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

PRINTED: 07/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315512	A. BUILDING ______ B. WING ______	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TCU	**308 WILLOW AVENUE** **HOBOKEN, NJ 07030**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS STANDARD SURVEY: 6/13/24-6/18/24 CENSUS: 13 SAMPLE SIZE: 8+2 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to ensure a medication was administered in accordance with the physician's order and professional standards of clinical practice. The deficient practice was identified for one (1) of four (4) residents (Resident #309), administered by one (1) of two	F 658	1. All 13 residents have the potential to be affected by this deficient practice. The state surveyor stopped the medication pass observation and brought to the attention of the [US FOIA] that she failed to administer the fifth medication of five, a [NJ Ex Order 26.4(b)(1)] medication. After the state surveyor brought this to the [US FOIA (b)(6)]s	7/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/27/2024

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

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F 658	Continued From page 1 (2) nurses, observed during the medication pass observation, and was evidenced by the following: 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 registered professional nurse is defined as diagnosing and treating human responses to actual or 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." On 6/14/24 at NJ Ex Order 26.4b1, during the medication administration observation, the surveyor observed Registered Nurse (RN) prepare medications for Resident #309 on the medication cart situated at the end of the resident's bed, in the resident's room. The RN reviewed the electronic Medication Administration Record (eMAR) against the medications in a unit dose (UD) packaging (a dose of medicine prepared in	F 658	attention she administered the fifth medication. Resident number 309 NJ Ex Order 26.4 encounter a NJ Ex Order 26.4b1. 2. Resident number 309 completed NJ Ex O rehabilitation stay and was discharged back to the community. NJ Ex Ord NJ Ex Order 26.4 experience a NJ Ex Order 26.4b1. 3. The US FOIA (b)(6) failed to follow the facility policy and procedure and was re-educated by the Interim DON on 6/14/2024. 4. The Consultant Pharmacist conducted a medication administration observation on this NJ Ex Order 2 on 6/28/2024 and again on 7/2/2024, this issue did not re-occur. The consultant pharmacist is contracted monthly to conduct a unit inspection as well as medication pass observations. At least annually, all nurses will be observed by the consultant pharmacist for proper medication administration. In addition, on a daily basis this facility utilizes an electronic medication bar scanning system that records electronically all medications given by all licensed nursing professional staff and on a weekly basis reviewed by the Interim DON and Administrator. Their performance is graded by a percentage with the benchmark of 98%, 1st quarter of 2024 we achieved a 97% compliance rate. Those that fall below the 98% are coached by the DON and provided re-education where needed. This nurse has achieved 100% compliance. In addition, this information is tracked and trended monthly and reviewed quarterly by the QAPI team members. The results from the Consultant Pharmacist visit is	

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F 658	Continued From page 2 an individual package) which included a physician's order for NJ Ex Order 26.4(b)(1)), give one (1) tablet every 12 hours, hold if NJ Ex Order 26.4(b)(1) ; give with meals for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) . Administration times were for 9:00 AM and 21:00 [9:00 PM]. At NJ Ex Order 26.4b1 , the resident informed the nurse that he/she preferred the application of the NJ Ex Order 26.4(b)(1) later that day. At that time, the RN stated she had taken the resident's NJ Ex Order 26.4(b)(1)) about 15 minutes ago, and had the result written on paper. The surveyor observed that a data entry of the NJ Ex O was required on the eMAR. At that time, the RN pulled the NJ Ex Order 26.4(b)(1) towards the resident and began to take the resident's NJ Ex Order 26.4(b)(1) At NJ Ex Order 26.4b1 , the RN removed the resident's UD medication from the medication cart cassette, scanned each medication bar code, then took an empty medication cup and walked over to the resident's bedside. The RN emptied each medication into the medication cup, explained to the resident the indication for each medication dispensed into the empty medication cup, one at a time, while the resident self-administered. At that time, the RN confirmed she had signed for the administered medications to Resident #309 and was ready to administer to the resident's room mate assigned to the door side of the room. At NJ Ex Order 26.4b1 , the surveyor stopped the medication pass. The surveyor and the RN reviewed the (4)	F 658	shared immediately (verbally) after the visit is complete and followed up thereafter with a written report. The data is shared with the Administrator and/or DON. The Administrator and DON shares this information with the employee. 5. Any findings from the Consultant Pharmacist report will be shared with the employee and corrective action immediately implemented. The Consultant Pharmacist completes her reports monthly both verbally and in writing to Administrator and/or DON after her monthly visit. 6. All nurses in-serviced on our Medication Administration Policy and Procedure with return demonstration where applicable by the DON or designee by July 31, 2024. 7. The DON or Administrator shares these findings with members of the QAPI team quarterly. Appropriate actions and PIPS completed when necessary.	

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F 658	Continued From page 3 four emptied UD medication packages which consisted of the following: 1. NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) , (NJ Ex Order 26.4(b)(1))) 2. NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) 3. NJ Ex Order 26 NJ Ex Order 26.4(b)(1)) 4. NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) At that time, the surveyor asked the RN where the emptied UD package for the NJ Ex Order 26.4(b)(1) was. The RN reviewed the emptied UD medication packages, looked on the medication cart, searched her pockets, looked in the cassette, searched her pockers again and found the unit dose for the NJ Ex Order 26.4(b)(1) At that time, the RN stated, "I missed it". At that time, the RN informed the resident that she had missed the administration of the "pink one" and administered to the resident. At that time, the RN confirmed all administration of the medications were already signed. The surveyor reviewed the medical record for Resident #309. A review of Resident #309's Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)	F 658		

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F 658	Continued From page 4 NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) A review of Resident #309's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b)(1) reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated that Resident #309's cognition was NJ Ex Order 26 A review of the Physician's Progress Note included a documentation that the NJ Ex Order 26.4(b)(1) was administered for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the Registered Nurse's most recent medication pass observation, dated NJ Ex Order 26.4(b)(1) conducted by the U.S. FOIA (b) (6)) reflected the RN had no errors. On 6/14/24 at 11:08 AM, in the presence of surveyor #2, the U.S. FOIA (b) (6) the U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6)), the surveyor discussed the concern regarding the signing of NJ Ex Order 26.4(b)(1) as administered to the resident while the administration was omitted, during the medication pass administration observation. On 6/18/23 at 10:00 AM, in the presence of the survey team, and the U.S. FOIA (b) (6) the U.S. FOIA (b) stated, she had reviewed the chart of the resident. The U.S. FOIA (b) stated that the RN should have gone back to verify everything, prior to signing to allow for self-correction. A review of the provided facility policy titled: Medications, dated/revised on 5/24 included	F 658		

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F 658	Continued From page 5 under Policy/Procedure E. All medications are to be recorded on patient's Medication Administration Record (MAR) immediately after administration to the patient. The policy did not reflect a procedure for reconciliation of administered medications to the residents to recapture omission of administration. NJAC 8:39-29.2 (d)	F 658		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of documentation provided by the facility, it was determined that the facility failed to a) maintain proper kitchen sanitation practices and clean equipment, and b) properly store foods in a safe	F 812	1. All 13 residents have the potential to be affected by this deficient practice. All food was immediately dated and labelled with use by dates or expiration dates and opened dates. All 13 residents were	7/31/24

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F 812	Continued From page 6 manner to prevent the development of food borne illness. These deficient practices observed as evidenced by the following: On 6/13/24 at 10:16 AM, in the presence of the U.S. FOIA (b) (6)), the surveyor toured the kitchen and observed the following: 1. In the walk-in freezer, the surveyor observed several boxes of opened food items that were unlabeled with open expiration date. Those items were as follows: *Flat bread, opened, sealed, out of original box, placed on top of box, used and unlabeled with open expiration date. *Whipped topping, opened, sealed out of original box, placed on shelf and unlabeled with open expiration date. *Tater tots, opened, sealed in bag, out of original box, placed on shelf, and unlabeled with open expiration date. All listed items were opened, unlabeled with open date or expiration dates. The U.S. FOIA (b) (6) was unable to say when the packages were opened. 2. In the walk-in freezer, the surveyor observed several boxes of opened food items that were exposed to the freezer air unsealed, and unlabeled with open expiration date. Those items were as follows: *Pate Pizza; small round, unsealed large quantity bag, unlabeled with open date. *Pizza crust large round; opened and unsealed large quantity bag, unlabeled with open date. *Vegetable burger sleeve; opened to the element and unsealed, unlabeled with open expiration date. *Loose premade pretzels, large quantity bag,	F 812	observed for any adverse outcome of eating food supplied by the kitchen and no one reported any gastrointestinal issues or foodborne illnesses. The residents showed no adverse health outcomes. 2. All trash cans will always remain covered with lids. The porters will round at least three times per day to ensure that the trash is not overflowing. This measure will be put in to the porter's worklist and job responsibilities and monitored for at least the next six months and any concerns brought forth at the quarterly QAPI meetings. In addition, if a porter fails to do this, the appropriate disciplinary action will be taken and corrective actions will be implemented and documented in his/her personnel file. 3. All existing opened food items were appropriately labeled and dated. All food products that have been opened will be labeled and dated consistently with product name and expiration date. All open products will be sealed to avoid freezer burn. 4. Food and nutrition employees will ensure that there are no unlabeled products in the storage area. All food and nutrition service employees responsible for handling food products received in-service training to ensure food products are labeled appropriately during their weekly huddle meeting on Thursdays. 5. Food safety audits, including monitoring of unlabeled food products, will be conduted daily by food and nutrition manager. Results of the audits will reported to the TCU Quality Assurance Performance Improvement Committee	

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F 812	Continued From page 7	F 812		

opened to the element and unsealed, unlabeled with open expiration date.
*Beef burger, loose, large quantity bag, opened to the element and unsealed, unlabeled with open expiration date.
All listed items were opened, unlabeled with open date or expiration dates. The U.S. FOIA (b) (6) was unable to say when the packages were opened or when they expired.

1. In the food preparation area,the surveyor observed that 3 of 3 trash cans were filled with garbage and food debris which were uncovered in locations as follows:
1) food prep table that had bread on it,
2) chef prep table that had dessert in 3 pans covered with clear plastic wrap,
3) and, one under the tray line.

In the food preparation area, the can opener was observed with brown and red sediment build up and was able to be scratched off by the U.S. FOIA (b) (6). The holder for the can opener had visible debris. The U.S. FOIA (b) (6) could not recall the cleaning policy for the can opener and was unable to say when it had been washed and cleaned. The U.S. FOIA (b) (6) stated, "I changed the blade when I first got hired, NJ Ex Order 26.4(b)(1) ago."

The catch trays under 3 of 5 cooktop units had copious amounts of blackened, burnt on and sticky residue that was on foil and under the foil on the pan. The foil was shredded to pieces exposing the tray.

The survey observed 2 of 4 double door convention ovens that the glass doors were opaque with brown hard and sticky residue. The U.S. FO and U.S. FOIA (b) (6) could not comment on when it

every quarter until 100% compliance has been achieved and maintained.
6. Can openers cleaned daily at the EOB each day, catch trays cleaned by cooks at the EOB each day, and cleaning logs updated outlining specific tasks for cleaning.
9. The Food Service Director or designee conducts daily food safety audits, in-service all food and nutrition employees on checking expiration dates and storing, preparing, distributing and serve food in accordance with professional standards for food service safety. Weekly staff huddles are held with the cooks and porters on proper food storage and labelling and kitchen sanitation. These meetings are documented in writing and the administator will receive copies of in-service and attendance sheets. The administrator or designee will do random spot checks in the kitchen bi-weekly for the period of the next 90 days, then once per month thereafter for the next six months.

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F 812	Continued From page 8 was cleaned last. On 6/13/24 at 10:15 AM, the surveyor interviewed the U.S. FOIA (b) (6), who stated, "that labeling of food is a requirement in the kitchen and his expectation of his staff." The food should be labeled with expiration date and if opened it should be labeled with open date and the package should be resealed to keep the contents fresh. Labeling allows for first in first out concept which saves food integrity, prevents freezer burn, and waste production. It also prevents food born illness." On 6/13/24 at 10:15 AM, the surveyor interviewed the U.S. FO regarding the cleaning process for equipment and food storage in the freezer, who stated, "I need to educate the staff of what cleaning means on the log and have it more defined." "The cooks should be sealing the opened bags of food in the freezer to maintain the food integrity." On 6/14/24 at 11:30, the survey team presented the concerns to the U.S. FOIA (b) (6) U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6)) for kitchen. The U.S. FOIA (b) (and the U.S. FOIA (had no further information to provide. The surveyor reviewed a policy titled "food storage", effective date of 03/2016 and revised date of 09/2021, which revealed: Purpose: To prevent contamination by transmission of disease-carrying microorganisms. Policy: It is the policy of the Food Services Department to develop a mechanism to ensure the safe and accurate storage of food and nonfood products.	F 812		

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F 812	Continued From page 9 Food storage methods are strictly defined. Procedures: 2.) Inspect food regularly for damage due to spoilage. 3.) Rotate Stock so that older items are used first. Date products to ensure the use of "First in-First out" procedures. The surveyor reviewed the policy titled, "Food Safety HACCP", effective date of 7/2012 and a revised date 5/2023, which revealed: Policy: The food and nutrition services department has a comprehensive food safety and self-inspection system that includes equipment monitoring to ensure the effectiveness and quality of the food safety program for all of our food service customers. Purpose: Our Hazard Analysis Critical Control Points (HACCP) Program looks at the flow of potentially hazardous foods, the path that food travels throughout delivery of products, storage, preparation, holding or displaying, serving, cooling, and storing leftovers for the following day, and reheating foods. The surveyor reviewed a document titled, "Food Safety Management System, food safety product labeling and dating guidelines", document code 1.2.19, revision date 12/06/2022, page 1 of 3, which revealed, Purpose and Scope: Assist with labeling requirements on food products and use by dates. Note: Where a State, Provincial and or Local health regulation is more stringent than our company standard, you are required by law to follow those regulations. NJAC 8:39-17.2(g)	F 812		

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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. 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 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	S 560	1. All 13 residents have the potential to be affected by this deficient practice. 2. The facility is reviewing it's current staffing model and evaluating several interventions to put in practice to ensure that at all times the facility meets the minimum State ratios for Certified Nursing Assistants. The DON spoke to one of two Certified Nursing Assistants that currently works on night shift. He has agreed to transfer to the afternoon shift. The Administrator and DON are exploring possibly introducing twelve hour shifts for the Certified Nursing Assistants like the nursing staff have with staff and union approval. We are also reviewing the	8/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09006	A. BUILDING: ___ B. WING ___	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TC	308 WILLOW AVENUE HOBOKEN, NJ 07030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 effective 2/1/21. 1. 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 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	S 560	current worklist of our nursing staff to determine if we can assign a nurse (RN or LPN) to a direct caregiving position in the afternoons. 3. The Interim DON, Administrator or designee will review staffing on a daily basis to ensure that the minimum staffing ratios are being met according to our current census for the next three quarters. 4. Our findings will be brought forth to the QAPI team and together we will brainstorm and develop a recruitment and retention strategy for TCU. The QAPI team consists of the Administrator, DON, MDS Coordinator, Consultant Pharmacist, Clinical Nutritional Services Manager, a member of the governing body, Director of Rehabilitation Therapy, Director of Recreation, Infection Preventionist and Medical Director. We meet on a quarterly basis and will monitor staffing for the next three quarters and annually thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TC	308 WILLOW AVENUE HOBOKEN, NJ 07030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2	S 560		

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" for the weeks of 5/26/24 and 6/2/24 revealed the following:

The facility was deficient in CNA staffing for residents on 5 of 14 day shifts and deficient in CNAs to total staff on 3 of 14 evening shifts as follows:

-05/26/24 had 0 CNAs for 9 residents on the day shift, required at least 1 CNA.
-05/26/24 had .4 CNAs to 2.4 total staff on the evening shift, required at least 1 CNA.
-05/27/24 had 0 CNAs for 9 residents on the day shift, required at least 1 CNA.
-05/29/24 had .5 CNAs to 2.5 total staff on the evening shift, required at least 1 CNA.
-06/03/24 had 1.5 CNAs to 3.5 total staff on the evening shift, required at least 2 CNAs.
-06/06/24 had 1 CNA for 13 residents on the day

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09006	A. BUILDING: ______ B. WING ______	06/18/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 shift, required at least 2 CNAs. -06/07/24 had 1 CNA for 14 residents on the day shift, required at least 2 CNAs. -06/08/24 had 1 CNA for 14 residents on the day shift, required at least 2 CNAs. On 6/18/24 at 12:30 p.m., the surveyor informed the Director of Nursing and Licensed Nursing Home Administrator of the deficient staffing ratios.	S 560		
S2345	8:39-31.6(o) Mandatory Physical Environment (o) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 6/13/24, in the presence of the Facility Manager and Supervisor of Engineering it was determined the facility failed to invite state, county and municipal Emergency Management Officials (EMOs) to attend at lease one Emergency Preparedness (EP) evacuation drill annually. This deficient practice had the potential to affect all 13 residents and was evidenced by: During record review at 2:45 PM the facility provided a copy of the last EP evacuation drill. The drill was a table top-evacuation exercise dated 12/21/23. There were no other EP	S2345	1. All 13 residents have the potential to be affected by this deficient practice. 2. The facility Manager and facility Administrator scheduled the annual evacuation drill for Thursday, July 18th, 2024. On July 5th, 2024 the invitation inviting local OEM officials to this drill was sent via electronic communication, received and accepted at approximately 4:15 p.m. 3. This state regulation requiring facilities to notify local OEM's of their evacuation drills or tabletop exercises was communicated via e-mail 13 days in	7/5/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09006	A. BUILDING: ______ B. WING ______	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S2345	Continued From page 4 evacuation drills provided. There were no invitations to state, county or municipal EMOs to attend an annual EP drill in the last 12 months. In an interview at 2:45 PM the Facility Manager confirmed that state, county and municipal EMO were not invited to a emergency preparedness evacuation drill in the last year. The facility Administrator was was informed of the deficient practice during the Life Safety Code exit conference at 3:45 PM.	S2345	advance exceeding the timeframe of 10 days. The invitation was acknowledged, received and the local OEM office affirmatively confirmed their attendance. 4. The Administrator will monitor and ensure that all local OEM are notified within the ten day notification period. This information will be shared at QAPI and monitored for the next three quarters of 2024 and ending on January 31, 2025.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315512	A. Building B. Wing	8/20/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TCU	308 WILLOW AVENUE HOBOKEN, NJ 07030

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 07/31/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 07/31/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
6/18/2024	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
09006		8/20/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TCU	308 WILLOW AVENUE HOBOKEN, NJ 07030

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 08/19/2024	ID Prefix S2345 Reg. # 8:39-31.6(o) LSC	Correction Completed 07/05/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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	
6/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315512	A. BUILDING 01 B. WING ______	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TCU	308 WILLOW AVENUE HOBOKEN, NJ 07030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 6/13/24, and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Hoboken University Medical Center Transitional Care Unit is a wing on the 7th floor of a multi-story building that was built prior to 2012. The building is composed of Type I protected construction. The unit is a 9,334 sq. ft. single smoke compartment. The diesel (660 KW) generator does only red outlets on the unit and serves other areas of the building as per the Supervisor of Engineering. The current occupied beds are 13 of 15 licensed beds. The unit is fully sprinklered and utilizes an electric fire pump with city water.	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324		7/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/27/2024

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
	315512	A. BUILDING 01 B. WING ______	06/18/2024

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K 324	Continued From page 1 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 06/13/2024 in the presence of facility management, it was determined the facility failed to perform the semiannual kitchen fire suppression system inspection in accordance with NFPA 101:2012 edition Section 9.2.3. The deficient practice had the potential to affect all 13 residents and is evidenced by: A record review revealed that there was no semiannual kitchen fire suppression system inspection report provided for the last 8 and half months. The last report presented was dated 10/3/23. In an interview at 2:20 PM, the U.S. FOIA (b) (6) [redacted] indicated she was aware the inspection had not been conducted and was missing, and the service company did not come in 2024 yet to inspect. The facility manager was present at the time.	K 324	1. All 13 residents have the potential to be affected by this deficient practice. The biannual inspection was not scheduled. This deficient practice will be corrected by scheduling the missed inspection on July 1, 2024 at 7 p.m. with the vendor. 2. On an annual basis, the FSD or designee maintains an equipment inventory list. This equipment inventory list will be reviewed monthly and all preventative maintenance and/or testing will be scheduled according to state, federal and local rules and regulations. The PM schedule will be prepared on an annual basis or as needed when equipment is added or discarded to outliving their useful life. 3. The biannual inspection of the Ansel hood fire suppression system occurred on July 1, 2024 at 7 p.m. The next inspection date is scheduled for January of 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315512	A. BUILDING 01 B. WING	06/18/2024

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K 324	Continued From page 2 The facility U.S. FOIA (b) (6) was was informed of the deficient practice during the Life Safety Code exit conference at 3:45 PM. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 96 2011 Edition	K 324	4. The FSD or designee will review the equipment list monthly to ensure that all inspections are completed timely and not overlooked. 5. The FSD or designee will report the inspection findings on a quarterly basis to the TCU QAPI team members for review and discussion for the next three quarters. Findings will be tracked, trended and monitored for completeness and timeliness.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/13/24 in the presence of facility management, it was determined the facility failed to ensure the double smoke doors entering the Transitional Care Unit resisted the passage of smoke in accordance with NAPA 101 Section 8.2.2.4 and 19.3.7 (2012 edition), and NAPA 105 (2010 edition). This	K 374	1. All 13 residents have the potential to be affected by this deficient practice. The engineering department on 6/18/2024 fixed the doors so that no resident or staff member could be adversely affected by a smoke condition from the acute care hospital in to the skilled nursing facility by	7/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315512	A. BUILDING **01** B. WING ______	**06/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 374	Continued From page 3 deficient practice had the potential to affect all 13 residents and was evidenced by: An observation at 2:55 PM, in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6), revealed a 3/16-inch space between the the double doors that ran 14-inches from the bottom of the doors up. In an interview at the time of observation, the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) confirmed the observed space between the smoke doors. The facility U.S. FOIA (b) (6) was was informed of the deficient practice during the Life Safety Code exit conference at 3:45 PM. N.J.A.C. 8:39-31.2(e)	K 374	the 3/16 inch space between the double doors that ran 14-inches from the bottom of the doors up. 2. The engineering department inspected the door and determined that the smoke barrier seals in between the doors was missing. On 6/18/2024, staff members from the engineering department installed the seals eliminating the 3/16 inch space between the double doors that ran 14-inches from the bottom of the doors up, bringing the doors back in to substantial compliance. The engineering department inspected the other set of fire doors from the TCU Activity Room to SDS (Same Day Surgery/Acute Care Hospital) and determined that those doors are in substantial compliance. 3. The administrator, DON or designee will conduct monthly rounds with a representative from the engineering department and/or environmental services department to ensure that all doors are in good working order and in compliance according to State, Federal and local rules and regulations. Monthly rounds will be completed as part of our regular worklist. 4. Any findings discovered on monthly rounds will be addressed immediately by the appropriate manager or scheduled with a vendor within a reasonable timeframe for correction. The QAPI team will review this information. The QAPI team meets quarterly and for the next three quarters all findings will be reviewed at this meeting and annually thereafter.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		8/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315512	A. BUILDING **01** B. WING ______	**06/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 4 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 6/13/24 in the presence of facility management, it was	K 918	1. All 13 residents have the potential to be affected by this deficient practice. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315512	A. BUILDING **01** B. WING	**06/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TCU	**308 WILLOW AVENUE** **HOBOKEN, NJ 07030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 5 determined the facility failed to conduct a 90 minute annual loadbank test on their Emergency Power Generator (EPG) in accordance with NFPA 110 section 8.4 (2010 edition) for 1 of 2 EPGs. This deficient practice had the potential to affect all 13 residents and was evidenced by: A record review of the emergency power generator log revealed the diesel generator was exercised monthly under load at less than 30% of the emergency power systems nameplate rating for the following dates: 5/16/24, 4/18/24, 3/21/24, 2/15/24, 12/21/23, 11/16/23, 9/21/23, 8/17/23, 7/20/23, 6/18/23, 5/18/23, 4/20/23, 3/16/23, 2/16/23 and 1/21/23. There was no record of an annual 90 minute supplemental load exercise necessary when not meeting the monthly requirements of NFPA 110 section 8.4.2 (2010 edition). In an interview at 10:24 AM the U.S. FOIA (b) (6) stated that the facility did not conduct a 90 minute load test last year and did not run the generator at or above the 30% nameplate rating during the monthly full load tests. The facility U.S. FOIA (b) (6) was was informed of the deficient practice during the Life Safety Code exit conference at 3:45 PM. N.J.A.C. 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	engineering director and/or representative will ensure that generator testing will be done in accordance with all Federal, State, and local rules and regulations. 2. The missed 90 minute load test from 2023 is scheduled with the vendor on July 31, 2024. 3. The administrator or designee will review the weekly generator tests for completion. She will also review the monthly test to ensure that the monthly test is occurring for 30 minutes under full load. Any irregularities will be reported to the Director of Engineering or designee immediately for their correction. 4. The administrator or designee will review these weekly and monthly reports for the next six months for sustainability and ensure that the systemic issues are corrected. 5. The results of the monthly reports will be reviewed by the administrator and or designee and on a quarterly basis reported to he QAPI team members over the next six months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315512	A. Building 01 - HOBOKEN TCU B. Wing	8/20/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TCU	308 WILLOW AVENUE HOBOKEN, NJ 07030

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 Reg. # NFPA 101 LSC K0324	Correction Completed 07/31/2024	ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 07/31/2024	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 08/16/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO