STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315501	A. BUILDING _____ B. WING _____	03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WALL LLC	**1725 MERIDIAN TRAIL WALL, NJ 07719**

(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 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 Survey date: 03/17/2023 Census: 85 Sample: 18 + 3 closed records The facility is in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities.	F 000		

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

Electronically Signed | 04/03/2023

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.

New Jersey Department of Health

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	13301	A. BUILDING: _____ B. WING _____	03/17/2023

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S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be in 2007, with no current major renovations or noted additions. It is a two story building Type II (222) construction and is fully sprinklered. The partial basement has laundry, mechanical and storage rooms. The outside diesel generator does 100 % of the building. The facility is divided into 8 smoke zones and has piped in medical gas on floor 2. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 130 certified beds. At the time of the survey the census was 85. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 211	Means of Egress - General	K 211		3/31/23

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K 211 SS=F	Continued From page 1 CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 03/16/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was identified for 12 of 12 fire doors observed and was evidenced by the following: On 03/14/23 at approximately 9:45 AM, the surveyor asked the MD and RPOD to provide the annual testing requirements for fire door assemblies in accordance with NFPA 80. The MD stated that currently the facility did inspect fire doors, but did not have any documentation on fire door assemblies. The Administrator was informed of the finding at the Life Safety Code Exit Conference on 03/16/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80: Standard for fire doors assemblies and other opening protectives NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to	K 211	We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: Based on the RCA the team identified the cause of the deficient practice to be failure to inspect the fire door assemblies in accordance with NFPA 80. Corrective Actions taken for residents: All residents have the potential to be affected All Fire Doors and Assemblies inspected and in compliance. Measures / Changes put into place: Fire Door and Assembly inspection audit tool reviewed and revised to list all aspects of the inspection including assembly. Education provided to Plant Operations Director and Maintenance Tech on the annual testing requirements and inspection procedures for fire door assemblies. How the corrective actions will be	

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K 211	Continued From page 2 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	monitored to ensure the deficient practice will not recur: Fire door and assembly inspection audit tool will be completed annually by the director of plant operations and/or designee and results reviewed by the Director of Plant Operations. Fire door assembly inspection results will be reported annually to the QAPI committee.	
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 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	K 324		3/27/23

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/16/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that cooking equipment was protected in accordance with NFPA (National Fire Protection Association) 96. This deficient practice was evidenced for 1 of 1 electric food heating systems and was evidenced by the following: At 10:33 AM, the surveyor, MD and RPOD observed in the small Physical Therapy (PT) room closet that an electric food warming system was covered and surrounded by combustible cardboard boxes. The heating system was hard wired into the electrical system and when checked to see if the electrical breaker was off, it was determined that the food warming system was still in operation if turned on. An interview was conducted with the MD and RPOD at the time of the observation and they both stated that nothing combustible should be stored on or around the food warming system at any time. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 03/16/23. NFPA 96 NJAC 8:39-31.2(e) NFPA 101-2012 : 19.3.2.5	K 324	We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: - Based on the RCA the team identified the cause of the deficient practice to be failure to disconnect cooking equipment that was no longer in operation. Corrective actions taken for residents: - All residents have the potential to be affected. - Breakers to equipment were turned off and equipment was disconnected from the breaker. Measures / Changes put in place: - Monthly safety round compliance audit tool revised to include the inspection of cooking equipment and equipment no longer in operation. How the corrective actions will be monitored to ensure the deficient practice will not recur: - Monthly safety round compliance audit tool will be completed by the Director of Plan Operations and/or designee and results reviewed for efficacy by the Director of Plan Operations on a monthly basis. - Monthly safety rounds compliance audit tool will be done for 6 months and then quarterly thereafter and results will be reported at the quarterly QAPI meeting by the Director of Plant Operations.	

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K 351 SS=E	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 observation, interview and record review on 03/16/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to a.) provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment and b.) install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in this area. This deficient practice was identified for 1 of 1 closets and was	K 351	We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: -Based on the RCA the team identified the cause of the deficient practice to be failure to provide sprinkler coverage to an HVAC closet approximately 5’ x 2’. Corrective actions taken for residents: -All residents have the potential to be affected. Measures / Changes put in place: -Scheduled the installation of a sprinkler head in the 2nd floor rehab gym HVAC	4/5/23

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K 351	Continued From page 5 evidenced by the following: At 10:37 AM, the surveyor, MD, and RPOD observed in the small Physical Therapy room HVAC closet, approximately 5' x 2', that no fire sprinkler coverage was provided. The MD and RPOD both confirmed the finding during the HVAC closet observation and they stated when observed that the area was not provided with any fire sprinkler protection. The Administrator was informed of the finding at the Life Safety Code exit conference on 03/16/23. NJAC 8:39-31.2(e) NFPA 13 standard for the installation of sprinkler systems.	K 351	closet. Service scheduled for 4/5/23. -Safety round compliance audit tool was reviewed and revised to include the inspection of all closets to ensure they have sprinkler coverage. How the corrective actions will be monitored to ensure the deficient practice will not recur: -Monthly safety round compliance audit tool will be completed by the Director of Plan Operations and/or designee and results reviewed for efficacy by the Director of Plan Operations on a monthly basis. -Monthly safety rounds compliance audit tool will be done for 6 months and then quarterly thereafter and results will be reported at the quarterly QAPI meeting by the Director of Plant Operations.	
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 _____	K 353		4/5/23

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K 353	Continued From page 6 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 record review and interview on 03/16/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to have 4 of 4 private fire hydrants inspected annually according to NFPA 25. This deficient practice was evidenced by the following: At approximately 11:30 AM, the surveyor reviewed all related documentation from the fire sprinkler vendor. The reports did not indicate any annual inspection of the (4) four private fire hydrants on the facility's property as required by NFPA 25. The MD and RPOD both indicated that the annual fire hydrant inspection requirement was not performed, and no further documentation was provided. The Administrator was informed of the findings at the Life Safety Code conference on 03/16/23. NFPA 25 NJAC 8:39-31.2(e)	K 353	We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: -Based on the RCA the team identified the cause of the deficient practice to be failure to have 4 of 4 fire hydrants inspected annually. Corrective actions taken for residents: -All residents have the potential to be affected. Measures / Changes put in place: -Scheduled vendor to come out to inspect all 4 fire hydrants on 4/5/23. -Reviewed and updated the Plant Operations Inspection Compliance audit tool to include the annual fire hydrant inspection. How the corrective actions will be monitored to ensure the deficient practice will not recur: -Plant Operations Inspection Compliance audit tool will be updated monthly by the Director of Plan Operations and/or designee and reviewed for efficacy by the Assistant Administrator and/or designee. -Plant Operations Inspection Compliance audit tool will be reported at the quarterly QAPI meeting by the Director of Plant Operations.	

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K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that there was documented evidence that all existing elevators; having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key.19.5.3, 9.4.2, 9.4.3).	K 531	We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: Based on the RCA the team identified the cause of the deficient practice to be failure to conduct Phase I and Phase II testing of the elevators. Corrective actions taken for residents: All residents have the potential to be affected. Measures / Changes put in place: -Education provided to Plant Operations	3/28/23

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K 531	Continued From page 8 This deficient practice was identified for 2 of 2 elevators and was evidenced by the following: On 03/14/23, the surveyor reviewed all LSC documentation provided by the MD. The monthly testing of the firefighters Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 was not provided. An interview was conducted with the MD, during the record review. He confirmed there was no current firefighter's monthly service log for 2 of 2 elevator devices. The Administrator was informed of the findings at the Life Safety Code exit conference on 03/16/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3 & 9.4.3 Fire Fighters Emergency Operations: 9.4.3.2	K 531	Director and Maintenance Tech on the monthly inspection and testing requirements for all elevators. -All elevators Phase I and Phase II testing conducted and documented for compliance. -Reviewed and updated the Plant Operations Inspection Compliance audit tool to include the monthly Phase I and Phase II testing of elevators. How the corrective actions will be monitored to ensure the deficient practice will not recur: - Phase I and Phase II testing will be conducted and documented monthly by the Plant Operations Director and/or designee and will be reviewed for efficacy by the Director of Plant Operations on a monthly basis. - Results of the Phase I and Phase II testing will be reported at the quarterly QAPI meeting by the Director of Plant Operations. - Plant Operations Inspection Compliance audit tool will be updated monthly by the Director of Plan Operations and/or designee and reviewed for efficacy by the Assistant Administrator and/or designee. - Plant Operations Inspection Compliance audit tool will be reported at the quarterly QAPI meeting by the Director of Plant Operations.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm	K 712		4/6/23

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COMPLETE CARE AT WALL LLC	**1725 MERIDIAN TRAIL** **WALL, NJ 07719**

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K 712	Continued From page 9 signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 03/14/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was evidenced by the following: Based on document review and interview on 03/14/23, with the MD and RPOD, the facility fire drill reports revealed method for the simulation of emergency fire conditions were not varied and specific to location for 13 of 13 fire drills: Date Type of alarm transmission: Pull, Smoke or Page? specific location, what went on fire? how do staff respond with no specific location. - 02/25/23 smoke, 2nd floor rehab, page - 01/12/23 smoke, 2nd floor, class-C fire - 12/21/22 smoke, 1st floor, - 11/09/22 smoke, dietary, page - 10/16/22 smoke & flame? 2nd floor rehab gym	K 712	We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: -Based on the RCA the team identified the cause of the deficient practice to be failure to ensure fire drills are held under varying conditions and were not specific to location. Corrective actions taken for residents: -All residents have the potential to be affected. Measures / Changes put in place: -In-service scheduled for 4/6/23 with vendor to educate on the requirements for fire drills in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. -Created a fire drill audit tool to ensure fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift, including varying activation types, simulation of specific emergency fire conditions, and with specific location	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315501	A. BUILDING **01** B. WING _____	**03/17/2023**

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COMPLETE CARE AT WALL LLC	**1725 MERIDIAN TRAIL** **WALL, NJ 07719**

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K 712	Continued From page 10 - 09/30/22 electrical fire ,2nd floor rehab, fire in heater? - 08/16/22 smoke, laundry, page - 07/28/22 smoke, 2nd floor? - 06/29/22 smoke, 2nd floor? - 05/29/22 smoke, laundry, page - 04/18/22 heating unit failure, 2nd floor? - 03/10/22 smoke due to electrical fire, rehab, 2nd floor - 02/28/22 smoke, laundry? An interview was conducted with the MD after documentation review, where he stated and confirmed the findings that current fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions were not identified, varied and specific to areas for 13 of 13 fire drills documented on the forms. The Administrator was informed of the finding at the Life Safety Code exit conference on 03/16/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4	K 712	identified. How the corrective actions will be monitored to ensure the deficient practice will not recur: - Fire drill audit tool will be completed monthly by the Director of Plant Operations and/or designee and reviewed for efficacy by the Assistant Administrator and/or designee. - Fire drill audit tool will be done monthly and results will be reported at the quarterly QAPI meeting by the Director of Plant Operations.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 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.	K 918		4/18/23

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	315501	A. BUILDING **01** B. WING _____	**03/17/2023**

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K 918	Continued From page 11 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 observation and interview on 03/16/23, in the presence of the Maintenance Director (MD) and Regional Plant Operation's Director (RPOD), it was determined that the facility failed to ensure a remote manual stop station for one of one generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 1:05 PM, the surveyor, MD and RPOD observed the exterior 750 KW (kilowatt) Kohler diesel generator. There was no remote manual	K 918	We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: -Based on the RCA the team identified the cause of the deficient practice to be failure to ensure a remote manual stop station was installed for the generator in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1 Corrective actions taken for residents: -All residents have the potential to be	

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K 918	Continued From page 12 stop station observed outside the area of the generator location. An interview was conducted during the time of the observation with the MD and RPOD, who both confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover. The Administrator was informed of the findings at the Life Safety Code exit conference on 03/16/2023. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	affected. Measures / Changes put in place: -Contracted electrician to install a remote manual stop station. Vendor ordered the parts needed for installation and are awaiting delivery. Installation is scheduled. -Monthly safety round compliance audit tool reviewed and revised to include remote manual stop station for generator How the corrective actions will be monitored to ensure the deficient practice will not recur: -Monthly safety round compliance audit tool will be completed by the Director of Plan Operations and/or designee and results reviewed for efficacy by the Director of Plan Operations on a monthly basis. -Monthly safety rounds compliance audit tool will be done for 6 months and then quarterly thereafter and results will be reported at the quarterly QAPI meeting by the Director of Plant Operations.	

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
315501 Y1	A. Building 01 - MERIDIAN SUBACUTE REHAB B. Wing Y2	4/26/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WALL LLC	1725 MERIDIAN TRAIL WALL, NJ 07719

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	03/31/2023	LSC K0324	03/27/2023	LSC K0351	04/05/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	04/05/2023	LSC K0531	03/28/2023	LSC K0712	04/06/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	04/18/2023	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	
3/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO