STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. BUILDING _____ B. WING _____	C 12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

(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 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00153345, NJ00159409, NJ00160088, NJ00160965, NJ00162255, NJ00164006, NJ00165103, NJ00165790, NJ00166779, NJ00167680, NJ00169771, NJ00169757, NJ00169869. Survey Dates: 12/27/23 to 12/29/23 Survey Census: 123 Sample Size: 15 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint # NJ 160965 Based on observation, interview, record review, and review of facility investigation and policies,	F 689	Concern. F689 SS=D	1/1/24

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

Electronically Signed | 01/19/2024

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F 689	Continued From page 1 the facility failed to ensure a fall risk assessment was completed upon admission and quarterly for one of three residents (Resident (R) 1) reviewed for falls out of 15 sample residents. This failure placed the resident at risk of NJ Exec Order 26.4b1 and a diminished quality of life. Findings include: Review of R1's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R1 was admitted to the facility on NJ Exec Order 26.4b with diagnoses that included a history of NJ Exec Order 26.4b1. Review of the admission "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b revealed R1 had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec out of 15 which indicated she had NJ Exec Order 26.4 The assessment further revealed that R1 had a history of NJ Exec O and had a NJ Exec Order 26.4b1 prior to admission. Review of the "Assessments" tab of the EMR did not show that an admission NJ Exec risk assessment had been completed in NJ Exec Order 26.4b and a quarterly NJ Exe risk assessment had not been completed in NJ Exec Order 26.4b1. Review of a NJ Exec Or Investigation," provided by the Director of Nursing (DON), dated NJ Exec Order 26.4b revealed " ...R1 admitted to the facility on NJ Exec Order 26.4b with a NJ Exec Order 26.4b1 [------]. On NJ Exec Order 26.2 at approximately 3:15 AM, upon answering call light initiated by roommate, R1 was observed sitting on floor close to her roommate's bed. R1 was assessed with NJ Exec Order 26.4b and NJ Exec Order 26.4b1 in	F 689	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) How the corrective action will be accomplished for any resident affected by deficient practice. This deficient practice was immediately in-serviced with Unit Managers and licensed nursing staff. All fall care plans were reviewed, updated to ensure interventions were individualized and are in place. NJ Exec O assessment of one sample resident #1 was re assessed, no other residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice, Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Unit Managers and nursing staff in-serviced regarding fall risk assessments. DON will run a report weekly to ensure fall assessments are completed timely. Interdisciplinary Team will review new	

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F 689	Continued From page 2 NJ Exec Order 2 R1 was administered NJ Exec Order 2 and NJ Exec Orde were ordered of the NJ Exec Order 26.4b1 NJ Exec Order taken at facility at 9:15 AM and demonstrated NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 noted NJ Exec Order 26.4b1 changes noted' ...R1 is being sent to the hospital for evaluation and treatment ..." Review of the NJ Exec O Care Plan," initiated on NJ Exec Order 26.2, revealed "R1 is NJ Exec Order 26.4b1 r/t [related to] history of NJ Exec Order 26.4b1. NJ Exec Order 26. ." Interventions included, " ...Anticipate and meet needs. Frequent NJ Exec Order 26.4b1 checks throughout the evening, while awake, dated NJ Exec Order 26.4b ...Be sure call light is within reach and encourage to use it for assistance as needed. The resident needs prompt response to all requests for assistance, dated NJ Exec Order 26.4b ...Bed in lowest position at HS [hour of sleep] and when in bed, dated NJ Exec Order 26.4b ...Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, dated NJ Exec Order 26.4b1 Encourage to wear appropriate footwear, use of non-skid socks when ambulating or mobilizing in w/c [wheelchair], dated NJ Exec Order 26.4b ...Ensure R1 is NJ Exec Order 26 before going to bed, dated NJ Exec Order 26.2 ...Keep room clutter free, dated NJ Exec Order 26.4b ..." During an observation and interview on 12/27/23 at 8:32 AM, R1 was dressed and seated in a NJ Exec Order 26.4b1 wheelchair with the over bed table in front of her. She was NJ Exec Order 26.4b1. R1 was asked if she had NJ Exec Orde recently. She stated, "NJ Exec O ." R1 was asked if there was anything she remembered that was put into place to keep her NJ Exec Order 26.4b1	F 689	admissions for the completion of admission assessments daily in morning clinical meeting. DON or designee will review 5 charts fall risk assessments to ensure compliance weekly. X 90 days, then monthly and thereafter. Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. DON or designee will monitor all admission and quarterly fall risk assessments weekly X 90 days and report findings to the administrator in morning meeting for immediate resolution. This will be a part of monthly QAPI and quarterly QA program. Dates when concern will be completed. 1/1/24.	

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F 689	Continued From page 3 She stated, "That bed over there, with the covers, it keeps me safe." During an interview on 12/28/23 at 7:40 AM, the DON was asked about the missing admission and quarterly [NJ Exec] risk assessments in the "Assessments" tab of the EMR. The DON looked through the EMR "Assessments" tab and confirmed they were not done. During an interview on 12/28/23 at 7:56 AM, the Unit Manager (UM) 2 was asked about the missing [NJ Exec] risk assessments. She stated, "I did a [NJ Exec] risk assessment when she came back from the hospital in [NJ Exec Order 26.4b1]. I was off the entire month of [NJ Exec], and I don't know if any other assessments were completed." Review of the facility's policy titled, "Falls Management," revised 01/23, revealed " ...Any resident/patient who is at risk for falls will be identified through an assessment process. Any resident/patient found to be at a significant risk for falls will have appropriate interventions addressed in the individualized care plan ...Fall Risk Assessment form will be completed: upon admission; quarterly and annual MDS review ..." NJAC 8:39-27.1	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		1/1/24

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F 842	Continued From page 4	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 5 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 165790 Based on interview, record review, and review of facility policy, it was determined that the facility failed to ensure the medical record was accurate in accordance with acceptable standards of practice for one of 15 residents (Resident (R) 5) whose medical records were reviewed. The facility failed to ensure the SBAR [situation, background, assessment, recommendation-documentation that is used to facilitate prompt and appropriate communication] was completed by the staff person who witnessed the event. This failure placed residents at risk for unmet care needs and falsification of documentation. Findings include: Review of R5's "Admission Record" located in the	F 842	Concern. F842 SS=D Resident Records – Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) How the corrective action will be accomplished for any resident affected by deficient practice. This deficient practice was immediately in-serviced with Unit Managers and nursing licensed staff. Affected Unit manager was counselled	

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F 842	Continued From page 6 "Profile" tab of the electronic medical record (EMR) revealed R5 was admitted to the facility on NJ Exec Order 26.4b and was discharged to the hospital on NJ Exec Order 26.4b. R5 had a diagnosis that included NJ Exec Order 26.4b1 which required her to have a NJ Exec Order 26.4b1 [redacted] Review of the admission "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b revealed R5 had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec out of 15 which indicated she had NJ Exec Order 26.4 [redacted] The assessment further revealed that R5 had a NJ Exec Order 26.4b1 and required NJ Exec Order 26.4b1 Review of the "SBAR" documentation located in the "Progress Notes" tab of the EMR revealed on NJ Exec Order 26.4b at 6:04 PM, the Unit Manager (UM) 2 documented, " ...Late Entry: Situation: resident presented in a NJ Exec Order 26.4b1 with NJ Exec O [redacted]. VS [vital signs] NJ Exec Order 26.4b1 [redacted] MD [medical doctor] notified pending call back ... Assessment (RN) [Registered Nurse]/Appearance (LPN) [Licensed Practical Nurse]: Resident appeared in a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 in room, husband at bedside unable to describe chain of events to staff. Recommendations: n/o [new order] given by MD for administration of NJ Exec Order 26.4b1 [redacted] however, husband called 911 himself ..." During an interview on 12/27/23 at 12:56 PM,	F 842	regarding improper documentation and communication. Documentation must only be done by the staff person who witnessed the event and will be the one to complete the documentation. All active charts were reviewed for SBAR communication re assessment, and recommendation for accuracy and completeness in accordance with acceptable standards of practice to met the care needs. No other residents were affected with this deficient practice. Resident #5 discharged from facility on NJ Exec Order 26 [redacted]. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Unit Managers and nursing staff in-serviced regarding SBAR communication, assessment, and recommendation. DON or designee will review 5 charts weekly x 90 days and thereafter for accuracy, timeliness and completeness of SBAR	

