. from the facility's maintenance software system prior to each quarterly QAPI During Life Safety Code exit on 11/23/22 at meeting for the next 4 Quarterly QAPI approximately 12:05 PM, the surveyor informed meetings and will be reviewed by the the Licensed Nursing Home Administrator of the Quality Assurance Performance finding. Improvement Committee and the committee will make recommendations to NFPA 101-2012 edition Life Safety Code 7.8 the Administrator for any further actions. Illumination of Means of Egress 7.8.1.3* (2). NJAC 8:39-31.2 (e).

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | LE CONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|--|---------------|--|
| | | 315234 | B. WING | | 11/23/2022 | |
| | ROVIDER OR SUPPLIER | I AND HEALTHCARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 261 TERHUNE DRIVE WAYNE, NJ 07470 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION | |
| K 321 K 321 SS=E | , | Enclosure | K 32 K 32 | | 1/23/23 | |
| | having 1-hour fire refire rated doors) or a system in accordance. When the approved system option is use separated from other partitions and doors. Doors shall be self-and permitted to have protective plates the from the bottom of the Describe the floor as | e protected by a fire barrier sistance rating (with 3/4 hour an automatic fire extinguishing be with 8.7.1 or 19.3.5.9. automatic fire extinguishing ed, the areas shall be ar spaces by smoke resisting in accordance with 8.4. closing or automatic-closing are nonrated or field-applied at do not exceed 48 inches are door. | | | | |
| | c. Repair, Maintenand. Soiled Linen Rooe. Trash Collection I (exceeding 64 galloof. Combustible Stora (over 50 square feet g. Laboratories (if cl Hazard - see K322) This REQUIREMENDY: Based on observatifacility provided doc presence of facility in determined that the | ired Heater Rooms than 100 square feet) nce, and Paint Shops ms (exceeding 64 gallons) Rooms ns) nge Rooms/Spaces d) assified as Severe T is not met as evidenced on, interview, and review of umentation on 11/22/22 in the | | What corrective action(s) will be accomplished for those residents state to have been affected by the deficient practice. ~~ | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 315234 B. WING 11/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 TERHUNE DRIVE** ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER **WAYNE, NJ 07470** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 321 Continued From page 7 K 321 self-closing, and were separated by smoke No residents were identified. resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 2. How the Facility will identify other 8.5.6.2 and 8.7. This deficient practice was residents having the potential to be identified for 1 of 7 fire-rated doors to hazardous affected by the same stated deficient areas (Stairwell D) and was evidenced by the practice and what corrective action will be following: taken. ~~ During the survey entrance on 11/22/22 (day one All residents have the potential to be of survey) at 9:41 AM, the surveyor requested the affected. Maintenance Director (MD) to provide a copy of 1)On 12/22/2022 the facility installed a the facility layout which identified the various new fire rated door on storage room rooms and smoke compartments in the facility. located on top level within Stairwell "D" as required by code. 2)On 12/22/2022 the A review of the facility provided layout identified facility installed an automatic door closer that there were three (3) floors. The second floor arm on door to the storage room located had 28 resident sleeping rooms; the first floor had in the exit access corridor right outside 29 resident sleeping rooms; and the ground floor doorway to stairwell "D" as required by had offices, Kitchen, Rehabilitation Gym, code. Commercial Laundry, Boiler Room and Mechanical Room. 3. What measures will be put into place or On 11/22/22 starting at approximately 10:02 AM, what systemic changes will the facility the surveyor in the presence of the Regional make to ensure that the stated deficient Director of Plant Operations (RDPO) and MD practice will not recur. ~~ conducted a tour of the building and the surveyor observed the following hazardous locations: 1)On 11/28/2022 the Maintenance Director was in-serviced on requirement 1. At approximately 11:01 AM, an inspection on to have smoke resisting partitions and the second floor inside Stairwell "D" identified at doors that are self closing as part of the the top level of the stairwell a 5 feet wide by 15 required fire barrier to prevent fire or feet deep (75 square feet) room. The 1-1/2 smoke from spreading. The in-service fire-rated door was removed from its frame. The also included that when completing audits surveyor observed inside this room contained that are triggered by the facility's multiple combustible cardboard boxes, paintings, Maintenance/Safety work order and task and other combustible products. The area is management software system, he/she larger than 50 square feet which would allow fire, must thoroughly review the detailed step smoke, and poisonous gases to enter the exit by step instructions for each audit.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--------------------------|-----|--|-------------------------------|----------------------------|
| | | 315234 | B. WING _ | | | 11/ | 23/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | • | • | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| ADROD D | INGE PEHARII ITATION | AND HEALTHCARE CENTER | 261 TERHUNE DRIVE | | 1 TERHUNE DRIVE | | |
| ANDONIN | IDGE REHABILHATION | AND HEALTHOAKE CENTER | | W | /AYNE, NJ 07470 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| K 321 | the exit access corric Stairwell "D" identifie by 12 feet deep room approximately 45 box paper files and other in the room. The sur doors automatic door This door did not self required by code whi and poisonous gases the event of a fire. T square feet. The RDPO and MD of time. During Life Safety Co | of a fire. 11:39 AM, an inspection of for next to the first floor d a five feet ten inches wide in. This inspection identified was filled with combustible combustible products stored veyor observed that the raclosure had been removed. Solution of the control of the area was larger than 50 confirmed the finding at the code exit conference on the exit corridor in the area was larger than 50 confirmed the finding at the code exit conference on the exit conf | К3 | 321 | 2)There is a task in the facility's Maintenance Software system that is d monthly for Maintenance Director or designee to audit that all doors seal properly when closed and latch automatically. All open/due task reports are automatically sent by email weekly the Regional Director of Operations, th Regional Director of Plant Operations at the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficien practice will not recur, i.e. what QA program will be put into place. ~~ 1)Starting on 1/23/2023 the Administra or designee will audit 10 doors monthly 3 months that they seal properly when closed and latch automatically 2)The above mentioned audits will be reviewe by the Quality Assurance Performance Improvement Committee at their month meeting for 3 months and the QAPI committee will make recommendations the Administrator for any further actions 3)An audit report of all open tasks will be ran from the facility's maintenance software system prior to each quarterly QAPI meetings and will be reviewed by the Quality Assurance Performance Improvement Committee and the | to e and to red ally to s. oe | |
| K 324 SS=E | Cooking Facilities | | K 3 | 324 | committee will make recommendations the Administrator for any further actions | | 1/23/23 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDIN | IPLE CONSTRUCTION NG 01 | (X3) DATE SURVEY COMPLETED | | |
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| | | 315234 | B. WING _ | | 11/23/2022 | |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 261 TERHUNE DRIVE WAYNE, NJ 07470 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | JLD BE COMPLETION | |
| K 324 | with NFPA 96, Stand and Fire Protection of Operations, unless: * residential cooking appliances such as in toasters) are used for cooking in accordance to cooking in accordance to cooking facilities oper compartments with 3 with the conditions until or * cooking facilities in 30 or fewer patients of 18.3.2.5.4, 19.3.2.5.4 Cooking facilities proper 9.2.3 are not required hazardous areas, but corridor. | s protected in accordance ard for Ventilation Control f Commercial Cooking equipment (i.e., small nicrowaves, hot plates, r food warming or limited be with 18.3.2.5.2, 19.3.2.5.2 een to the corridor in smoke 0 or fewer patients comply nider 18.3.2.5.3, 19.3.2.5.3, smoke compartments with comply with conditions under 1. tected according to NFPA 96 uired to be enclosed as a shall not be open to the | K 3 | 324 | | |
| | by: Based on interview a documentation on 11 presence of facility m determined that the f range-hood fire supp semi-annually (every with NFPA 96. This cidentified in 1 of 4 randocuments) | acility failed to inspect the | | What corrective action(s) will be accomplished for those residents s to have been affected by the defici practice. ~~ No residents were identified. How the Facility will identify other. | ent | |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---|-----|--|--------------------------------------|----------------------------|
| | | 315234 | B. WING _ | | | 11/ | 23/2022 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| 4 DD OD D | IDOE DELLA DIL ITATIONI | AND UEALTHOADE OF MED | | 26 | 1 TERHUNE DRIVE | | |
| ARBOR R | IDGE REHABILITATION | AND HEALTHCARE CENTER | | W | AYNE, NJ 07470 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| K 324 | Continued From page | ± 10 | K 3 | 324 | | | |
| | of survey) at 9:41 AM | rance on 11/22/22 (day one , the surveyor requested the | | | residents having the potential to be affected by the same stated deficient practice and what corrective action will taken. ~~ | be | |
| | review. Review of the facility's suppression system in 22 months identified the semi-annual inspection 8/5/22 (8 months between spections). On 11/22/22 at approximate approximate to the Reg Operations (RDPO) and the semi-annual inspection semi-annual inspection. | s from 1/1/21 to 11/21/22 for s range-hood fire aspections for the previous he system had three (3) ons on 5/11/21, 12/15/21 and ween semi-annual eximately 2:05 PM, a request ional Director of Plant and MD if they can provide a on between 12/15/21 and | | | All residents have the potential to be affected. 1)The facility has scheduled an inspect of the range hood which was complete by 12/23/2022. 3. What measures will be put into place what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by facility's Maintenance/Safety work order and task management software system. | d e or t the er | |
| | approximately 9:11 At the RDPO and asked a semi-annual inspect suppression system by 8/5/22. The RDPO in inspection had not be The RDPO and MD cotime. During Life Safety Co | M, the surveyor interviewed if the facility had performed tion of the Kitchen between 12/15/21 and formed the surveyor the en done. onfirmed the finding at the de exit conference on ately 12:05 PM, the surveyor d Nursing Home | | | to thoroughly review the detailed step is step instructions for each audit. 2)Ther a task in the facility's Maintenance Software system that is due every 6 months for Maintenance Director to complete and to schedule the range horizontal inspection. All open/due task reports at automatically sent by email weekly to the Regional Director of Operations, the Regional Director of Plant Operations at the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA | oy e is ood re ne and | |

Facility ID: NJ61625

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--------------------|-----|---|-------------------------------|----------------------------|
| | | 315234 | B. WING _ | | | 11/ | 23/2022 |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE 61 TERHUNE DRIVE VAYNE, NJ 07470 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| K 351 SS=E | CFR(s): NFPA 101 Spinkler System - Ins 2012 EXISTING Nursing homes, and I construction type, are approved automatic s accordance with NFP Installation of Sprinkle In Type I and II construction in or local regulations provided in the construction of the closet does not sprinkler coverage corequired by NFPA 13, Sprinkler Systems. | stallation tallation nospitals where required by protected throughout by an sprinkler system in A 13, Standard for the er Systems. ruction, alternative protection ed to be substituted for specific areas where state | | 324 | program will be put into place. ~~ 1)On 1/23/2023 and every 6 months thereafter for a duration of 18 months to Administrator or designee will audit all range-hood fire suppression systems to the ensure they were inspected satisfactor within the last 6 months. 2)The above audits and an audit report all open tasks in the facility's maintenant software system will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee every other quarterly QAPI meeting (bi-annual for the next 18 months and the commit will make recommendations to the Administrator for any further actions. | o illy t of nce e | 1/23/23 |

| NAME OF PROVIDER OR SUPPLIER ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER BISHAMPS STATEMENT OF SEPTICEMENTS (EACH DEFICIENCY) (EACH DEFICIENCY MIST SEPTICEMENT OF SEPTICEMENTS) (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH CENTER) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH CENTER) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CENTER) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS. REFERENCED TO THE APPROPRIENT T | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD | | PLE CONSTRUCTION G 01 | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--|---------|---|-------------|-------------------------------|--|
| ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER STREET LADDRESS, CITY, STATE, 2IP CODE 281 TERNUNE DRIVE WAYNE, NJ 07470 291 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 MINARY STATEMENT OF DEPOLENCIES 281 TERNUNE DRIVE WAYNE, NJ 07470 292 TERNUNC TO PERCENT TO THE APPROPRIATE 292 TERNUNC TO THE APPROPRIATE 293 TERNUNC | | | 315234 | B. WING | | 1 | 1/23/2022 | |
| MAYNE, NJ 97470 SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCY (MS) THE PRECEDED BY PULL RECOLLATIONY ORLSE (DENTEYTING INFORMATION) TAG PREFIX TAG CONSENERENCEID TO THE APPROPRIATE K 351 | NAME OF PI | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP COD | • | | |
| MAYNE, NJ 07470 MAYNE, NJ | | | | | 261 TERHUNE DRIVE | | | |
| REGULATORY OR LSC IDENTIFYING INFORMATION TAG TAG | ARBOR R | IDGE REHABILITATION | AND HEALTHCARE CENTER | | WAYNE, NJ 07470 | | | |
| 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/22/22 and 11/23/22, it was determined that the facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. This deficient practice was identified for 7 out of 200 sprinkler heads observed and was evidenced by the following: During the survey entrance on 11/22/22 (day one of survey) at 9.41 AM, the surveyor requested the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility provided layout identified there were three floors in the facility. Starting on 11/22/22 at approximately 10:02 AM and continued on 11/23/2022, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/28/2022 tha proximately 10:54 AM, the surveyor observed that the stated deficient practice will not recur. ~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility s Maintenance/Safety work order | PRÉFIX | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | I SHOULD BE | COMPLETION | |
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| Mentioned Up-Rite sprinkler. 3)On 11/23/2022 the facility repaired sprinkler there were three floors in the facility. Starting on 11/22/22 at approximately 10:02 AM and continued on 11/23/2022, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no mentioned Up-Rite sprinkler. 3)On 11/23/2022 the facility repaired sprinkler head stated to be hanging down from the drop ceiling 1/2 of an inch. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | | | 1 * | | | |
| A review of the facility provided layout identified there were three floors in the facility. Starting on 11/22/22 at approximately 10:02 AM and continued on 11/23/2022, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers head stated to be hanging down from the head stated to be hanging down from the drop ceiling 1/2 of an inch. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | rooms and smoke co | mpartments in the facility. | | | | | |
| there were three floors in the facility. Starting on 11/22/22 at approximately 10:02 AM and continued on 11/23/2022, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no head stated to be hanging down from the drop ceiling 1/2 of an inch. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | | | | | | |
| drop ceiling 1/2 of an inch. Starting on 11/22/22 at approximately 10:02 AM and continued on 11/23/2022, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no drop ceiling 1/2 of an inch. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | | | | • | | |
| and continued on 11/23/2022, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | • | | | wn from the | | |
| presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | | | | | | |
| Operations (RDPO) and MD conducted a tour of the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | _ | | | | | |
| the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | | | | | | |
| observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | | | | | | |
| fire sprinkler protection in the following locations: 1)On 11/28/2022 the Maintenance 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | | | | d deficient | | |
| 1)On 11/28/2022 the Maintenance 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | | | | practice will not recur. ~~ | | | |
| 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order | | lire sprinkler protection | on in the following locations: | | 1)On 11/28/2022 the Meinten | anco | | |
| surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no completing audits that are triggered by the facility's Maintenance/Safety work order | | 1 On 11/22/22 of and | provimately 10:54 AM the | | , | | | |
| near stairwell "F" two (2) sprinklers that had no facility's Maintenance/Safety work order | | | | | | | | |
| | | | | | 1 | | | |
| | | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONSTRUCTION NG 01 | . , | (X3) DATE SURVEY COMPLETED | |
|---|---|--|-------------------------|---|--|-------------------------------|--|
| | | 315234 | B. WING _ | | | 11/23/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, 2 | · · · · · · · · · · · · · · · · · · · | | |
| | | | | 261 TERHUNE DRIVE | | | |
| ARBOR R | IDGE REHABILITATIO | ON AND HEALTHCARE CENTER | | WAYNE, NJ 07470 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE DIENCY) | (X5) COMPLETION DATE | |
| K 351 | Continued From p | age 13 | K | 351 | | | |
| K 351 | one (1) sprinkler h the ceiling tile and 3/8 of an inch gap not allow the fire s the event of a fire. 2. On 11/22/22 at a surveyor observed elevators one (1) and of an inch gap in the allow the fire sprine event of a fire. 3. On 11/22/22 at a surveyor observed dining room #2 clo head installed app from the wall board no evidence of a d 4. On 11/22/22 at a surveyor observed area one (1) sprint had no evidence of 1/2 of an inch gap | kler head and the ceiling tile); ead left a 1/4 of an inch gap in one (1) sprinkler head left a in the ceiling tile. This would prinkler to function properly in approximately 11:09 AM, the don the first floor next to the sprinkler. This fire sprinkler had escutcheon cap leaving a 1/4 ne ceiling tile. This would not kler to function properly in the approximately 11:18 AM, the dinside the first floor residents' uset one "Up-Rite" sprinkler roximately two (2) inches away d. This Up-Rite sprinkler had deflector plate. approximately 11:52 AM, the din on the first floor Nurse Station kler head. This fire sprinkler of an escutcheon cap leaving a in the ceiling tile. This would prinkler to function properly in | K | he/she must thoroughly detailed step by step in audit. 2)There is a task Maintenance Software monthly for the Mainter designee to audit the sensure Escutcheon ring clean. All open/due tas automatically sent by e Regional Director of Open Regional Director of Plathe Facility Administrate follow-up as necessary 4. How the corrective a monitored to ensure the practice will not recur, i program will be put into 1)Starting on 1/23/2023 or designee will audit a monthly for 3 months to Escutcheon rings instal and deflector plate is put up-Rite sprinkler heads mentioned audits will be for 3 months by the Qu Performance Improvem and the committee will | estructions for each in the facility's system that is due nance Director or prinkler heads to g is present and k reports are mail weekly to the perations, the ant Operations and for to review and for to review and for the estated deficient for each of the perations will be the stated deficient for ensure they have alled with no gaps fresent for any so 2) The above the reviewed monthly ality Assurance from the system of the form of the factor of t | | |
| | surveyor observed machine area one head was hanging of an inch. This le ceiling tile. This w to function properl | approximately 10:16 AM, the lin the kitchen's dish washing sprinkler head. This sprinkler down from the drop ceiling 1/2 ft a 3/8 of an inch gap in the could not allow the fire sprinkler y in the event of a fire. | | recommendations to the any further actions. 3)A open tasks will be ran functional maintenance software each quarterly QAPI meet reviewed by the Quality Performance Improvement and the committee will | e Administrator for an audit report of all from the facility's system prior to eeting for the next ings and will be / Assurance nent Committee | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | E CONSTRUCTION D1 | (X3) DATE SURVEY COMPLETED |
|--|--|--|-------------|---|----------------------------|
| | | 315234 | B. WING | | 11/23/2022 |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | : | STREET ADDRESS, CITY, STATE, ZIP CODE 261 TERHUNE DRIVE WAYNE, NJ 07470 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 5.75 |
| K 351 | area one (1) sprinkler had no evidence of an 1/2 of an inch gap in the not allow the fire sprinthe event of a fire. With the openings in a fire the heat would by areas and not activate. The RDPO and MD of time. On 11/23/22 at approsurveyor informed the Administrator of these Administrator of these Fire Safety Hazard. NJAC 8:39-31.1(c), 3 NFPA 13. Portable Fire Extinguing CFR(s): NFPA 101 Portable Fire extinguing Portable fire extinguing inspected, and mainta NFPA 10, Standard for Extinguishers. 18.3.5.12, 19.3.5.12, | the kitchen by the plating head. This fire sprinkler in escutcheon cap leaving a che ceiling tile. This would akler to function properly in the ceilings, in the event of a pass the fire sprinkler in the extreme the fire sprinkler system. In the ceilings, in the event of a pass the fire sprinkler system. In the ceilings, in the event of a pass the fire sprinkler system. In the ceilings, in the event of a pass the fire sprinkler system. In the ceilings, in the event of a pass the fire sprinkler system. In the ceilings, in the event of a pass the fire sprinkler system. In the ceilings, in the event of a pass the fire sprinkler system. In the ceilings in the event of a pass the fire sprinkler in the event of a pass the event of a pass the fire sprinkler in the event of a pass the event of a | K 351 | recommendations to the Administrator any further actions. | for 1/23/23 |
| | Based on observation facility documentation in the presence of fact determined that the facinspect all portable firms. | n, interview, and review of on 11/22/22 and 11/23/22 illity management, it was acility failed to failed to e extinguishers annually, as Fire Protection Association | | What corrective action(s) will be accomplished for those residents state to have been affected by the deficient practice. ~~ No residents were identified. | d |

| | DF DEFICIENCIES CORRECTION | | | | | | |
|--------------------------|---|---|--------------------|------|--|----------------------------|----------------------------|
| | | 315234 | B. WING | | | 11/ | /23/2022 |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | · | 26 | TREET ADDRESS, CITY, STATE, ZIP CODE 61 TERHUNE DRIVE /AYNE, NJ 07470 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| K 355 | as required by NFPA 19.3.5.12, 9.7.4.1 and Association (NFPA) 1 6.1, 6.1.3.8.1 and 6.1 This deficient practice portable fire extinguis the following: Reference: NFPA 10 portable fire extinguis - 7.3 Maintenance 7.3.1.1 All Fire Ext - 7.3.1.1.1 Fire extin to maintenance at int years at the time of h specifically indicated electronic notification Reference: NFPA 10- date the inspection w of the person perform recorded at least mor be kept on a tag or la extinguishers. During the building to 11/23/22, the surveyor facility Regional Direct (RDPO) and Mainten | 101, 2012 Edition, Section d National Fire Protection 0, 2010 Edition, Sections .3.8.3 and N.J.A.C. 5:70. It was identified for 1 of 20 shers and was evidenced by Edition 2010 Standard for shers: inguishers. guishers shall be subjected ervals of not more than 1 ydrostatic test, or when by an inspection or 4-3.4 At least monthly, the as performed and the initials hing the inspection shall be nthly and that records shall bel attached to the fire our on 11/22/22 and or in the presence of the ctor of Plant Operations ance Director (MD) ted twenty (20) portable fire | K | 3355 | 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will taken. ~~ All residents have the potential to be affected. 1)The facility has scheduled an inspect of Fire Extinguisher #13 which will be completed by 12/23/2022. 2)On 11/23/2022 the Maintenance Director vin-serviced to ensure that the inspecto inspects external Extinguishers during annual inspection. 3. What measures will be put into place what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by facility's Maintenance/Safety work order and task management software system to thoroughly review the detailed step is step instructions for each audit. 2)Ther a task in the facility's Maintenance | vas r e or nt the er n, by | |
| | 1. On 11/22/22 at 11: extinguisher on the fil patio area had no evi inspection tag attache this time, the MD info | 57 AM, one (1) ABC type fire rest floor outside the resident dence of an annual ed to the extinguisher. At rmed the surveyor that the ewly installed extinguisher. | | | Software system that is due monthly for Maintenance Director to check all fire extinguishers in building to ensure they are in good working order and that anrinspection tag is present and up to dat All open/due task reports are automatically sent by email weekly to the Maintenance of the Maintenan | y nual e. | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | | CONSTRUCTION 1 | (X3) DATE COMF | SURVEY PLETED |
|--------------------------|--|---|------------------------------------|-----|---|--------------------------------------|----------------------------|
| | | 315234 | B. WING | | | 11/ | 23/2022 |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | | 26 | TREET ADDRESS, CITY, STATE, ZIP CODE 61 TERHUNE DRIVE /AYNE, NJ 07470 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| K 355 | The surveyor made a open the front plastic extinguisher cabinet. The surveyor turned the extinguisher manufactured in A review of the facility extinguisher log for Cothe extinguisher log for Cothe extinguisher #13 in the area on 10/28/22. The RDPO and MD of time of observations. During Life Safety Cotapproximately 12:05 Home Administrator with the company of the plant of the company of the c | request to obtain the key to break-away panel of the fire. The MD opened the or removed the extinguisher, er over, and observed the f the fire extinguisher which 2016. If provided monthly fire extober 2022 identified that a monthly inspection of fire the resident outside pation on firm the extension of the extension of the extension of the findings at the extension of the findings at the PM, the Licensed Nursing was notified of the finding. | | 355 | Regional Director of Operations, the Regional Director of Plant Operations at the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficier practice will not recur, i.e. what QA program will be put into place. ~~ 1)Starting on 1/23/2023 the Administrator designee will audit all fire extinguish in building monthly for 3 months to ensure they are in good working order and that annual inspection tag is present and update. 2)The above mentioned audits where we will above mentioned audits where the Quality Assurance Performance Improvement Committee and the committee will make recommendations the Administrator for any further actions 3)An audit report of all open tasks will ran from the facility's maintenance software system prior to each quarterly QAPI meetings and will be reviewed by the Quality Assurance Performance Improvement Committee and the committee will make recommendations the Administrator for any further actions the Administrator for any further actions. | tor ers ure t t to to ill by s to s. | 1/23/23 |
| | Subdivision of Buildin Construction 2012 EXISTING | g Spaces - Smoke Barrier be constructed to a 1/2-hour | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD | | PLE CONSTRUCTION G 01 | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|---|-------------------------------|--|
| | | 315234 | B. WING _ | | , | 11/23/2022 | |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 261 TERHUNE DRIVE WAYNE, NJ 07470 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| K 372 | Continued From pag | ge 17 | К3 | 72 | | | |
| | be permitted to term Smoke dampers are penetrations in fully an approved sprinkle smoke compartment barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechasin REMARKS. This REQUIREMEN by: Based on observatifacility provided door was determined that the integrity of smok deficient practice was barrier walls and was During the survey er of survey) at 9:41 Al Maintenance Director the facility layout who rooms and smoke condition; that there were two second floor; two (2) first floor; and two (2) first floor; and two (2) first floor of Plant Opic conducted a tour of Along the tour at appropriate the surveyor in the point of the four at appropriate the surveyor at approximate the surveyor at a surveyor a | proximately 10:18 AM, the | | 1. What corrective action(s) will accomplished for those residents to have been affected by the defipractice. ~~ No residents were identified. 2. How the Facility will identify ot residents having the potential to affected by the same stated defic practice and what corrective activataten. ~~ All residents have the potential to affected. 1)On 12/15/2022 the facility seal above mentioned penetration in fire/smoke wall. 2)On 12/15/2022 facility properly mounted above rulluminated Exit Sign". 3. What measures will be put into what systemic changes will the facility appared to appare that the stated definition in the systemic changes will the facility appared to appare that the stated definition in the systemic changes will the facility appared to appare that the stated definition in the systemic changes will the facility appared to appare that the stated definition in the systemic changes will be put into the systemic changes will the facility appared to appare the systemic changes will be put into the systemic changes will be systemic changes. | her be cient on will be ed the ed the mentioned | | |
| | surveyor observed t | oroximately 10:18 AM, the ne following smoke barrier n the 1/2-hour fire-rated | | | acility | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | 2) MULTIPLE CONSTRUCTION BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---------------------|--|---|--|-------------------------------|--|
| | | 315234 | B. WING _ | | | 11. | /23/2022 | |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | | 26 | TREET ADDRESS, CITY, STATE, ZIP CODE 61 TERHUNE DRIVE /AYNE, NJ 07470 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| K 372 | Continued From page construction as requilocation: On the second floor rabove the double smilluminated exit sign to securely to the wall. behind the hanging of 1-1/2-inch penetration running through the story through the smoke bewas not sealed close and fire from passing compartment. The RDPO and MD of time. During Life Safety Co. | red by code in the following mext to Resident Room #228 hoke barrier doors an that was not fastened The surveyor observed exit sign a 1 inch by In with a BX electrical cable smoke barrier wall. Tobserved on both sides arrier wall, indicating that it ad to prevent smoke, fumes, of through to the other smoke confirmed the finding at the code exit conference on lately 12:05 PM, the surveyor and Nursing Home | | 372 | | the er n, by re is call lant tor for es vill | | |
| | | | | | Quality Assurance Performance Improvement Committee and the committee will make recommendations the Administrator for any further action 3)An audit report of all open tasks will ran from the facility's maintenance software system prior to each quarterly QAPI meeting for the next 4 Quarterly QAPI meetings and will be reviewed by the Quality Assurance Performance | s to s. be | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDIN | | CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|--|---|---------------------|-----|---|------|----------------------------|
| | | 315234 | B. WING _ | | | 11. | /23/2022 |
| | ROVIDER OR SUPPLIER | AND HEALTHCARE CENTER | | 261 | REET ADDRESS, CITY, STATE, ZIP CODE I TERHUNE DRIVE AYNE, NJ 07470 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| K 372 | Continued From page 19 | | К3 | 72 | Improvement Committee and the committee will make recommendations the Administrator for any further actions | | |
| K 911 SS=E | Electrical Systems - 0 CFR(s): NFPA 101 | Other | K 9 |)11 | | | 1/23/23 |
| | are not addressed by are deficient. This info applicable Life Safety citation, should be incompleted (NFPA 99). This REQUIREMENT by: Based on observation and 11/23/22, in the promanagement, it was a failed to ensure that a next to a water source Ground-Fault Circuit. | section any NFPA 99 systems requirements that the provided K-Tags, but ormation, along with the Code or NFPA standard cluded on Form CMS-2567. is not met as evidenced in and interview on 11/22/22 irresence of facility determined that the facility all electrical outlets located be were equipped with interrupter (GFCI) | | | What corrective action(s) will be accomplished for those residents state to have been affected by the deficient practice. ~~ No residents were identified. | d | |
| | for 2 of 13 electrical of source observed and following: During the survey ent of survey) at 9:41 AM Maintenance Director the facility layout which rooms and smoke con A review of the facility that there were three | ient practice was identified utlets located near a water was evidenced by the rance on 11/22/22 (day one , the surveyor requested the (MD) to provide a copy of the identified the various mpartments in the facility. It provided layout identified (3) floors in the facility. | | | 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will taken. ~~ All residents have the potential to be affected. On 11/23/2022 the facility replaced bot mentioned duplex outlets with new dup outlets equipped with GFCI. | h | |
| | _ | at approximately 10:02 AM, esence of the Regional | | | 3. What measures will be put into place | e or | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 315234 B. WING 11/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 TERHUNE DRIVE** ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER **WAYNE, NJ 07470** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 20 K 911 Director of Plant Operations (RDPO) and MD what systemic changes will the facility make to ensure that the stated deficient conducted a tour of the building. During the two-day tour (11/22/22 and 11/23/22) practice will not recur. ~~ of the facility, the surveyor observed and tested thirteen (13) electrical outlets (within 4 feet of a 1)On 11/28/2022 the Maintenance sink) in wet locations with a GFCI tester to Director was in-serviced that when de-energize the outlets. The surveyor observed completing audits that are triggered by the the following: facility's Maintenance/Safety work order and task management software system, 1. On 11/22/22 at approximately 11:03 AM, the to thoroughly review the detailed step by surveyor observed inside the second floor Social step instructions for each audit. 2)There is Workers office one (1) duplex electrical outlet a task in the facility's (Maintenance located 14 inches to the left of a sink. When the Software system) that is due annually for surveyor tested the duplex electrical outlet with a Maintenance Director or designee to audit GFCI tester to de-energize, the outlet did not physical integrity of all electrical de-energize as required by code. receptacles and where applicable the GFCI function. All open/due task reports 2. On 11/22/22 at approximately 11:52 AM, the are automatically sent by email weekly to the Regional Director of Operations, the surveyor observed inside the second floor Regional Director of Plant Operations and resident Central Bathing room one (1) duplex electrical outlet located 16 inches to the left of a the Facility Administrator to review and sink. When surveyor tested the duplex electrical follow-up as necessary. outlet with a GFCI tester to de-energize, the outlet did not de-energize as required by code. 4. How the corrective actions will be The RDPO and MD confirmed the finding at the monitored to ensure the stated deficient time. practice will not recur, i.e. what QA program will be put into place. ~~ During Life Safety Code exit conference on 11/23/22 at approximately 12:05 PM, the surveyor 1)On 1/23/2023 and every 6 months informed the Licensed Nursing Home thereafter for a duration of 18 months the Administrator of these findings. Administrator or designee will audit all outlets located next to a water source to NJAC 8:39 -31.2 (e) ensure they have properly working NFPA 99: -6.3.2.1, NFPA 70: -210.8 Ground-Fault Circuit Interrupter (GFCI) protection. 2)The above audits and an audit report of all open tasks in the facility's maintenance software system will be reviewed by the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | ULTIPLE CONSTRUCTION LDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|---|----------------------|--|-------------------------|---|---|-------|-------------------------------|--|
| | | 315234 | B. WING _ | | | 11/2 | 23/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CI | TY, STATE, ZIP CODE | • | | |
| ADROD D | IDGE PEHARII ITATION | AND HEALTHCARE CENTER | | 261 TERHUNE DRIVE | i . | | | |
| ANDON | IDGE KEHADIEHAHON | AND HEAEITIGARE GENTER | | WAYNE, NJ 07470 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CO | DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| K 911 | Continued From page | 21 | KS | Quality Assura Improvement (other quarterly for the next 18 will make reco | ance Performance (QAPI) Committee every QAPI meeting (bi-annuals months and the committe mendations to the for any further actions. | ally) | | |

POST-CERTIFICATION REVISIT REPORT

| | · | | | | | |
|------------------------------|-----------------------------------|---------------------------------------|-----------------|----|--|--|
| PROVIDER / SUPPLIER / CLIA / | MULTIPLE CONSTRUCTION | | DATE OF REVISIT | Ī | | |
| IDENTIFICATION NUMBER | A. Building 01 - MAIN BUILDING 01 | | | | | |
| | | | 0/0/0000 | | | |
| 315234 _{Y1} | B. Wing | Y2 | 2/9/2023 | Y3 | | |
| NAME OF FACILITY | • | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| ARBOR RIDGE REHABILITATION | AND HEALTHCARE CENTER | 261 TERHUNE DRIVE | | | | |
| | | WAYNE, NJ 07470 | | | | |
| | | | | | | |

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).

| ITE | M | DATE | ITEM | | | DATE | ITEM | | | DATE |
|--|----------|--|-----------|--------|----------------|----------------|-----------|----------|------|------------|
| Y4 | | Y5 | Y4 | | | Y5 | Y4 | | | Y5 |
| ID Prefix | | Correction | ID Prefix | | | Correction | ID Prefix | | | Correction |
| Reg.# | NFPA 101 | Completed | Reg. # | NFPA 1 | 01 | Completed | Reg.# | NFPA 101 | | Completed |
| LSC | K0222 | 12/19/2022 | LSC | K0281 | | 01/23/2023 | LSC | K0321 | | 01/23/2023 |
| ID Prefix | | Correction | ID Prefix | | | Correction | ID Prefix | | | Correction |
| Reg.# | NFPA 101 | Completed | Reg. # | NFPA 1 | 01 | _ Completed | Reg.# | NFPA 101 | | Completed |
| LSC | K0324 | 01/23/2023 | LSC | K0351 | | 01/23/2023 | LSC | K0355 | | 01/23/2023 |
| ID Prefix | | Correction | ID Prefix | | | Correction | ID Prefix | | | Correction |
| Reg.# | NFPA 101 | Completed | Reg. # | NFPA 1 | 01 | Completed | Reg.# | | | Completed |
| LSC | K0372 | 01/23/2023 | LSC | K0911 | | 01/23/2023 | 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 | | | |
| REVIEWE STATE AC | | REVIEWED BY (INITIALS) | DATE | | SIGNATURE OF S | SURVEYOR | | | DATE | |
| REVIEWE CMS RO | D BY | REVIEWED BY (INITIALS) | DATE | | TITLE | | | | DATE | |
| FOLLOWUP TO SURVEY COMPLETED ON 11/23/2022 | | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? | | | | | ☐ YE | s 🗆 no | | |