STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCLAIM REHABILITATION AND NURSING CENTER	**198 STEVENS AVE JERSEY CITY, NJ 07305**

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F 000	INITIAL COMMENTS Complaint # : NJ 179416, NJ 182884, NJ 184270 Survey dates: 3/31/25 through 4/4/25 Census: 142 Sample Size: 24 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		5/17/25

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

Electronically Signed | 04/22/2025

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F 623	Continued From page 1 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and	F 623		

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F 623	Continued From page 2 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to notify the resident's representative in writing for an emergency transfer to [NJ Ex Order 26.4(b)(1)]. This deficient practice was identified for 2 of 2	F 623	I. Immediate action a. The [U.S. FOIA (b) (6)] was in serviced on 4/3/25 by the Regional Director of Business Development on importance of ensuring that the facility will	

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F 623	Continued From page 3 residents, Resident #101 and #105 reviewed for hospitalization. On 04/1/25 at 4:06 PM, the surveyor reviewed the electronic medical records for resident #101. A review of Resident #101's face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the nursing progress note dated NJ Exec Order 26.4b1, revealed that the resident was NJ Exec Order 26.4b1 and admitted with a diagnosis of NJ Exec Order 26 A review of the Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4, reflected that Resident #101 was discharged to NJ Ex Order 26.4(b)(1) with a return anticipated back to the facility. On 4/1/25 at 11:56 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that they did not send letters to the families when a resident had an unplanned discharge and stated that would have been the nursing department. On 4/2/25 at 9:35 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the facility does not send a letter to the family for unplanned discharge and that they would just call the family to inform them. On 4/2/25 at 10:00 AM, The U.S. FOIA (b)(6) [redacted] who stated that the	F 623	notify resident's representative in writing for an emergency transfer to the hospital. b. Notification of Transfer to NJ Ex Order 26.4(b)(1) letters were sent to the families of resident #101 and resident #105 on 4/17/25, according to facility policy and state guidelines. II. Identification of others a. The facility respectfully submits that all residents who are being transferred to the hospital are potentially affected III. Systemic Changes: a. The Policy and Procedure titled Discharge policies and procedures which includes emergency transfer, was reviewed by the Director of Nursing and Regional Director of Business Development and was found to be in compliance. b. U.S. FOIA (b) (6), U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) were in serviced on 4/17/25 by the Regional Director of Business Development on the facility policy for Transfer to the Hospital which includes written notification to the residents representative IV. Quality Assurance: a. Audit of 5 residents who were transferred to the hospital will be performed by the Administrator or designee, to ensure the written notice of transfer was sent to the residents representative, weekly x 4 weeks, monthly x 2 months, and then quarterly x 3 quarters	

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F 623	Continued From page 4 facility does not send a letter to the family for unplanned discharges. A review of the facility's policy titled, " Discharge Policies and Procedures" with a review date of 1/8/25, included for am emergency transfer the facility will notify the responsible party. The Admission Director would complete the bed hold and Notification of any transfer to the hospital form and notifies resident/family via phone/email/regular mail depending on availability or preferences. NJAC 8:39-5.3; 5.4 2. On 4/3/25 at 10:54 AM, the surveyor reviewed the EMR for resident #105. A review of Resident #105's face sheet revealed the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted]. A review of the nursing progress note dated [redacted] at 10:39 PM, revealed that the resident was [redacted] and admitted with a diagnosis of [redacted]. A review of the Discharge MDS, dated [redacted] reflected that Resident #105 was discharged to [redacted] with a return anticipated back to the facility. On 4/1/25 at 11:56 AM, the surveyor interviewed the [redacted] who stated that they	F 623	b. Any negative findings will be corrected immediately and brought to the Regional Director of Business Developments attention c. The results of all audits will be brought to the Quality Assurance and Performance Improvement (QAPI) committee quarterly x 3 quarters V. Responsible person: Regional Director of Business Development/Administrator or designee	

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F 623	Continued From page 5 did not send letters to the families when a resident had an unplanned discharge and stated that would have been the nursing department. On 4/2/25 at 9:35 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the facility does not send a letter to the family for unplanned discharge and that they would just call the family to inform them. On 4/2/25 at 10:00 AM, U.S. FOIA (b)(6)) who stated that the facility does not send a letter to the family for unplanned discharges. A review of the facility's policy titled, " Discharge Policies and Procedures" with a review date of 1/8/25, included for am emergency transfer the facility will notify the responsible party. The Admission Director would complete the bed hold and Notification of any transfer to the hospital form and notifies resident/family via phone/email/regular mail depending on availability or preferences.	F 623		
F 640 SS=D	NJAC 8:39-5.3; 5.4 Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates.	F 640		5/17/25

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F 640	Continued From page 6 (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and	F 640		

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F 640	Continued From page 7 approved by CMS. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS - an assessment tool used to facilitate the management of care) in accordance with federal guidelines. This deficient practice was identified for 6 (six) of 28 residents (Resident #3, #10, #29, #47, #68, and #138) reviewed. This deficient practice was evidenced by the following: The MDS is a comprehensive tool federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 4/3/25 at 11:00 AM, the surveyor provided the U.S. FOIA (b)(6)) with the list of 6 residents who completed more than 14 (fourteen) days after an entry date. The surveyor also requested a copy of the resident's final validation report (a report generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS). On 4/3/25 at 11:05 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the U.S. FOIA (b)(6)) would submit the assessment as soon as she was done. The U.S. FOIA (b)(6) further indicated that they followed the RAI (Resident Assessment	F 640	I. Immediate Action a. Residents #3, #10, #29, #68 and #138 records were reviewed on NJ Exec Order 26. and no other current overdue assessments were found b. Resident #47 is no longer in the facility, discharged NJ Exec Order 26.4b1 c. Facility U.S. FOIA (b)(6) was in serviced on 4/3/25 by the Regional MDS coordinator on timely completion, submittal and transmission of MDS data to the CMS system II. Identification of Others a) The facility respectfully submitted that potentially all residents may be affected b) An audit will be completed of all MDS due in the last 30 days to ensure they are completed and submitted timely, according to guidelines. c) Any negative findings will be brought to the Regional Nurses attention, will be completed and submitted immediately. III. Systemic Changes a. The Policy and Procedure on Minimum Date Set S was reviewed by Administrator, Director of Nursing and Regional MDS Coordinator and was found to be in compliance b. All personnel involved in the completion of the quarterly assessments/MDS were reeducated on 4/17/25 by the Regional MDS coordinator on the importance of timely completion of their respective section to ensure that all	

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F 640	Continued From page 8 Instrument, a tool that helps gather information about a resident's strengths and needs, which is used to create an individualized care plan) Manual. On 4/4/25 at 9:05 AM, the surveyor interviewed the U.S. FOIA (b)(6), who stated that she tried to submit the MDS assessment at least every day and she was made aware that the assessment was signed on the past date but needed to wait for every discipline to sign their section before submitting it. The surveyor and the U.S. FOIA (b)(6) reviewed the 6 residents' MDS assessments that were not submitted within 14 days of completion as follows: 1. Resident #3 had an admission MDS (A/MDS) assessment with an Assessment Reference Date (ARD - the last day of the observation period) of U.S. FOIA (b)(6) that was signed as completed on NJ Ex Order 26 and was not transmitted until NJ Ex Order 26.4 2. Resident #10 had A/MDS assessment with an ARD of U.S. FOIA (b)(6) that was signed as completed on NJ Ex Order 26.4(and was not transmitted until NJ Ex Order 26.4(. 3. Resident #29 had A/MDS assessment with an ARD of U.S. FOIA (b)(6) that was signed as completed on NJ Ex Order 26.4(b)(and was not transmitted until NJ Ex Order 26.4(b)(1) 4. Resident #47 had the following assessment and was completed late: a. The A/MDS with an ARD of U.S. FOIA (b)(6) . It was signed as completed and transmitted on NJ Ex Order 26.4(b)(. b. The discharge return not anticipated MDS (DCRNA/MDS) with an ARD of U.S. FOIA (b)(6) was signed as completed on NJ Ex Order 26.4 and was not	F 640	MDS are submitted timely. IV. Quality Assurance a. Audits will be conducted for 10 residents with scheduled assessments to ensure completion and submission of the assessment. b. These audits will be conducted weekly x 4 weeks, then monthly x 2 months then quarterly x 3 quarters. c. All negative findings will be brought to the Regional MDS coordinators attention. d. The results of all audits will be brought to the QAPI committee quarterly x 3 quarters. V. Person Responsible: Regional MDS coordinator or designee	

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F 640	Continued From page 9 transmitted until [NJ Ex Order 26]. c. The A/MDS assessment with an ARD of [NJ Ex Order 26.4(b)], It was signed as completed and transmitted on [NJ Ex Order 26.4(b)] 5. Resident #68 had A/MDS assessment with an ARD of [NJ Ex Order 26.4(b)] that was signed as completed on [NJ Ex Order 26.4(b)] and was not transmitted until [NJ Ex Order 26.4(b)]. 6. Resident #138 had A/MDS assessment with an ARD of [NJ Ex Order 26.4(b)] that was signed as completed on [NJ Ex Order 26.4(b)] and was not transmitted until [NJ Ex Order 26.4(b)]. On 4/4/25 at 10:30 AM, the surveyor met with the [U.S. FOIA (b)(6)] the above concern, and no further information was provided.	F 640		
F 755 SS=E	NJAC 8:39-11.1 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		5/17/25

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F 755	Continued From page 10 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure (a). that a medication was administered according to the physician orders (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in 1 (one) of 8 (eight) residents (Resident #34) observed during the medication observation pass and (b), to follow acceptable standards of clinical practices for accurately administering medications according to PO. This deficient practice was identified in 1 (one) and 7 (seven) residents (Resident #10) reviewed for medication administration. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title	F 755	I. Immediate Action a) Licensed Practical Nurse (LPN) #1 and U.S. FOIA (b)(6) was in serviced on 4/3/25 by the Director of Nursing on the importance of completion and accuracy of Controlled Medication Accountability Record b) Licensed Practical Nurse (LPN) #2 and LPN #3 were in serviced on 4/3/25 by the Director of Nursing on the importance of including in the U.S. FOIA (b)(6) orders the site and amount units administered c) U.S. FOIA (b)(6) administration for resident U.S. FOIA was reviewed and corrected d) U.S. FOIA (b)(6) orders for resident #10 was corrected to reflect NJ Ex Order 26.4(b)(1) and amount of units of U.S. FOIA (b)(6) II. Identification of Others	

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F 755	Continued From page 11 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." A). On 04/02/25 at 9:10 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN#1) in the room of Resident #34. The surveyor observed RN #1 checking the resident's identification bracelet and informed Resident #34 that she would be administering the resident's medications. On 04/08/25 at 8:35 AM, the surveyor observed LPN #1 preparing to administer nine (9) medications to Resident #34 which included the following: NJ Exec Order 26.4b1 [redacted]),	F 755	a) The facility respectfully submits that all residents have the potential to be affected e) Audit for all residents on insulin was conducted on 4/17/25 by Unit manager to ensure all orders include site of administration and units of insulin administered b) All negative findings were corrected and reported to the Director of Nursing immediately. III. Systemic Changes a) The Facility Policy and procedure titled Controlled Substances was reviewed by Administrator and Director of Nursing and was found to be in compliance b) The Facility Policy and procedure titled Medication Administration was reviewed by Administrator and Director of Nursing and was found to be in compliance c) Nursing staff Inservice was conducted by the Director of Nursing on 4/18/25 to include signing for narcotic administration according to facility policy and correct insulin orders which must include administration site and units of insulin administered. IV. Quality Assurance a) Audits for 10 residents on narcotics will be conducted by Unit Manager/Designee to ensure that all narcotic drug administrations are documented on the Narcotic declining sheet and in the electronics Sigma Medication record timely and accurately.	

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F 755	Continued From page 12 NJ Exec Order 26.4b1 [redacted]. Prior to LPN#1 preparing the resident's [redacted] the surveyor noticed the amount of tablets in the bingo card (medication packaging) did not match the amount remaining in the [redacted] inventory book. At that time, the surveyor interviewed LPN#1 who stated that she just took over the medication cart from the Registered Nurse/Unit Manager (RN#1/UM) who had to take care of another situation on the nursing unit. She stated that the RN#1/UM) already administered Resident #34's [redacted] LPN#1further acknowledge that both the electronic medication administration record (EMAR) and narcotic inventory book were both not documented as being administered by the RN#1/UM. On 4/08/25 at 8:40 AM, the surveyor interviewed RN#1/UM who acknowledge that she administered Resident #34's [redacted] and that she should have documented both the EMAR and the [redacted] inventory book. She stated that the proper practice is to full out the [redacted] log book while preparing the medication for administartion and signing the EMAR after the medication was administered. On 4/8/25 at 8:45 AM, during medication administration, LPN#1 informed the resident that they were not receiving the [redacted] since that other nurse already administered the medication. At that time, the surveyor interviewed Resident	F 755	Audits will be conducted weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters. b) Audits of 10 residents on insulin will be conducted by Unit manager or designee to ensure all insulin orders include site of administration and amount of insulin units administered. Audits will be conducted weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters. c) All negative findings will be brought to the attention of the Director of Nursing immediately. d) All findings will be reviewed at the Quality Assurance meeting x 3 quarters. Person Responsible : Director of Nursing or Designee	

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F 755	Continued From page 13 #34 who's [NJ Exec Order 26.4b1]. The resident told the surveyor that they already received [redacted] On 4/8/25 at 10:15 AM, the surveyor inspected all of the facility's medication storage areas which included 6 (six) medication carts and three (3) medication refrigerators. The surveyor inspected all [redacted] storage area and conducted a [redacted] count with all nurses who were present during medication storage inspection. The surveyor found no discrepancies with the narcotic counts with all [redacted] in the facility being accounted for and all nurses who were interviewed stating that [redacted] counts are done with every shift change. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to [NJ Exec Order 26.4b1] [redacted] . A review of the annual Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident's cognitive skills for daily decision-making score was [redacted], which indicated that the resident's cognition was [NJ Exec Order 26.4b1]. A review of the [redacted] Physician's Orders	F 755		

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(PO) revealed a Physician's Order dated [NJ Exec Order 2], for NJ Exec Order 26.4b1 [redacted]

A review of the [NJ Exec Order 26.4b1] EMAR revealed an order dated NJ Exec Order 26.4b1 [redacted].

B). On 3/31/25 at 12:08 PM, the surveyor observed Resident #10 during initial tour seated in their wheelchair on the J unit activity room watching television with other residents.

A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to NJ Exec Order 26.4b1 [redacted]).

A review of the quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4b] reflected that the resident's cognitive skills for daily decision-making score was [NJ Exec Order 26.4b1], which indicated NJ Exec Order 26.4b1 [redacted].

A review of the [NJ Ex Order 26.4(b)(1)] Physician's Orders (PO) revealed a Physician's Order dated [NJ Exec Order 26.4b] for U.S. FOIA (b)(6) [redacted] unit/ml

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F 755	Continued From page 15	F 755		

NJ Exec Order 26.4b1 solution, inject units' NJ Exec Order 26.4b1 route NJ times per day NJ Exec Order 26.4b1). NJ Ex Order 26.4(b)(1) , call U.S. FOIA) with NJ Exec Order 26.4b1 levels of NJ Exec Or and above or below NJ Exec

A review of the NJ Ex Order 26.4(b)(1) EMAR revealed an order dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 unit/ml NJ Exec Order 26.4b1, inject units' NJ Exec Order 26.4b1 route NJ E times per day (NJ Exec Order 26.4b1). NJ Ex Order 26.4(b)(1) , call U.S. FOIA (b)(6)) with NJ Exec Order 26.4b1 of NJ Exec Or and above or below NJ Exec with a plotted time of NJ Exec Order 26.4b1 A further review of the March 2025 EMAR revealed that the amount of NJ Ex Order 26.4(b)(1) administered, and NJ Ex Order 26.4(b)(1) was omitted 66 times on the following dates and time:

NJ Ex Order 26.4 at 7:30 AM
NJ Ex Order 26.4(at 7:30 AM
NJ Ex Order 26.4(at 4:30 PM
NJ Ex Order 26.4(at 7:30 AM
NJ Ex Order 26.4(at 11:30 AM
NJ Ex Order 26.4(at 4:30 PM
NJ Ex Order 26.4(at 11:30 AM
NJ Ex Order 26.4(at 7:30 AM
NJ Ex Order 26.4(at 11:30 AM
NJ Ex Order 26.4(at 4:30 PM
NJ Ex Order 26.4(at 7:30 AM
NJ Ex Order 26.4(at 11:30 AM
NJ Ex Order 26.4(at 4:30 PM
NJ Ex Order 26.4(at 7:30 AM
NJ Ex Order 26.4(at 11:30 AM
NJ Ex Order 26.4(at 4:30 PM
NJ Ex Order 26.4(at 7:30 AM

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F 755	Continued From page 16 [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 4:30 PM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 7:30 AM [redacted] at 11:30 AM [redacted] at 4:30 PM [redacted] at 7:30 AM [redacted] at 11:30AM [redacted] at 4:30 PM	F 755		

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NJ Ex Order 26.4(b)(1) at 7:30 AM
NJ Ex Order 26.4(b)(1) at 11:30 AM
NJ Ex Order 26.4(b)(1) at 4:30 PM
NJ Ex Order 26.4(b)(1) at 7:30 AM
NJ Ex Order 26.4(b)(1) at 11:30 AM
NJ Ex Order 26.4(b)(1) at 4:30 PM
NJ Ex Order 26.4(b)(1) at 7:30 AM
NJ Ex Order 26.4(b)(1) at 11:30 AM
NJ Ex Order 26.4(b)(1) at 4:30 PM
NJ Ex Order 26.4(b)(1) at 4:30 PM

A review of the NJ Ex Order 26.4(b)(1) EMAR revealed an order dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 unit/ml NJ Exec Order 26.4b1 ' NJ Exec Order 26.4b1 route NJ Exec Order 26.4b1 times per day). NJ Ex Order 26.4(b)(1) , call U.S. FOIA (b) (6)) with NJ Ex Order 26.4(b)(1) of NJ Exec O and above or below NJ Exec with a plotted time of NJ Exec Order 26.4b1 PM. A further review of the NJ Ex Order 26.4(b)(1) EMAR revealed that the amount of NJ Ex Order 26.4(b)(1) administered, and NJ Ex Order 26.4(b)(1) were omitted 5 times on the following dates and time:

NJ Ex Order 26.4(b)(1) at 7:30 AM
NJ Ex Order 26.4(b)(1) at 4:30 PM
NJ Ex Order 26.4(b)(1) at 11:30 AM
NJ Ex Order 26.4(b)(1) at 4:30 PM
NJ Ex Order 26.4(b)(1) at 7:30 AM

On 04/03/25 at 10:45 AM, the surveyor in the presence of LPN#2 and LPN#3 reviewed Resident #10's PO for U.S. FOIA (b)(6) for sliding scale administration. Both LPN#2 and LPN#3 (NJ Exec Order 26.4b1 nurses on the N unit) acknowledge that they were no documentation on how many units of [redacted] that were administered. Both LPN #2 and LPN#3 stated that the amount

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F 755	Continued From page 18 of [redacted] that was administered should have been documented on the EMAR. On 4/3/25 at 1:00 PM, the surveyor discussed the above concerns with the U.S. FOIA (b) (6) [redacted]. There was no additional information provided. A review of the facility's policy for "controlled substances" dated 1/8/25, included the following: "5. Nurse must document administration in the electronic health record and the declining sheet." A review of the facility's policy for "Medication Administration" dated 1/8/25, included the following: "16. Document administration of medication in the EMAR immediately following administration. Notes in EMAR medications not administered (i.e refused, etc.) and identifies."	F 755		
F 812 SS=F	NJAC 8:39-11.2 (b), 29.2 (d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		5/17/25

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F 812	Continued From page 19 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 3/31/25 at 9:14 AM, the surveyor in the presence of the U.S. FOIA (b)(6) observed the following during the kitchen tour. 1. In walk-in refrigerator #1, the surveyor observed a blackish dust like substance in the gasket. 2. The surveyor observed on the 3-spout coffee machine a hard water build up on top of machine and on the first coffee spout had a brownish sticky substance on the spout. 3. The surveyor observed puddle of water below the hand washing, the water was coming from a leaking pipe. 4. In the Chef preparatory area, the surveyor observed a standing blender with a crumblike substance on base and outside of blender along	F 812	I. Immediate Action a. The area in walk in refrigerator #1 with blackish dust like substance in gasket was immediately cleaned and cleaning schedule and policy was reviewed with employees by FSD b. The 3-spout coffee machine with a hard water build up on top of machine and the first coffee spout with a brownish sticky substance on the spout were immediately cleaned and cleaning schedule and policy was reviewed with employees by FSD. c. The Maintenance Director inspected the area with puddle of water below the hand washing station (the sink itself and under the sink) and no leak or drip found. The water in the area was residue from water that had spilled from washing. The area was cleaned immediately. d. The Chef preparatory area, which had a standing blender with a crumblike substance on base and outside of blender along with a sticky blackish colored substance on blender was immediately cleaned and cleaning schedule and policy was reviewed with employee by FSD. The blender was also painted to improve appearance	

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F 812	Continued From page 20 with a sticky blackish colored substance on blender. 5. On top of the standing oven, the surveyor observed a blackish dust-like substance and on the inside of the oven was observed with a burnt on blackish colored substance. 6. The surveyor observed the [redacted] skillet with yellowish grease-like substance that had pooled in the corner. 7. The surveyor observed 1 Dietary aide (DA#1) with large hoop earrings and 1 Dietary aide (DA#2) observed with hair not fully covered under hairnet. Both DAs interviewed, DA#1 stated she forget to take, DA#2 stated they are aware hair needs to be fully covered and had not realized their hair was not covered On 4/01/25 at 10:00 AM, during the follow up inspection of the kitchen, the surveyor observed Dietary aide (DA#3) observed with large hoop earrings. DA #3 stated they had forgot to take them before work started. On 4/1/25 at 11:30 AM, the [redacted] provided the surveyor with two facility policies, "Uniform policy and procedures" with an effective date of 1/20/2022. The uniform policy stated under the procedure section, "wear hair restraints to prevent from contacting exposed food. Jewelry is kept to a minimum; facial piercings are to be removed or covered." Surveyor asked on two occasions for a policy regarding kitchen equipment cleaning but was not provided by facility. On 4/3/25 at 1:04 PM, the surveyor met with the U.S. FOIA (b) (6)	F 812	e. The top of the standing oven with a blackish dust-like substance and on the inside of the oven which was observed with a burnt on blackish colored substance were immediately cleaned. f. Dietary aide #1 and dietary aide #3 with large loop earrings and the dietary aide #2 with hair not fully covered under hairnet were immediately given written warnings and education by the Food Service Director about proper attire, proper jewelry and use of hairnet in the kitchen area. The earrings were removed in front of FSD and FSD checked the employee in question to see if hair was under the hair net and it was done. II. Identification of others a) All residents have the potential of being affected b) The Food Service Director (FSD) performed an audit of all areas identified with issues and no additional findings were noted. Completion date 4/17/2025 III. Systemic Changes a) The Policy and Procedure titled Uniform Policy and Procedures was reviewed by the Administrator and Food Service Director and was found in compliance b) The Policy and Procedure titled Kitchen Cleaning was reviewed by the Administrator and Food Service Director and was found in compliance c) All kitchen staff were in serviced on 4/18/25 by the Food Service Director on the above policies.	

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F 812	Continued From page 21 U.S. FOIA (b) (6) to review survey concerns. The U.S. FOIA (b) (6) stated they kitchen equipment cleaning policy the surveyor requested would be provided by tomorrow morning. On 4/3/25 at 11:00 AM, the surveyor met with the U.S. FOIA (b)(6) for the exit conference. The facility did not provide any further pertinent information. NJAC 8:39-17.2(g)	F 812	IV. Quality Assurance a) Audits will be conducted by the Food Service Director (FSD) of all areas of the kitchen including kitchen cleaning procedures and kitchen proper attire. b) Audits will be done by the Food Service Director (FSD)/supervisor weekly x 4 weeks, monthly x 2 months, quarterly x 3 quarters. c) Any negative findings will be brought to the Administrator immediately. The results of all audits will be brought to the Quality Assurance and Performance Improvement (QAPI) committee quarterly x 3 quarters V. Person Responsible: Food Service Director (FSD)	
F 926 SS=E	Smoking Policies CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop and implement NJ Ex Order 26.4(b)(policies in accordance with state law and regulations to provide " NJ Ex Order 26.4(b)(1) " which prohibits NJ Ex Order 26.4(b)(1) in healthcare facilities. This deficient practice was observed for 1 of 1 designated NJ Ex Order 26.4(b)(areas and was evidenced by the following:	F 926	I: Immediate Action: " NJ Ex Order 26.4(b)(1 was moved outdoors " NJ Ex Order 26.4(b)(1) equipped with NJ Ex Order 26.4(b)(1), the inside NJ Ex Order 26.4(b)(room was closed, " three fire blankets and 3 fire extinguishers available in the designated NJ Ex Order 26.4(b)(area, " smoking policy was revised to include the new smoking area outside by the Main Entrance,	5/17/25

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F 926	Continued From page 22 Reference: N.J.A.C. 8:6 "Smoke-Free Air" prohibits smoking in most workplaces as well as in indoor public areas. It included a list of all of the "indoor public places" and "workplaces" where smoking was banned, which included healthcare facilities. A review of the Smoking Policy last updated 7/7/24, provided by the [U.S. FOIA (b)] on 3/31/25, included that the smoking area for the facility was located on the K floor (3rd floor) of the facility (provisional due to renovations) down the hallway from the dayroom close to the high side room numbers. On 3/31/25 at 11:15 AM, during the initial tour of the [NJE]-Unit on the [NJ Exec O] floor, the surveyor observed double doors that led to the designated [NJ Exec Order 26.4b] room ([NJ Ex Order 26] Inside the room, there were two residents observed [redacted] The surveyor observed that the windows in the room were unable to be opened. There was a designated employee, the [U.S. FOIA (b)] outside of the [NJ Exec Order 26.4b] room who was monitoring the residents who were inside the [NJ Exec Order 26.4b] room. At that same time, the surveyor interviewed the [U.S. FOIA (b)] who stated that the windows did not open and that the patio door was locked and was closed off. She further stated that the residents were only permitted to [NJ Exec Order 26] inside of the room and did not go outside to [NJ Exec Order 26]. On 3/31/25 at 11:20 AM, the surveyor observed Resident #47 in the [NJ Ex Orde] sitting next to an open NJ Exec Order 26.4b1 [redacted] On that same date and time, the surveyor	F 926	" education was provided to the staff by the Director of Nursing regarding the new [NJ Ex Order 26.4(b)(] location and revised smoking policy, " all residents who [NJ Exec Order 26] including residents #47 and #119 were informed both verbally and in writing that the indoor [NJ Exec Order 26.4b1] area on the [NJ E] floor was closed and that the new [NJ Exec Order 26.4b] area will be outside in front of the main entrance, " the secure [NJ Ex Order 26.4(b)(] cart containing all NJ Ex Order 26.4(b)(1) [redacted] was moved to the first floor lobby by the door leading to the outside [NJ Ex Order 26.4(b)(] area, " the [NJ Ex Order 26.4(b)(] monitors were informed of the new [NJ Ex Order 26.4(b)(] area by phone, " Ad hoc resident council meeting with [NJ Ex Order 26.4(b)(] residents was held on 3/31/25 to inform them of the new [NJ Ex Order 26.4(b)(] policy and location, " the facility assessment was reviewed on 3/31/25. II. Identification of Others: All residents who smoke have the potential of being affected III.Systemic changes: a. Policy and Procedure on Smoking was reviewed and revised on 3/31/25, by the Regional nurse, Director of Nursing and Administrator, to include the new location of the smoking area, outdoors, by the Main Entrance. b. On 4/17/25 all staff were in serviced	

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	315083	A. BUILDING _____ B. WING _____	C 04/04/2025

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F 926	Continued From page 23 interviewed Resident #47, who stated they [redacted] in the [redacted] three times per day and have been since their admission into the facility. The resident further stated that the windows in the [redacted] did not open and that the residents who [redacted] did not go onto the adjoined patio. Resident #47 further stated they had a [redacted] assessment completed on their third day in the facility and signed a contract stating they understood and would not break the facility's [redacted] rules and regulations. On that same date and time, the surveyor observed that all windows were unable to be opened and a balcony door was closed off and locked in the [redacted] which was verified by the [redacted] The surveyor observed two [redacted] and four NJ Ex Order 26.4(b)(1) that were missing the self-closing lids. A review of the manufacture's specifications for the ashtrays provided by the [redacted], revealed that the two NJ Ex Order 26.4(b)(1) were made of stainless steel and the four NJ Ex Order 26.4(b)(1) were made of alloy steel. On 3/31/25 at 11:30 AM, the [redacted] acknowledged that the [redacted] in the [redacted] did not have covers. On 3/31/25 at 12:00 PM, the surveyor reviewed the medical record for Resident #47. A review of Resident #47's face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted].	F 926	by the Director of Nursing on the new smoking location IV. QA Monitoring a. The Administrator or designee will perform audits on the smoking area to ensure it is outdoors and smoking safety practices are followed at all times b. Audits will be performed weekly x 4 weeks, monthly x 3 months then quarterly x 3 quarters c. All findings will be reviewed at the Quality Assurance meeting x 3 quarters. V. Person responsible: Administrator or designee	

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F 926	Continued From page 24 A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Exec Order 26.4b], reflected a Brief Interview for Mental Status (BIMS) score of [NJ Ex Order 26.4(b)(1)], which indicated that the resident had an [NJ Exec Order 26.4b1] A review of Resident #47's "New/Re-admission Assessments" created on [NJ Exec Order 26], revealed under the [NJ Exec Order 26.4b] assessment tool, that the resident displayed a safe [NJ Exec Order 26.4b] technique and was able to [NJ Exec Order 26] safely. A further review of Resident #47's medical record revealed a form titled, "Acknowledgement of [NJ Exec Order 26.4b] polices and agreement to follow the [NJ Exec Order 26.4b] rules," that was signed by Resident #47 and witnessed on [NJ Exec Order 26.4b]. A review of Resident #47's individualized comprehensive care plan (ICCP) included a focus area dated [NJ Exec Order 26.4b] that the resident has an activity: [NJ Exec Order 26.4b] related to (r/t) known history of [NJ Exec Order 26.4b]. Interventions included: "I verbalize and demonstrate knowledge and understanding of the [NJ Exec Order 26.4b] rules, I will only [NJ Exec Order 26] in designated areas, and I will remain compliant with the [NJ Exec Order 26.4b] contract as per facility policy." On 3/31/25 at 11:20 AM, the surveyor observed Resident #119 in the DSR finish [NJ Exec Order 26.4b1] and placed the [NJ Exec Order 26.4b] into an open [NJ Exec Order 26]. At that same time, the surveyor interviewed Resident #119 who stated "this is where I was told by facility staff, we can [NJ Exec Order 26]." On 3/31/25 at 12:10 PM, the surveyor reviewed the medical record for Resident #119.	F 926		

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F 926	Continued From page 25 A review of Resident #119's face sheet revealed the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1 . A review of the resident's quarterly MDS dated NJ Exec Order 26.4, reflected a BIMS score of NJ Exec Order 26.4b1 which indicated that the resident had NJ Exec Orde A review of Resident #119's "Recreation Admission/Readmission Assessments" created on NJ Exec Order 26.4b, revealed under the NJ Exec Order 26.4b assessment tool, that the resident displayed a safe NJ Exec Order 26.4b technique and was able to NJ Exec Order 26 safely. A further review of Resident #119's medical record revealed a form titled, "Acknowledgement of NJ Exec Order 26.4b polices and agreement to follow the NJ Exec Order 26.4b rules," that was signed by Resident #119 and witnessed on NJ Exec Order 26.4b A review of Resident #119's ICCP included a focus area dated NJ Exec Order 26.4, that the resident has an activity: NJ Exec Order 26.4b related to (r/t) known history of NJ Exec Order 26.4b. Interventions included: "I verbalize and demonstrate knowledge and understanding of the NJ Exec Order 26.4b rules, I will only NJ Exec Order 26 in designated areas, and I will remain compliant with the NJ Exec Order 26.4b contract as per facility policy." On 3/31/25, at 1:49 PM, the surveyor conducted an interview with the NJ Exec Order 26.4b1 who stated that the NJ Exec Order 26.4b1 were disposed of NJ Exec O times per day, placed into a metal container after water was poured into the	F 926		

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F 926	Continued From page 26 container and all ashes were disposed of with the regular trash in the facility. On 3/31/25 at 2:30 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that indoor [NJ Exec Order 26.4b1] had been on-going since [NJ Exec Order 26.4b1] but was not sure of the exact date. NJAC 8:39-31.6(e)	F 926		

New Jersey Department of Health

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documentation, it was determined the facility failed to: a.) maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey, and b.) follow the New Jersey [NJ Exec Order 26] Free Act by allowing residents to [NJ Exec Order 4] on the [NJ Exec Ord] floor on 1 of 1 units inside the healthcare facility. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the	S 560	I. Immediate Action 1. The facility respectfully submits that staff to resident ratios were reviewed on 4/4/25 to ensure compliance with New Jersey minimal staffing requirements. 2. Staffing coordinator was re in-serviced by the Director of Nursing on 4/4/25 on staffing ratio requirements. II. Identification of Others: i. The facility respectfully submits that all residents may be affected by this practice. III. System Changes 1. Policy and Procedure for Minimal	5/17/25

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

Electronically Signed | 04/22/25

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S 560	Continued From page 1 Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C. 30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. A. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth	S 560	Staffing was reviewed on 4/17/24 by Administrator and Director of Nursing and noted to include staffing ratio of Certified Nursing Assistant (C.N.A.) of 1:8 for day shift, 1:10 for evening shift and 1:14 for the night shift. 2. Director of Nursing and Administrator will review open positions and applications plus results of any interviews weekly to look for opportunities to hire. 3. The Administrator and Director of Nurses will continue to utilize all possible means to increase the facility staff. This will include continued timely interviews, job fairs, reaching out to agencies for supplemental staff, setting up booths at nursing schools, utilization of all possible avenues to increase staffing in the facility. IV. Quality Assurance 1a) Audits will be completed by the Director of Nursing or designee to ensure that all staffing complies with staffing ratios. 1b) Audits will be done weekly x 4 weeks, monthly x 2 months and quarterly x 2 quarters. 1d) The results of all audits will be brought to the QAPI committee quarterly x 3 quarters. V. Responsibility 1. Director of Nursing 2. Staffing coordinator 3. Administrator	

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S 560	Continued From page 2 place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" revealed that the facility was deficient in CNA staffing for residents on 3 of 3 day shifts as follows: -03/27/25 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. -03/28/25 had 11 CNAs for 141 residents on the day shift, required at least 18 CNAs. -03/29/25 had 10 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 4/3/25 at 5:18 PM, the surveyor emailed the Licensed Nursing Home Administrator (LNHA) who was made aware of the deficient nursing	S 560		

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S 560	Continued From page 3 staff and no further information was provided. A review of the Director of Nursing Services Job description revealed that the purpose of the Director of Nurses (DON) is to plan, organize, develop, and direct the overall operations of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility ...to ensure that the highest degree of quality of care is maintained at all times. B. Reference: N.J.A.C. 8:6 "Smoke-Free Air" prohibits smoking in most workplaces, as well as, in indoor public areas. Included in the ACT was a list of all of the "indoor public places" and "workplaces" where smoking was banned, which included healthcare facilities. On 3/31/25 at 11:15 AM, during the initial tour of the [redacted] Unit on the [redacted] floor, the surveyor observed double doors that led to the designated [redacted] ([redacted] Inside the room were two residents observed [redacted]. There was a designated employee, the [redacted] Room Monitor ([redacted] outside of the [redacted] room, who was monitoring the residents inside the [redacted] room. At that same time, the surveyor interviewed the [redacted] who stated that residents were only permitted to [redacted] inside of the room, and did not go outside to [redacted]. On 3/31/25 at 11:20 AM, the surveyor observed Resident #47 in the [redacted] sitting next to an open [redacted]. On that same date and time, the surveyor interviewed Resident #47, who stated they [redacted] in the [redacted] three times per day and have been	S 560		

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S 560	Continued From page 4 since their admission into the facility. The resident further stated that the residents who [NJ Exec Order 26.4b] did not go onto the adjoined patio because the door was locked. Resident #47 further stated they had a [NJ Exec Order 26.4b] assessment completed on their third day in the facility and signed a contract stating they understood and would not break the facility's [NJ Exec Order 26.4b] rules and regulations. On 3/31/25 at 11:20 AM, the surveyor observed Resident #119 in the [NJ Ex Orde] [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] At that same time, the surveyor interviewed Resident #119 who stated "this is where I was told by facility staff, we can [NJ Exec Order 26.]" On 3/31/25, at 1:49 PM, the surveyor conducted an interview with the [redacted], who stated that the [redacted] were disposed of four times per day. On 3/31/25 at 2:30 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that [NJ Ex Order 26.4(b)(1)] had been on-going since [NJ Exec Order 26.4b1], but was not sure of the exact date. The [U.S. FOIA (b)(6)] stated this was done due to building renovations. A review of the facility's Smoking Policy, last updated [redacted], included that the designated [NJ Exec Order 26.4b] area for the facility was located on the [redacted] floor [redacted]) of the facility, down the hallway from the dayroom and close to the high side room numbers.	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing	S1680		5/17/25

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S1680	Continued From page 5 (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

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S1680	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports AAS-12 for the 2 weeks of staffing from 3/16/25 to 3/29/25 for the it was determined that the facility failed to provide at least minimum staffing levels. The required staffing hours and actual staffing hours are as follows: For the week of 3/23/25 the required staffing hours are 370. On 3/29/25 the facility had 370 nurse staffing hours, for a difference of -2.0 hours. On 4/3/25 at 5:18 PM, the surveyor emailed the Licensed Nursing Home Administrator (LNHA)	S1680	VI. Immediate Action 3. The facility respectfully submits that minimum nursing staffing levels were reviewed on 4/4/25 to ensure compliance with New Jersey minimal staffing requirements. 4. Staffing coordinator was re in-serviced on 4/4/25 by the Director of Nursing on minimum nursing staffing levels requirements. VII. Identification of Others: ii. The facility respectfully submits that all residents may be affected by this practice.	

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S1680	Continued From page 7 who was made aware of the deficient nursing staff and no further information was provided. A review of the Director of Nursing Services Job description revealed that the purpose of the Director of Nurses (DON) is to plan, organize, develop, and direct the overall operations of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility ...to ensure that the highest degree of quality of care is maintained at all times.	S1680	VIII. System Changes 1. Policy and Procedure for Minimal Staffing was reviewed on 4/17/24 by Administrator and Director of Nursing and found in compliance 2. Director of Nursing and Administrator will review open positions and applications plus results of any interviews weekly to look for opportunities to hire. 3. The Administrator and Director of Nurses will continue to utilize all possible means to increase the facility staff. This will include continued timely interviews, job fairs, reaching out to agencies for supplemental staff, setting up booths at nursing schools, utilization of all possible avenues to increase staffing in the facility. IX. Quality Assurance 1a) Audits will be completed by the Director of Nursing or designee to ensure that all staffing complies with staffing ratios and minimum nursing staffing requirements. 1b) Audits will be done weekly x 4 weeks, monthly x 2 months and quarterly x 2 quarters. 1d) The results of all audits will be brought to the QAPI committee quarterly x 3 quarters. X. Responsibility 4. Director of Nursing 5. Staffing coordinator 6. Administrator	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315083 Y1	A. Building B. Wing Y2	5/30/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCLAIM REHABILITATION AND NURSING CENTER	198 STEVENS AVE JERSEY CITY, NJ 07305

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 F0926 Reg. # 483.90(i)(5) LSC	Correction Completed 05/17/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315083 Y1	A. Building B. Wing Y2	5/30/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCLAIM REHABILITATION AND NURSING CENTER	198 STEVENS AVE JERSEY CITY, NJ 07305

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0623	Correction	ID Prefix F0640	Correction	ID Prefix F0755	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	05/17/2025	LSC	05/17/2025	LSC	05/17/2025
ID Prefix F0812	Correction	ID Prefix F0926	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.90(i)(5)	Completed	Reg. #	Completed
LSC	05/17/2025	LSC	05/17/2025	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/4/2025	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060909	A. Building B. Wing	5/30/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCLAIM REHABILITATION AND NURSING CENTER	198 STEVENS AVE JERSEY CITY, NJ 07305

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 05/17/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/4/2025	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060909	A. Building B. Wing	6/26/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 06/13/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	
4/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: FD4Y13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING **01** B. WING _____	**04/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCLAIM REHABILITATION AND NURSING CENTER	**198 STEVENS AVE** **JERSEY CITY, NJ 07305**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Acclaim Rehabilitation and Nursing Center is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/02/25 to 04/03/25 and was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Acclaim Rehabilitation and Nursing Center is a three-story building with a basement and sub-basement that was built in 1908. It is composed of Type II protected construction. The facility is divided into 13 - smoke zones. The facility has one interior and two exterior diesel emergency generators. The current occupied beds are 142 of 183.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.	K 211		5/17/25

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

Electronically Signed | 04/23/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING 01 B. WING _____	04/04/2025

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K 211	Continued From page 1 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/02/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure exits were maintained free of obstructions and impediments for full and instant use in accordance with NFPA 101:2012 Edition, Section 7.1.10.1. for 1 of 5 exits observed in the kitchen area. This deficient practice had the potential to affect 15 of 142 residents and was evidenced by the following: An observation at 10:40 AM revealed that the kitchen fifth exit door to the corridor had a thumb turn lock on the egress side of the door. The fastening device on the door was engaged and could restrict emergency use of the designated exit discharge door. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The facility's U.S. FOIA (b)(6) [redacted] U.S. FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 04/03/2025 at 3:35 PM. N.J.A.C. 8:39-31.2(e)	K 211	K211 Means of Egress Corrective Actions The thumb-turn lock on the kitchen exit door was removed to ensure the door remained unobstructed and freely opened into the corridor. Identification of Others Potentially Affected The Maintenance Director, or designee, confirmed that no other kitchen or hallway egress doors were similarly obstructed. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes The U.S. FOIA (b) (6) [redacted] were in-serviced on egress requirements and confirmed that exit doors must remain clear and unobstructed at all times. Quality Assurance The Maintenance Director, or designee, will perform weekly audits X 4 weeks of all kitchen-area exit doors to confirm proper function. If substantial compliance is not met, audits will continue monthly until resolved. Results will be reported at QA meetings. Responsible Party and Date of Correction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING 01 B. WING _____	04/04/2025

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K 211	Continued From page 2	K 211	The Administrator is responsible for oversight of this process.	
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/02/2025 in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that exit stair landings and exit stair handrails were marked in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3, 7.2.2.5.5.2 and 7.2.2.5.5.3. This deficient practice had the potential to affect 15 of 142 residents and was evidenced by the following: Observations during the tour between 8:15 AM and 3:48 PM in the presence of the U.S. FOIA (b)(6) [redacted], revealed 2 of 2 basement boiler room area exit stairways had no marking stripes on the steps and the upper surface of the handrails were not marked as required by the Code. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The facility's U.S. FOIA (b)(6) [redacted]	K 225	K225 Stairways and Smokeproof Enclosures Corrective Actions Stair tread markings and handrail indicators were repainted in both boiler room stairways to bring them into compliance. Identification of Others Potentially Affected The Maintenance Director inspected all facility stairwells and found no additional areas lacking required markings. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes The Maintenance team was re-educated on the requirement for stair marking	5/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING **01** B. WING _____	**04/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 225	Continued From page 3 U.S. FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 04/03/2025 at 3:35 PM. NJAC 8:39 31.2 (e)	K 225	visibility leading to exits. Quality Assurance The Maintenance Director, or designee, will conduct weekly inspections X 4 weeks of all stairwells and handrails to verify proper marking. If substantial compliance is not met, inspections will continue monthly until resolved. QA committee will review results. Responsible Party and Date of Correction The Administrator is responsible for oversight of this process.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		5/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 321	Continued From page 4 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/02/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2, 19.3.5.9 and 8.4. This deficient practice had the potential to affect all 142 residents and was evidenced by the following: An observation at 09:44 AM revealed that the house keeping right combustible storage room door did not latch closed and there was gap along the top when tested by the U.S. FOIA [redacted]. An observation at 11:10 AM revealed that the supplement combustible storage room door did not latch closed when tested by the U.S. FOIA [redacted]. An observation at 12:10 PM revealed that the K-floor soiled utility room door had a gap along the top when tested by the U.S. FOIA [redacted] An observation at 1:15 PM revealed that the J-floor soiled utility room door had a gap along the top when tested by the U.S. FOIA [redacted] In an interview at the time, the U.S. FOIA (b)(6)	K 321	K321 Hazardous Areas Enclosure Corrective Actions The following doors were repaired to ensure they fully closed and latched without gaps: - Housekeeping right combustible storage room door - Supplemental combustible storage room door - K-floor soiled utility room door - J-floor soiled utility room door Identification of Others Potentially Affected The Maintenance Director inspected all other hazardous area doors to confirm there were no additional latching or gap issues. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes Maintenance and Housekeeping staff were re-inserviced on ensuring hazardous area doors latch properly and have no visible gaps when closed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 321	Continued From page 5 confirmed the observation. The facility's U.S. FOIA (b)(6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 04/03/2025 at 3:35 PM. NJAC 8:39 31.2 (e)	K 321	Quality Assurance The Maintenance Director, or designee, will inspect all hazardous area doors weekly X 4 weeks. If substantial compliance is not met, monthly inspections will continue. Results will be reported to QA. Responsible Party and Date of Correction The Administrator is responsible for oversight of this process.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview on	K 351	K351 Sprinkler System Installation	5/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING 01 B. WING _____	04/04/2025

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K 351	Continued From page 6 04/02/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012 Edition, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all 142 residents and was evidenced by the following: Observations during the tour between 8:15 AM and 3:48 PM in the presence of the U.S. FOIA (b)(6) [redacted] revealed that the H-1 and H-19 exit stairways were not provided with fire sprinkler coverage under the first accessible landing. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The facility's U.S. FOIA (b)(6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 04/03/2025 at 3:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	Corrective Actions The sprinkler vendor was contacted to schedule installation of sprinkler heads in the stair landings at H1 and H19, which previously lacked coverage. Installation is in progress and being coordinated to ensure full compliance with NFPA 13. Identification of Others Potentially Affected The Maintenance Director inspected all other stairwells and confirmed that sprinkler coverage is present in all other areas. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes Sprinkler installation at H1 and H19 will be verified upon completion. The Maintenance Director was reminded to include all stairwell landing spaces when evaluating coverage during routine inspections. Quality Assurance Once installation is complete, the Maintenance Director, or designee, will inspect the affected stairwells weekly X 4 weeks. If substantial compliance is not met, monthly inspections will continue. Results will be reported at QA meetings. Responsible Party and Date of Correction The Administrator is responsible for	

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	315083	A. BUILDING 01 B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCLAIM REHABILITATION AND NURSING CENTER	198 STEVENS AVE JERSEY CITY, NJ 07305

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K 351	Continued From page 7	K 351	oversight of this process.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 04/02/2025 and 04/03/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to maintain the sprinkler system and ensure the ceiling level was smoke resistant in accordance with NFPA 101:2012 Edition, Section 9.7.5,9.7.7,9.7.8, NFPA 25:2011 Edition. These deficient practices had the potential to affect all 142 residents and was evidenced by the following:	K 353	K353 Sprinkler System Maintenance and Testing Corrective Actions Sprinkler heads in the washing and dryer areas were cleaned, damaged heads and missing escutcheons were addressed, and ceiling tiles were replaced or resealed as needed. The sprinkler vendor was contacted to provide documentation of the five-year hydrostatic and pressure gauge tests.	5/17/25

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K 353	Continued From page 8 Observations during the tour between 8:15 AM and 3:48 PM in the presence of the U.S. FOIA (b)(6) revealed the following: At 9:53 AM, one of 3 fire sprinkler heads by the washing area had heavy buildup of a foreign material on the frangible bulb. At 9:57 AM, four of 12 fire sprinkler heads by the dryer were covered with lint. At 10:10 AM, one of 2 fire sprinkler heads in the corridor between the staff break room and the kitchen was missing the escutcheon ring. At 10:51 AM, the Maintenance office had nine (2-foot by 4-foot) ceiling tiles that were not in place. At 12:03 PM, the third floor oxygen storage room fire sprinkler head had a gap around the pipe in the ceiling. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. A documentation review on 04/03/2025 at 1:24 PM, revealed that the records for the 5-Year Fire department Connection Hydrostatic test and the 5-Year fire sprinkler gauges inspection were not provided. No further documentation was provided. In an interview at the time, the U.S. FOIA (b) confirmed the review. The facility's U.S. FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit	K 353	Identification of Others Potentially Affected All areas with sprinkler heads and ceiling tiles were inspected by the Maintenance Director. No further issues were found. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes The U.S. FOIA (b) (6) was in-serviced on proper sprinkler head maintenance and recordkeeping. The five-year test documentation will be kept in the facility's compliance binder. Quality Assurance The Maintenance Director, or designee, will conduct weekly audits X 4 weeks of sprinkler head condition and ceiling tile integrity. If substantial compliance is not met, monthly audits will continue. QA will monitor results. Responsible Party and Date of Correction The Administrator is responsible for oversight of this process.	

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K 353	Continued From page 9 conference at 3:35 PM. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		5/17/25

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K 363	Continued From page 10 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/02/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Section 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect 24 of 142 residents was evidenced by the following: An observation at 1:15 PM revealed that the J-floor treatment room door had a gap along the top when tested by U.S. FOIA [redacted]. An observation at 1:51 PM revealed that the Director of nursing office door had a gap along the top when tested by the U.S. FOIA [redacted]. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. The facility's U.S. FOIA (b)(6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 04/03/2025 at 3:35 PM. NJAC 8:39 31.2 (e)	K 363	K363 Corridor Doors Corrective Actions Gaps around the doors to the J-floor treatment room and Director of Nursing office were corrected to ensure proper closure. Identification of Others Potentially Affected The Maintenance Director inspected other corridor doors for similar gaps or issues. No other deficiencies were identified. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes Maintenance staff were re-inserviced on the requirement that corridor doors must resist the passage of smoke and latch completely. Quality Assurance The Maintenance Director, or designee, will audit corridor doors weekly X 4 weeks. If substantial compliance is not met, monthly audits will continue. Results will be reviewed at QA.	

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K 363	Continued From page 11	K 363	Responsible Party and Date of Correction The Administrator is responsible for oversight of this process.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/02/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that ventilation and air conditioning complied with NFPA 101:2012 Edition, Sections 19.5.2.1 and 9.2. This deficient practice had the potential to affect all 142 residents and was evidenced by the following: Observations during the tour between 8:15 AM and 3:48 PM in the presence of the U.S. FOIA (b)(6) [redacted] revealed that the resident room bathroom ventilation for H-1 to H-26, J-1 to J-26 and K-1 to K- 26 were not functioning when tested the by the DM. In an interview at the time, the U.S. FOIA (b)(6)	K 521	K521 HVAC Corrective Actions The facility's HVAC contractor was contacted to evaluate and repair exhaust fans in identified resident bathrooms on H, J, and K floors. Identification of Others Potentially Affected The Maintenance Director checked all resident bathroom exhausts throughout the facility and confirmed functionality. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected.	5/17/25

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K 521	Continued From page 12 confirmed the observation. The facility's U.S. FOIA (b)(6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 04/03/2025 at 3:35 PM. N.J.A.C 8:39-31.2(e)	K 521	Systemic Changes Maintenance staff were reminded to monitor bathroom exhaust functionality during regular rounds. Quality Assurance The Maintenance Director, or designee, will inspect resident bathroom exhaust systems weekly X 4 weeks. If substantial compliance is not met, monthly inspections will continue. QA will review findings. Responsible Party and Date of Correction The Administrator is responsible for oversight of this process.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe	K 741		5/17/25

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K 741	Continued From page 13 design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/31/25 and 04/03/2025 in the presence of the facility's U.S. FOIA (b)(6) it was determined that the facility failed to ensure that ashtrays of noncombustible material and metal containers with self-closing cover devices were provided and readily available to all smoking areas in accordance with NFPA 101:2012 Edition, Section 19.7.4. This deficient practice had the potential to affect 28 of 142 residents and was evidenced by the following: An observation by the surveying team members on 03/31/2025, revealed that an unapproved room on the third floor was being used for smoking. Two of the 2 smoking ashtrays provided in the smoking area had no closure. A metal container with a self -closing cover device was not readily available to the smoking area. An observation with the U.S. FO on 04/03/2025 at 08:41 AM, revealed that the front smoking area contained four plastic smoker's receptacles and did not contain a metal container with a self-closing cover device into which ashtrays could be emptied. In an interview at the time, the U.S. FO confirmed the observation.	K 741	K741 Smoking Regulations Corrective Actions Noncompliant ashtrays were removed and replaced with non-combustible, self-closing metal containers in the designated smoking areas. Identification of Others Potentially Affected The smoking area were re-inspected and confirmed to have compliant ash disposal containers. The facility acknowledges all residents who smoke could be potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes Recreation and designated smoking monitors were re-inserviced on acceptable smoking container requirements and compliance expectations. Quality Assurance The Recreation Director, or designee, will audit all smoking areas weekly X 4 weeks. If substantial compliance is not met,	

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K 741	Continued From page 14 The facility' U.S. FOIA (b)(6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference at 3:35 PM. N.J.A.C 8:39-31.2 (e), 31.6(e)	K 741	monthly audits will continue. QA will monitor results. Responsible Party and Date of Correction The Administrator is responsible for oversight of this process.	
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/02/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that 2 of 13 electrical outlets located next to a water source were equipped with Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 and 99. This deficient practice had the potential to affect 12 of 142 residents and was evidenced by the following: An observation at 10:44 AM revealed that the fish tank by the elevator was plugged into a standard duplex wall outlet and not the required Ground	K 912	K912 Electrical System Corrective Actions GFCI outlets were installed at the locations where the hydrocollator and fish tank were previously connected to non-GFCI outlets. Identification of Others Potentially Affected The Maintenance Director inspected all receptacles located near water sources to confirm GFCI protection was in place. The facility acknowledges all residents and staff could be potentially affected by	5/17/25

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K 912	Continued From page 15 Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. An observation at 11:15 AM revealed that the physical therapy hydrocollator was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. The facility's U.S. FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 04/03/2025 at 3:35 PM. NJAC 8:39 -31.2 (e) NFPA 70, 99	K 912	this condition but respectfully submits that no residents were affected. Systemic Changes Maintenance staff were in-serviced on GFCI outlet requirements in areas near water. Quality Assurance The Maintenance Director, or designee, will audit GFCI compliance in all required areas weekly X 4 weeks. If substantial compliance is not met, monthly audits will continue. Results will be reviewed at QA. Responsible Party and Date of Correction The Administrator is responsible for oversight of this process.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923		5/17/25

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K 923	Continued From page 16 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/02/2025 in the presence of the [redacted] it was determined that the facility failed to 1) Store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping and rupture and 2) provide storage of cylinders planned so that cylinders can be used in the order in which they are received from the supplier and empty cylinders segregated from full cylinders in accordance with NFPA 99 Health Care Facilities Code (2012 Edition) Section 11.6.2.3(11). This deficient practice had the potential to affect 13 of 142 residents and was evidenced by the following:	K 923	K923 Gas Equipment Cylinder and Container Storage Corrective Actions Loose oxygen tanks were secured in the designated 'full' rack. All storage racks were organized by tank status (full/empty). Identification of Others Potentially Affected The Maintenance Director checked all oxygen storage rooms to ensure no freestanding tanks were present. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected.	

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K 923	Continued From page 17 An observation in the main oxygen storage room at 10:36 AM, revealed that nine full portable oxygen tanks were free standing not secured from tipping and rupture and eight full portable oxygen tanks were in rack with a sign indicating empties only. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. The facility's U.S. FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 04/03/2025 at 3:35 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K 923	Systemic Changes Maintenance and nursing staff were re-inserviced on proper cylinder storage and segregation of full and empty tanks. Quality Assurance The Maintenance Director, or designee, will inspect oxygen storage rooms weekly X 4 weeks to verify compliance. If substantial compliance is not met, monthly inspections will continue. QA will monitor results. Responsible Party and Date of Correction The Administrator is responsible for oversight of this process.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315083 Y1	A. Building 01 - ACCLAIM B. Wing Y2	5/30/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCLAIM REHABILITATION AND NURSING CENTER	198 STEVENS AVE JERSEY CITY, NJ 07305

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	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0211		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0225		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0321		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0351		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0353		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0363		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0521		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0741		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0912		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0923		05/17/2025
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #		Completed	
LSC			
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #		Completed	
LSC			
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #		Completed	
LSC			
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #		Completed	
LSC			

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/4/2025	☐ YES ☐ NO