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F 842	Continued From page 7 UM2 was asked about the events that night with R5. The UM stated, "I was not here when she went out (to the hospital). It was a weekend." The UM was asked why she had documented an SBAR on the day of the event when she did not witness or have firsthand knowledge of the event. The UM stated, "Staff told me. I think I took information from the note that the other nurse wrote." The UM further stated, "I should have had LPN1 type the note, but I was showing him how to do an SBAR, so I typed if for him." During an interview on 12/27/23 at 1:12 PM, the Director of Nursing (DON) stated, "I don't remember anything about the incident, in particular. Normally, I would expect them (nursing staff) to call me, they usually do, but they did not call me that night." The DON further stated, "The UM should have put 'per nurse' (to indicate she was not involved) however, she did not." Review of the facility's policy titled, "Charting and Documentation," revised 01/23, revealed " ...All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record ...Entries may only be recorded in the resident's clinical record by licensed personnel (i.e. RN, LPN/LVN [Licensed Vocational Nurse], physicians, therapists, etc.) in accordance with state law and facility policy ..." NJAC 8:39-35.2 (d) 6	F 842	documentation. Unit manager or designee will review SBAR documentation daily for residents with a changed in condition and those that went out “acute discharge” to the hospital to ensure SBARs are completed timely. If it is required that Unit Manager contact the nurse regarding an incomplete SBAR, he/she will not document under their name and will incorporate “Per nursing…” Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. DON or designee will review 5 charts weekly x 90 days and thereafter for accuracy, timeliness and completeness of SBAR documentation. Findings will be discussed in morning clinical meeting and this will be a part of monthly QA and quarterly QA Program. Dates when concern will be completed. 1/1/24.	

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ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	**685 SALINA ROAD SEWELL, NJ 08080**

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	08007	A. BUILDING: _____ B. WING _____	C 12/29/2023

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ADVANCED SUBACUTE REHABILITATION CENTER A	685 SALINA ROAD SEWELL, NJ 08080

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S 000	Initial Comments Complaint #: NJ00153345, NJ00159409, NJ00160088, NJ00160965, NJ00162255, NJ00164006, NJ00165103, NJ00165790, NJ00166779, NJ00167680, NJ00169771, NJ00169757, NJ00169869. Survey Dates: 12/27/23 to 12/29/23 Survey Census: 123 Sample Size: 15 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00153345, NJ00160965, NJ00162255, NJ00169771	S 560	Concern. S560- 8:39-5,1 (a) Mandatory Access to care.	1/1/24

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

Electronically Signed | 01/19/24

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S 560	Continued From page 1 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 9 of 45 day shifts and 1 of 7 evening shifts as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 6 weeks of staffing from 06/18/2023 to 06/24/2023, 07/16/2023 to 07/22/2023, 08/20/2023 to 08/26/2023 and 12/10/2023 to 12/30/2023, the staffing to resident ratios did not meet the minimum requirement of	S 560	8:39-5.1(a) Mandatory Access to Care S560 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00153345, NJ00160965, NJ00162255, NJ00169771 How the corrective action will be accomplished for any resident affected by deficient practice. All efforts to hire facility Certified Nursing Aide(s) C.N.A will continue until there is adequate staff to serve all residents. Until the time, facility will utilize staffing agencies to fill any open spots in the schedule. Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. Staffing records for 6/18/23 to 6/24/23, 7/16/23 to 7/22/23; 8/20/23 to 8/26/23; 12/10/23 to 12/30/23; 12/24 and 12/26/23 were reviewed. No resident was affected with this deficient practice. How we identified other residents/areas	

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ADVANCED SUBACUTE REHABILITATION CENTER A	685 SALINA ROAD SEWELL, NJ 08080

(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) COMPLETE DATE
S 560	Continued From page 2 one CNA to eight residents for the day shift and one direct care staff member to every 10 residents for the evening shifts as documented below: 1. For the week of staffing from 06/18/2023 to 06/24/2023, the facility was deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -06/18/23 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. 2. For the week of staffing from 07/16/2023 to 07/22/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -07/16/23 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. 3. For the week of staffing from 08/20/2023 to 08/26/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -08/22/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. 4. For the 3 weeks of staffing from 12/10/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 7 of 21 day shifts as follows: -12/12/23 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -12/16/23 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/17/23 had 14 CNAs for 124 residents on the	S 560	that could potentially be affected. 2. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. 1. Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. 2. The Administrator or designee will review staffing schedules weekly for 4 weeks and monthly for 3 months to ensure adequate staffing for all shifts. 3. Corporate staffing Director will monitor staffing needs daily to ensure facility is compliance with staffing requirements. 4. Staffing Coordinator placed on Performance Improvement Plan and has since resigned. Ad has been placed for Staffing Coordinator. In the interim DON, Administrator, Infection Preventionist, and Facility Educator are ensuring compliance with staffing requirements. Audits will be monitored for completion by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08007	A. BUILDING: _____ B. WING _____	C 12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER A	685 SALINA ROAD SEWELL, NJ 08080

(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) COMPLETE DATE
S 560	Continued From page 3 day shift, required at least 15 CNAs. -12/18/23 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -12/19/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/24/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/26/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs.	S 560	the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% cat compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. The results of these reviews will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed. 1/1/24.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315516	A. Building B. Wing	1/29/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

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 F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 01/01/2024	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 01/01/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08007 Y1	A. Building B. Wing Y2	1/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/01/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO