STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315396	A. BUILDING _____ B. WING _____	C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE BRIDGETON, NJ 08302**

(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 Complaint #: NJ 001052177, NJ 00150683, NJ00150837, NJ 00151536,NJ00152223, NJ00153534, NJ00159116 Survey Date: 02/23/2024 Census: 124 Sample: 27 + 3 closed records 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		3/23/24

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

Electronically Signed | 03/07/2024

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 584	Continued From page 1 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: NJ # 156264 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain a clean environment in the second and third floor shower room. The deficient practice was identified on 2 of 3 shower rooms (Second & third floor) under the Environmental Task. The deficient practice was evidenced by the	F 584	Element #1 □ In the second floor shower room, the uncapped, opened bottles of shampoo and aftershave were immediately removed and discarded. The discoloration on the shower floor and white shower tiles with orange stains were immediately cleaned. The personal clothing draped on the shower chair and pair of black shoes on the ground were immediately removed. The black, vegetative substance on the	

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F 584	Continued From page 2 following: On 02/16/2024 at 11:14 AM, the surveyor entered and observed the shower room located on the second floor. At that time, the surveyor observed uncapped, opened bottles of shampoo and aftershave, discoloration on the shower floor, and white shower tiles with stains orange in appearance. The shower room also contained personal clothing draped on a shower chair, and a pair of black shoes left on the ground. Further, the surveyor observed a black, vegetative substance on the shower walls. Lastly, the surveyor observed clothing hangars, tags, and papers left on top of a plastic shower gurney. On the same date at 11:30 AM, the surveyor entered and observed the shower room on the third floor. At that time, the surveyor observed linen draped over a shower chair. Secondly, the surveyor observed a whirlpool tub. Within the tub, there was a clear, plastic bag containing soiled linen, brown-stained towels and a stained hospital gown. On 02/21/2024 at 11:04 AM during an interview with the surveyor, the U.S. FOIA (b)(6)) replied that shower rooms are cleaned every day when the surveyor asked how often the rooms are cleaned. The U.S. FOIA (b) also confirmed that there should not be anything in the whirlpool tubs. On 02/22/2024 at 1:07 PM during an interview with the surveyor, the U.S. FOIA (b)(6) said that the nursing staff place linen in the shower room and the housekeeping staff removes it. During the same interview, the U.S. FOIA (b)(6) replied, "No" when the surveyor asked if soiled linens should be	F 584	shower wall was immediately cleaned. The clothing hangars, tags, and papers on top of the shower gurney were immediately removed. In the third floor shower room, the linen draped over the shower chair were immediately removed. The clear plastic bag with soiled linen, brown-stained towels, and a stained hospital gown was immediately removed form the whirlpool tub. Element #2 - All residents who use these shower rooms have the potential to be affected by this practice. Element #3 □ 1. The deep cleaning schedule for shower rooms was reviewed and revised as needed. Housekeepers were re-in-serviced on the new schedule and were re-educated on cleaning shower rooms on a daily or as needed basis. These in-services will be given during orientation for newly hired housekeeping staff, annually and as deemed necessary. 2. Shower room cleaning schedules will be logged in the housekeeping logbook/sheets. Element #4 □ Weekly environmental audits of each shower room across all units x 4 weeks and then monthly x 3 months will be conducted by the Director of Housekeeping/designee to ensure that deep cleaning of shower rooms is properly cleaned. Any negative findings will be corrected immediately through	

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F 584	Continued From page 3 stored in the whirlpool tub. On 02/23/2024 at 10:31 AM during an interview with the surveyor, the [U.S. FOIA (b)(6)] stated that the facility initiated an in-service for the staff on handling and placing soiled linens. A review of the facility policy titled, "Routine Cleaning and Disinfection" implemented on 8/2023, revealed under subsection, "Policy Explanation and Compliance Guidelines" that, "1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas..." NJAC § 8:39-31.4 (a)	F 584	one-on-one re-educations and disciplinary measures as appropriate. Results of all audits will be reported to the QAA committee by the Housekeeping Director who meets quarterly and will determine the necessity of future audits and recommendations.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: NJ # 154489 Based on observation, interview, record review,	F 686	Element 1 Resident # 222 treatment administration record and correlating nursing	3/23/24

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F 686	Continued From page 4 and review of pertinent facility documents, it was determined that the facility failed to provide necessary treatment and services to promote the healing of [redacted], specifically by leaving the Treatment Administration Record blank on specific dates and times. The deficient practice was identified for 1 of 4 residents (Resident # 222) investigated for [redacted] The deficient practice was evidenced by the following: A review of Resident # 222's Significant Change Minimum Data Set (MDS; an assessment tool) dated [redacted] and the Quarterly MDS dated [redacted] revealed that he/she had [redacted] A review of Resident # 222's Admission Record revealed a diagnosis of but not limited to, [redacted] A review of Resident # 222's Care Plan revealed a focus, [redacted] at risks for further [redacted] [related to] [redacted] " The Care Plan revealed interventions including but not limited to, [redacted] per orders - report any worsening or delayed healing PRN [as needed]." and, "tx [treatment] to [redacted] orders and report status changes and or s/s [signs and symptoms] infection..." A review of the "Treatment Administration Record" (TAR) for [redacted] revealed the following physician orders and blanks on the TAR:	F 686	documentation was reviewed by the Director of Nursing and [redacted] was noted. Element 2 All residents with treatment order have the potential to be affected □ all resident treatment administration records were reviewed to ensure that measures are taken by the licensed nurse to maintain compliance with treatment administration with correlating documentation on the treatment administration record. Element 3 License nurses will be re-educated related to proper process for treatment administration with correlating documentation on the treatment administration record. The education will be inclusive of the treatment administration policy and documentation. Element 4 The process for adherence to proper treatment administration with correlating documentation will be conducted by the Director of Nursing or Designee. The treatment administration observation tool will include an audit of the Physician order set and review of the treatment administration record to ensure documentation is completed on the treatment administration record. This audit tool will be utilized and completed weekly x 4 then monthly x 3. Negative findings will be reported to the DON and addressed through one-to-one re-education and disciplinary measures is	

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F 686	Continued From page 5 NJ Exec Order 26.4b1 Apply to NJ Exec Order 26.4b1 every day shift for NJ Exec Order 26.4b1 care apply with NJ Ex Order 26.4b1. The order was started on NJ Exec Order 26.4b1. The TAR revealed blanks on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 for the day and evening shifts. NJ Exec Order 26.4b1 every shift and PRN [as needed] NJ Exec Order 26.4b1 every shift for NJ Exec Order 26.4b1 The order was started on NJ Exec Order 26.4b1. The TAR revealed blanks on NJ Exec Order 26.4b1 for the night shift, NJ Exec Order 26.4b1 for the evening shift, and NJ Exec Order 26.4b1 or the night shift. A review of the TAR for NJ Ex Order 26.4b1 revealed the following physician orders and blanks on the TAR: NJ Exec Order 26.4b1 every day and evening shift". The order was started on NJ Exec Order 26.4b1. The TAR revealed blanks on NJ Exec Order 26.4b1 for the day and evening shifts. NJ Exec Order 26.4b1 and PRN [as needed] NJ Exec Order 26.4b1 every shift for NJ Exec Order 26.4b1]". The order was started NJ Exec Order 26.4b1. The TAR revealed blanks on the day and evening shifts on NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 while in bed. Every shift for NJ Exec Order 26.4b1 ". The order was started on NJ Exec Order 26.4b1. The TAR revealed blanks on NJ Exec Order 26.4b1 for the day and evening	F 686	applicable. The results of the audits will be reported by DON during the quarterly quality assurance and improvement meeting.	

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F 686	Continued From page 6	F 686		

shift. The TAR revealed blanks on [NJ Ex Order 26.4b1] for the day and night shift and blanks on [NJ Ex Order 26.4b1] for the day shift.

NJ Exec Order 26.4b1 ."

The order was started on [NJ Exec Order 26.4b1]. The TAR revealed blanks on [NJ Exec Order 26.4b1] for the day and night shift and [U.S. FOIA (b)(6)] for the day shift.

NJ Exec Order 26.4b1 . The order was started on [NJ Exec Order 26.4b1]. The TAR revealed blanks on [NJ Exec Order 26.4b1] for the day and night shift and [NJ Exec Order 26.4b1] for the day shift.

On 02/21/2024 at 10:37 AM during an interview with the surveyor, Licensed Practical Nurse # 3 replied, "No, we have codes to use. If it is a hold or refusal, there is a number that corresponds to that."

A review of the Progress Notes located in Resident # 222's electronic Medical Record did not reveal any notes of resident refusals of care for the above specified dates and time.

On 02/22/2024 at 11:22 AM during an interview with the surveyor, the [U.S. FOIA (b)(6)]) replied, "The nurse should be documenting in the progress notes." when the surveyor asked what is the procedure for documentation if a resident refuses care. Further, the [U.S. FOIA (b)] replied, "No, because there is a code that they [nurses] use." when the surveyor asked if the TAR should be left blank. When the surveyor asked if blank spaces on the TAR and no notes reflecting why it may be

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F 686	Continued From page 7 left blank, would you consider the treatment, order, or intervention as administered. The [redacted] replied, "Absolutely not." A review of the facility policy titled, "Medication Administration" last reviewed 1/2024 revealed under section, "Policy Explanation and Compliance Guidelines" that, "19. If a resident refuses medication, document refusal on MAR [Medication Administration Record] or TAR and/or in resident medical record..." § N.J.A.C. 8:39-27.1(a)	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and other facility documentation, it was determined the facility failed to ensure there was a Physician's Orders (PO) for 1 of 1 residents (Resident # 471) reviewed for NJ Exec Order 26.4b1. This deficient practice was evidenced by the following: On 2/14/24 at 11:48 AM during initial tour the surveyor observed Resident # 471 in bed with a	F 695	Element 1 Resident # 471 Physician□s order set was reviewed by the Director of Nursing. The Physician was consulted, and an order was secured for the utilization of NJ Exec Order 26.4b1 Element 2 All residents have the potential to be affected □ all facility resident medical records were reviewed and for those	3/23/24

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F 695	Continued From page 8 NJ Exec Order 26.4b1) applied to his/her NJ Exec Order with NJ Exec Order 26.4b being administered at NJ Ex Order 26.4b1 . At that time, Resident # 471 said that he/she always wears NJ Exec Order 26.4 . A review of Resident # 471's Admission Record revealed he/she was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b [redacted] A review of Resident # 471 Order summary report dated NJ Exec Order 26.4b1 did not show any orders for NJ Exec Order 26.4 A review of Resident # 471 Care Plan initiated on NJ Exec Order 26.4b1 and revised on NJ Exec Order 26.4b1 revealed a focus for NJ Exec Order 26.4b1 r/t [related to] Ineffective NJ Ex Order 26.4b1 , h/o [history NJ Exec Order 26.4b1 U.S. FOIA (b)(6)]. During an interview on 2/21/23 at 11:25 AM with Licensed Practical Nurse (LPN) # 1, when asked what the policy is for putting orders on admission, LPN # 1 replied, "We get the discharge packet from the hospital; we assess the resident then call the doctor with the assessment and orders to see what they want to continue." When asked if any medication should be given before orders are entered, LPN # 1 replied, "No". The surveyor then asked, "What about NJ Exec Order 26 ?" LPN # 1 replied "If they are in distress we have standard orders, and if they come in from the hospital, we don't take it off until we get the orders entered." When asked, "why is it important to have orders entered?" LPN # 1replied, "So the nurses know what to give and	F 695	residents requiring supplemental Oxygen a medical record review was conducted to ensure that an order set was in place for the utilization of Oxygen. Element 3 All licensed nurses will be re-educated related to the process for securing a physician□s order for those residents requiring supplemental Oxygen. The educational session will be inclusive of utilizing the Oxygen batch order set. The education will be provided by the staff educator. Element 4 The process for adherence to orders for supplemental Oxygen will be conducted via the Oxygen audit tool, the observation tool is to ensure an applicable order set was implemented for the utilization of Oxygen. The audit tool will be completed by the Director of Nursing or Designee weekly x 4 then monthly x 3. Negative findings will be reported to the DON and addressed through one-to-one re-education and disciplinary measures is applicable. The results of the audits will be reported by the Director of Nursing during the quality assurance and improvement meeting. The quality assurance committee will meet quarterly.	

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F 695	Continued From page 9 when last given, and to ensure their care is continued". During an interview on 2/21/24 at 12:08 PM, the U.S. FOIA (b)(6)) said that they have order sets that are entered for all residents and that they take the orders that the hospital gives them and review the orders with the doctor to clarify what orders to keep. When asked if medication should be given without orders, the U.S. FOIA (b) stated "No". The surveyor then asked, "What about [redacted]" The U.S. FOIA (b) replied, "If they are coming in the facility with NJ Exec Order 26 on we wouldn't take it off of them, but we would still get orders, the orders would be entered that same day." When asked why is that important the U.S. FOIA (b) replied, "Because we would never administer a medication without a doctor's orders." A review of a facility policy titled Oxygen with a revised date of 9/12/23, revealed under the "Procedure" section, "1. Check MD Order. And 9. Document initiation of oxygen in the resident medical record, including time, flow, indication and method: cannula or mask, in TAR (Treatment Administration Record and or in progress notes). Document use and resident reaction to Oxygen. N.J.A.C. § 8:39-27.1(a)	F 695		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 727		3/23/24

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F 727	Continued From page 10 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: NJ #154489 Based on interview, review of Nursing Staffing Report sheets and facility provided documents, it was determined that the facility failed to ensure a NJ Exec Order 26.4b1 worked 7 days a week for at least 8 consecutive hours a day for 2 of 14 days reviewed through NJ Exec Order 26.4b1 through U.S. FOIA (b)(6). The deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for the weeks of NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 revealed the facility had no U.S. FO coverage for all shifts on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 A review of the facility provided document titled, "Time Card Report" with a date range of NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 did not reveal any hours covered by an U.S. FOIA for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. On 02/23/2024 at 10:30 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) replied, "So far, I haven't found anything for those two days' when the surveyor	F 727	1. There were no care concerns reported on the shifts that were identified as not having an RN on site. 2. All residents have the potential to be affected by this practice. 3. Facility Staffing Coordinator was re-educated on the requirements for proper RN staffing and the need to review and address the staffing needs daily to meet federal requirements. Recruitment efforts are in place to assist the facility in hiring RN staff. RNs receive sign on bonuses and referral bonuses. The facility also has paid advertisements to help with our recruitment effort. 4. The Facility Administrator, Director of Nursing and the Staffing Coordinator will conduct weekly meetings x4 then monthly x 6 to review staffing schedules, upcoming needs, and the efficacy of the systems in place to fill the facility needs in addition to the recruiting strategies. Results of the audits will be submitted to the Quality Assessment and Assurance (QAA) committee who meets quarterly for review and to determine the frequency	

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PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE BRIDGETON, NJ 08302**

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F 727	Continued From page 11 asked if the facility had an [redacted] on duty for [redacted]. A review of the facility policy titled, "Registered Nurse Staffing" reviewed 8/2023 revealed under section, "Policy Explanation and Compliance Guidelines:" that, "1. Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week."	F 727	and necessity of future audits and actions taken.	
F 755 SS=D	NJAC 8:39-25.2(h) 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(g). 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 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.	F 755		3/23/24

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F 755	Continued From page 12 §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, record review, and review of other facility documentation, it was determined that the facility failed to follow appropriate standards of practice for, a. the storage of medications at proper temperatures and b. accountability of a narcotic count sheet. This deficient practice was observed in 1 of 2 medication rooms and 1 of 3 medication carts inspected for storage and labeling and was evidenced by the following: a. On 2/16/24 at 12:16 PM, the surveyor observed the first-floor medication room for storage and labeling in the presence of Licensed Practical Nurse #2(LPN#2). Upon opening the refrigerator, the surveyor observed that the thermometer reflected a temperature of 60 degrees Fahrenheit (60F.) The surveyor also observed a clear liquid which appeared to be melted ice on the lowest shelf in the refrigerator. LPN#2 verified the temperature of the refrigerator was 60F and that she believes that the clear liquid is most likely melted ice. LPN#2 stated that she believes the 11 to 7 shift is responsible for checking the temperature of the refrigerator. The surveyor observed the following medications in the first-floor medication refrigerator: 1.A box with NJ Exec Order 26.4b1	F 755	Element 1 The first-floor refrigerator was evaluated by Maintenance, and it was determined that the ground fault tripped. Maintenance did render the refrigerator to be operational. The medications were discarded and reordered from the pharmacy provider. The licensed nurse immediately signed the controlled drug record, facility□s narcotic inventory log for the removal of the medication (Tramadol) when it was brought to her attention. Element 2 All center refrigerators have the potential to be affected □ all refrigerators were evaluated to ensure proper function and temperature control. All controlled drugs were audited to ensure that the disposition of the controlled drugs is accurately reconciled. All residents have the potential to be affected by these deficient practices. Element 3 All licensed staff were re-educated related to proper refrigerator temperature. Re-educate inclusive of notification to	

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F 755	Continued From page 13 Medication (used to treat NJ Exec Order 26.4b1). The label reflected to store at 36F to 46F. LPN#2 stated, "The fridge temperature is too high". 2.One bottle of unopened NJ Exec Order 26.4b1 [redacted]). The label reflected to refrigerate until opened. 3. Two bottles of unopened [redacted]). The label reflected refrigerate until opened. 4. One bottle of unopened NJ Exec Order 26.4b1 [redacted]). The label reflected to refrigerate until opened. 5. One NJ Exec Order 26.4b1 [redacted]). The label reflected to refrigerate. LPN #2 stated that the medications that were stored in the refrigerator will not be administered to the residents. The UM#1 verified that the 11 to 7 shift is responsible for checking the refrigerator temperature. She furthered that she would remove the medications from the refrigerator "right now". The U.S. FOIA (b)(6) [redacted] verified that the refrigerator feels warm. He stated, "The ground fault tripped. It has never happened before." On 02/16/24 12:57 PM the U.S. FOIA (b)(6) [redacted] stated the refrigerator temperature should be between 37 -41 degrees "60 degrees was not proper". On 2/16/23 at 2:19 PM, the surveyor reviewed the facility provided policy titled "Medication Refrigerator Temperature Checks" which was created on 9/18/23. The policy reflected that the temperature range must be from 36-46 degrees. b. On 2/16/23 at 12:16 PM, the surveyor, in the presence of Licensed Practical Nurse #2 (LPN #2), reviewed the NJ Ex Order 26.4b1 [redacted] sheets for the	F 755	maintenance of operational concerns related to the refrigerator or temperature of the refrigerator. One-One education was provided to the licensed nurse that was responsible for signing out the controlled drug on the declining inventory log. All licensed staff will be re-educated related to the facility□s Controlled Substances and Medication Administration policy with emphasis on signing out controlled drugs on the declining inventory sheet at the time the medication is removed from inventory. Education nwill be complete by 3/23/24. Element 4 The process for adherence to proper refrigerator temperature will include conducting audits of the refrigerator temperatures with review of the corelating temperature log. The observation tool is to ensure appropriate temperature control of each refrigerator with correlating temperature log. The audits will be conducted by the Director of Nursing or Designee weekly x 4 then monthly x 3. The results of the audits will be reported by the Director of Nursing during the quality assurance and improvement meeting. The process for adherence to compliance with the Controlled Drug Record will include conducting audits on all medication carts weekly x 4 then monthly x 3. The audits will entail auditing the declining inventory countdown sheets to ensure controlled drugs are reconciled and signed out from the inventory sheet when the controlled drug is removed. The	

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F 755	Continued From page 14 NJ Ex Order 26.4b1 side medication cart. The surveyor observed the following: Resident #54's NJ Ex Order 26.4b1 sheet for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) reflected that there were NJ Exec pills. The blister packs of the NJ Exec Order 26.4b1 reflected that there were NJ Exec pills. LPN#2 stated she gave a NJ Exec Order 26.4b1 at 12:00 PM however she forgot to sign the NJ Ex Order 26.4b1 sheet for Resident #54. LPN #2 was able to show that the medication was given and signed in the residents' electronic medication administration record (MAR). On 2/16/24 at 12:57 PM, the U.S. FOIA (b)(6) stated the nurse should have signed in book when she took the U.S. FOIA (b)(6) out of the drawer. On 2/21/24 at 11:30 AM, the surveyor reviewed the facility policy titled "Controlled Substances" which was reviewed on 3/8/23. The policy reflected that controlled substances are reconciled upon ... administration ...	F 755	audits will be conducted by the Director of Nursing or Designee. Negative findings will be reported to the DON and addressed through one-to-one re-education and disciplinary measures is applicable. The results of the audits will be reported by the Director of Nursing during the quarterly quality assurance and improvement meeting. The quality assurance committee will meet quarterly.	
F 804 SS=D	NJAC: 8:39-29.4 Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced	F 804		3/23/24

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F 804	Continued From page 15 by: Complaint # NJ00158190 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure palatable temperature of food and beverage for 1 of 1 lunch meal served on 1 of 3 units (First Floor). This deficient practice was evidenced by the following: On 02/20/24 at 10:34 AM, the surveyor conducted a meeting with Resident Council which included five residents (Residents #23, #32, #54, #59, and #69). All five residents informed the surveyor that the breakfast meal was always served cold and "warm food was cold and cold food was hot" on all three nursing units. On 02/21/24 at 11:30 AM, the surveyor observed the U.S. FOIA (b)(6)) as she obtained food temperatures from the steam table. The surveyor observed that the [redacted] did not document the food temperatures that she obtained. The [redacted] stated, "I should have recorded the temperatures." On 02/21/24 at 11:45 AM, The U.S. FOIA (b)(6) [redacted] calibrated (to check the setting) his thermometer in the presence of the surveyor to 31.8 degrees Fahrenheit (F) and stated that 32 F was the desired calibration. The food truck left the kitchen at that time, and went to the [redacted] floor nursing station. On 02/21/24 at 11:47 AM, the food truck arrived on the [redacted] floor nursing unit where the nursing staff awaited meal delivery. On 02/21/24 at 11:54 AM, the last resident meal	F 804	Element 1 All cooks were immediately re-inserviced on proper documenting of temperatures of all foods/ beverages prior to meal service; ensuring all hot foods are held at above 135 and cold food below 40 at point of service. Resident #23, #32, #54, #59, and #69 were immediately interviewed by the food service director about their temperature preferences and noted it in the dietary sheets for each resident as appropriate. Element 2 Other residents were interviewed to ensure they are receiving food at the correct temperature. All residents receiving food from the Dietary Service have the potential to be affected by this practice. Element 3 The Food Service Director will conduct monthly meetings with residents to discuss temperatures and palatability. Food preferences and temperatures are discussed with the food service director at Resident council meetings. Dietary staff were re- educated regarding correct serving temperatures of food. This in-service will be given on orientation for a newly hired Dietary staff, annually and as deemed necessary. Element 4 Food Service Director/Dietician or designee will sample 5 trays weekly for four weeks and then monthly for 3 months	

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F 804	Continued From page 16 tray was passed. On 02/21/23 at 11:55 AM, the [U.S. FOIA] obtained food temperatures from a regular tray using a calibrated thermometer which included: cranberry juice 54 F, milk 49 F, and mixed fruit 56 F. The [U.S. FOIA (b)] stated that the cold food and beverages should be served below 41 F. On 02/21/24 at 11:59 AM, the [U.S. FOIA (b)] obtained food temperatures from a pureed (a way to change the texture of solid food so that it was smooth with no lumps) tray using a calibrated thermometer which included: milk 42 F, apple juice 55 F, and pureed mixed fruit 56 F. The [U.S. FOIA] stated the temperatures of the cold items were a little off from 41 F. On 2/22/24 at 12:40 PM, the surveyor returned to the kitchen and obtained a copy of the "Service Line Checklist" dated 02/21/24. The lunch meal temperatures were recorded on the form and indicated that milk was 34 F, and cold beverage/juice was 33 F, and fruit was 34 F. The [U.S. FOIA] was not available for interview at that time. On 02/23/24 at 10:32 AM, the [U.S. FOIA (b)(6)] presented the surveyor with a copy of the "Service Line Checklist" dated 02/21/24 and stated that food temperatures were obtained and milk was recorded at 33 F. [U.S. FOIA (b)(6)] further stated that temperature preference was subjective. The surveyor informed the [U.S. FOIA (b)(6)] that during the tray line observation on 02/21/24 at 11:30 AM, the surveyor did not observe the [U.S. FOIA] obtain cold food or beverage temperatures or document the hot food temperatures that were obtained prior to the lunch meal delivery to the first floor nursing unit.	F 804	covering all meals to ensure proper temperature of the food. 10 Resident surveys will be taken regarding the palatability and temperature of the food weekly times 4 weeks and then monthly times three months. All findings will be reported by the Food Service Director at the QAPI committee that meets quarterly and will determine the necessity of future audits and recommendations.	

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F 804	Continued From page 17 Review of a facility policy titled, "Food Temperatures" (Reviewed 08/2023) revealed the following: ...The cook is responsible to see all food is at the proper temperature. Temperatures of all food items will be recorded prior to meal service. ...The following range of temperatures is recommended for food at point of tray assembly:...Chilled Foods and Beverages (45 F or Below). According to USDA (United States Department of Agriculture) Food Safety and Inspection Service, ...Cold foods should be held at 40 F or colder... Reference: https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/steps-keep-food-safe NJAC 8:39-17.4(a)(2)	F 804		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		3/23/24

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F 880	Continued From page 18 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 19 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. 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 implement appropriate use of personal protective equipment, specifically by staff not wearing a gown while inside a resident room NJ Ex Order 26.4b1 [redacted] The deficient practice was identified for 1 of 6 residents (Resident # 470) reviewed under the Infection Control facility task. The deficient practice was evidenced by the following: On 02/15/2024 at 12:00 PM on the second floor, the surveyor observed a Certified Nurses Aide (CNA) # 1 enter a resident (Resident # 470) room with a sign on the door that revealed, "USE STANDARD PRECAUTIONS NJ Ex Order 26.4b1 [redacted] Prior to Entering the Room." The sign revealed a illustration of a gown along with gloves. CNA # 1 entered the room with a tray of food. Outside of the resident's room was a plastic bin containing disposable, blue gowns, gloves, and a container of bleach surface wipes. CNA # 1 did not wear a gown or gloves while inside the room.	F 880	Element# 1 The US FOIA (b)(6) [redacted] who was involved in the cited deficient practice was re-educated on the importance of following NJ Ex Order 26.4b1, PPE requirements, and proper donning and doffing for resident #470 on NJ Ex Order 26.4b [redacted] Completed on 2/15/2024. Element2. All residents have the potential to be affected by the cited deficient practice. Element #3 All staff were re-educated on isolation precautions, PPE requirements, proper donning, and doffing, return demonstration and competencies. This in-service will be given annually, during orientation for newly hired staff and when deemed necessary. Element # 4 Facility IP and or nurse designee will complete a weekly observation audit for 5 residents on TBP covering all shifts x 4	

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F 880	Continued From page 20 At that time from the hallway, the surveyor observed CNA # 1 and Resident # 470 inside the room. While inside the room, CNA # 1 was observed placing the tray of food on the bed side table, assisting with setting up the meal, adjusting the bed side table, and retrieving a pair of eyeglasses from the floor. CNA # 1 did not wear a gown or gloves during this time. Approximately five minutes later, CNA # 1 left the room and used alcohol-based hand rub during hand hygiene. On the same date at approximately 12:05 PM, during an interview with the surveyor, CNA # 1 replied, "I should have worn a gown in there." when the surveyor asked if she should have worn anything specific. On 02/16/2024 at 12:07 PM, during an interview with the surveyor, the U.S. FOIA (b)(6) confirmed Resident # 470 was on NJ Ex Order 26.4b1 due to a diagnosis of NJ Exec Order 26.4b1). The U.S. FOIA (b)(6) said that staff is expected to wear a gown, gloves, and a mask upon entering Resident # 470's room. Lastly, the U.S. FOIA (b)(6) clarified that alcohol-based hand rub can be used upon entrance of a room but not when exiting a room. She said, "They [staff] have to use soap and water." A review of Resident # 470's Admission Record revealed a primary diagnosis of but not limited to, NJ Exec Order 26.4b1 A review of Resident # 470's Electronic Medical	F 880	weeks and then monthly x 3 months on proper PPE usage, compliance, isolation precaution and ensure staff compliance. Negative results will be corrected immediately through re-education, PPE competencies and or disciplinary action as appropriate. Results of the audits will be submitted to the QAA committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.	

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F 880	Continued From page 21 Record (EMR) revealed a Care Plan focus, "[Resident # 470] is being treated with [NJ Exec Order 26.4b1 redacted] for community acquired [NJ Exec Order 26.4b1 redacted]. The Focus was initiated on [NJ Exec Order 26.4b1 redacted]. The Care Plan also revealed an Intervention, "[NJ Ex Order 26.4b1 redacted] initiated [NJ Exec Order 26.4b1 redacted] A review of Resident # 470's Order Summary Report revealed a physician's order initiated on [NJ Exec Order 26.4b1 redacted] to, "Maintain NJ Ex Order 26.4b1 [redacted] due to [NJ Exec Order 26.4b redacted]; check isolation cart every shift to ensure supplies and signage are in place..." On 02/20/2024 at 11:22 AM during an interview with the surveyor, the U.S. FOIA (b)(6) [redacted]) stated, "Any rooms that are under precautions, the staff should be using the proper PPE [personal protective equipment; including by not limited to gowns, gloves, masks]..." The [U.S. FOIA (b) redacted] replied, "Yes" when the surveyor asked if the staff member should be wearing a gown in the room if the sign on the door dictates that. A review of the facility policy titled, "Transmission Precautions - Contact" last revised on 1/2024 revealed under section "Procedure", part "3. Gowns:" to, "Wear a clean, non-sterile gown upon entering the resident's room if you anticipate substantial contact between your clothing and the resident, environmental surfaces, or items in the room. Wear a gown if the resident is incontinent, has diarrhea..." Further, the policy revealed under section, "General Information", that, "Contact precautions for enteric infectious diseases, such as clostridium difficile or norovirus includes washing hands with soap and water and performing daily cleaning of the resident's room and high touch surfaces using a C. difficile	F 880		

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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) COMPLETION DATE
F 880	Continued From page 22 sporicidal agent (EPA List K agent), such as bleach." A review of the facility policy titled, "Management of Clostridioides Difficile (C-Difficile) Infection" last revised 1/2024 revealed under section, "Policy Explanation and Compliance Guidelines:" number "4", "a. All staff are to wear gloves and a gown upon entry into the resident's room when providing care for the resident when anticipating substantial contact between your clothing and the resident, environmental surfaces, or items in the room."	F 880		
F 924 SS=D	§ 8:39-19.4 (a) Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that corridors were equipped with firmly secured handrails on each side. The deficient practice was identified on 1 corridor (Second Floor) and evidenced by the following: On 02/14/2024 at approximately 09:28 AM, a request was made to the U.S. FOIA (b)(6) [redacted]) to provide a copy of the facility lay-out which identifies the various rooms, common areas and smoke compartments in the facility. A review of the facility lay-out identified the facility is a three-story (3) building with 91 Resident sleeping rooms and common areas where Residents and Visitors could go.	F 924	Element 1 The facility will install handrails on the corridor leading from residents main dining room to the residents salon. Element 2 All residents that utilize this corridor have the potential to be affected by this practice. Facility was checked to ensure that handrails are installed as required by all local state and federal regulations Element 3 The maintenance staff were re-educated on the importance of handrails security in the corridors.	3/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315396	A. BUILDING _____ B. WING _____	C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE BRIDGETON, NJ 08302**

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F 924	Continued From page 23 Starting at approximately 10:10 AM on 02/14/2024 and continued on 02/15/2024 in the presence of the facility U.S. FOIA (b)(6) an inspection of the building was conducted. Along the two (2) day tour the surveyor observed the following location that the facility failed to provide handrails in the corridor. On 2/14/24 at approximately 10:30 AM the surveyor observed a resident in the salon getting their hair done. On 02/15/2024 at approximately 12:22 PM, the surveyor observed on the second floor, an approximately 79-foot-long section of corridor leading from the Residents Main Dining room to the Residents Salon that had no handrails on both sides of the corridor. At this time the surveyor asked the U.S. FOIA (b), "Do Residents come down this corridor." The U.S. FOIA (b) replied, "Yes." On 02/23/2024 at 10:31 AM during an interview with the surveyor, the U.S. FOIA (b)(6) stated, "It's not a corridor that is commonly frequented by residents. Our understanding that handrails are not required in this specific corridor. We initiated staff in-servicing asking that staff always accompany residents to the beauty salon and we are installing handrails." N.J.A.C § 8:39-31.2(e)	F 924	Element 4 Weekly maintenance audits of the corridor handrails across all units x 4 weeks and then monthly x 3 months will be conducted by the Director of Maintenance/designee to ensure that handrails are in place. Any negative findings will be corrected immediately. Results of all audits will be reported to the QAA committee by the Maintenance Director who meets quarterly and will determine the necessity of future audits and recommendations.	

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
315396 Y1	A. Building B. Wing Y2	4/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	154 SUNNY SLOPE DRIVE BRIDGETON, NJ 08302

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 F0584	Correction	ID Prefix F0686	Correction	ID Prefix F0727	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.35(b)(1)-(3)	Completed
LSC	03/23/2024	LSC	03/23/2024	LSC	03/23/2024
ID Prefix F0804	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/23/2024	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	
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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
2/23/2024	

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
315396 Y1	A. Building B. Wing Y2	4/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	154 SUNNY SLOPE DRIVE BRIDGETON, NJ 08302

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 F0584	Correction	ID Prefix F0686	Correction	ID Prefix F0695	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(i)	Completed
LSC	03/23/2024	LSC	03/23/2024	LSC	03/23/2024
ID Prefix F0727	Correction	ID Prefix F0755	Correction	ID Prefix F0804	Correction
Reg. # 483.35(b)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	03/23/2024	LSC	03/23/2024	LSC	03/23/2024
ID Prefix F0880	Correction	ID Prefix F0924	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)(3)	Completed	Reg. #	Completed
LSC	03/23/2024	LSC	03/23/2024	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/23/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315396	A. BUILDING **01** B. WING _____	**02/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE** **BRIDGETON, NJ 08302**

(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 02/14/2024 and 02/15/2024 and Cumberland Manor Nursing and Rehabilitation Center 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 Occupancies. Cumberland Manor Nursing and Rehabilitation Center is a three (3) story, Type II Protected building that was built in December 1997. The facility is divided into 11 smoke zones. The facility has a 500 KW Diesel Emergency Generator that supplies emergency electrical power to 100 percent of the building.	K 000		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and documentation review on 02/14/2024 and 02/15/2024 in the presence of the facility management, it was determined that the facility failed to:	K 345	#1 A technician from the fire alarm company performed a sensitivity test on all smoke detectors. The painters tape was	3/23/24

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

Electronically Signed | 03/07/2024

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
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K 345	Continued From page 1 1) To maintain the automatic fire alarm system in optimum working condition in accordance with NFPA 72. 2) Ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010) Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: Reference: 1) Fire Protection Association (NFPA) 72. National Fire Alarm and Signaling Code: - 10.4.3.2.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 10.4.3.2.3 On 02/14/2024 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the [U.S. FOIA (b)(6)] [redacted] to provide all mandatory inspections that had been conducted from [redacted] through [NJ Exec Order 26.4b1] for review later. The surveyor also requested the facility to provide a copy of the last smoke detectors sensitivity testing. The surveyor also told the [U.S. FOIA (b)(6)] that he might have to call the Fire Alarm and Detection inspection vendor and ask to obtain a copy of the last smoke detector sensitivity testing. Starting at approximately 10:10 AM on 02/14/2024 and continued on 02/15/2024 in the presence of the facility [U.S. FOIA (b)(6)] an inspection tour of the building was conducted. Along the two (2) day building tour the surveyor observed the following:	K 345	immediately removed from the smoke detectors in the maintenance shop and the 2nd floor shower room. #2 All residents have the potential to be affected by this deficient practice. Facility was checked to ensure no smoke detectors were covered with painters tape. #3 All maintenance staff were re-in-serviced on life safety and the importance of sensitivity testing and proper functioning of the smoke detectors. The education was provided by the administrator. #4 The maintenance director/designee will audit the smoke detectors for any issues weekly times four weeks and then monthly times three months and ensure proper functioning. All findings will be reported to the quarterly QAPI committee.	

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 345	Continued From page 2 On 02/14/2024: 1) At approximately 11:21 AM, the surveyor observed inside the Maintenance Shop area one (1) smoke detector had Blue Painter's tape covering the detectors sensing chamber of the detector preventing the devices from activating as designed. On 02/15/2024: 2) At approximately 11:52 AM, the surveyor observed inside the 2nd. floor [NJ Exec Order 26.4b] Resident shower room one (1) smoke detector had Blue Painter's tape covering the detectors sensing chamber of the detector preventing the devices from activating as designed. On 02/15/2024 at approximately 9:01 AM, the surveyor reviewed the following Fire Alarm and Detection system inspections that were provided and read in part: 03/21/2022, Smoke Detector- PE No sensitivity. 06/01/2022, Smoke Detector- PE No sensitivity. 09/26/2022, Smoke Detector- PE No sensitivity. 01.04.2023, Smoke Detector- PE No sensitivity. 04/03/2023, Smoke Detector- PE No sensitivity. 08/18/2023, Smoke Detector- PE No sensitivity. 11/13/2023, Smoke Detector- PE No sensitivity. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. Later at approximately 10:28 AM, the surveyor asked the [U.S. FOIA (b)] if he had called the Fire Alarm and Detection vendor and request to get a copy of the last smoke detector sensitivity testing. At this time the [U.S. FOIA (b)] told the surveyor that the vendor said, the facility had never asked to have a smoke detector sensitivity testing performed. The [U.S. FOIA (b)] confirmed the finding at the time of	K 345		

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K 345	Continued From page 3 review and interview. The U.S. FOIA (b)(6) was informed of the deficiency during the Life Safety Code survey exit on 02/15/2024 at approximately 1:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
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 and interview on 02/14/2024 and 02/15/2024, in the presence of facility management it was determined that: The Facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section	K 351	1. A fire sprinkler will be installed in the roof level elevator mechanical room and in the top landing of stairwell C. The sprinkler in room #340 was fixed to remove the gap. The missing ceiling tiles in the maintenance shop were replaced. The sprinklers at first floor nurses station	3/23/24

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 351	Continued From page 4 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 02/14/2024 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the U.S. FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3)building with 91 Resident sleeping rooms and common areas. Starting at approximately 10:10 AM on [redacted] and continued on 02/15/2024 in the presence of the facility U.S. FOIA (b) an inspection tour of the building was conducted. Along the two (2) day tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 02/14/2024: 1) At approximately 10:46 AM, the surveyor observed inside the roof level Elevator Mechanical room no evidence of fire sprinkler coverage in the fourteen (14') feet by nine feet six inch (9'-6") room. At this time the surveyor asked the U.S. FOIA (b)(6) [redacted] "Do you see a fire sprinkler inside the room." The U.S. FOIA (b)(6) [redacted] looked up and around and said, no. 2) At approximately 10:51 AM, the surveyor observed no evidence of fire sprinkler coverage inside the approximately sixteen feet by ten feet (16' by 10') top landing of stairwell "C".	K 351	and dirty utility room were fixed to remove the gap. The missing ceiling tile in the kitchen trash room was replaced. The escheon cap for the sprinkler in B-wing shower room was replaced. 2. All residents have the potential to be affected by this deficient practice. Facility was inspected to ensure that the fire sprinkler system is maintained and operating according to all local state and federal regulations. 3. All maintenance staff were re-in-serviced on life safety and the importance of having fire sprinklers and no gaps in the ceiling or around the sprinkler head. The education was provided by the administrator. 4. The maintenance director/designee will audit the fire sprinklers and ceiling tiles for any issues weekly times four weeks and then monthly times three months and ensure proper functioning. All findings will be reported to the quarterly QAPI committee.	

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 351	Continued From page 5 Code requires fire sprinkler coverage in stairwells at the top landing , bottom landing and every other floor in between. 3) At approximately 11:07 AM, the surveyor observed inside the 3rd. floor "Old Lab " room #340, one sprinkler hanging down 1/2 inch from the ceiling tile. This left an approximately/2 gap in the tile around the sprinkler pipe. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 4) At approximately 11:20 AM, the surveyor observed inside the Maintenance Shop area that the drop ceiling was missing ten (10) 2' by 2' ceiling tiles. At his time the [redacted] told the surveyor that there is a roof leak. With the missing ceiling tiles in the ceiling, in the event of a fire the heat would by pass the fire sprinklers in the area and not activate the fire sprinkler system. 5) At approximately 11:44 AM, the surveyor observed at the 1st. floor Nursing Station one (1) sprinkler that had an approximately 3/4 of an inch gap in the ceiling tile. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 6) At approximately 11:54 AM, the surveyor observed inside the 1st. floor Dirty Linen room one sprinkler with an approximately 1-1/4 gap in the ceiling tile around the sprinkler head. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system.	K 351		

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K 351	Continued From page 6 On 02/15/2024: 7) At approximately 10:46 AM, the surveyor observed inside the Kitchen trash room ceiling was missing one 2' by 2' ceiling tile. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 8) At approximately 11:52 AM, the surveyor observed inside the 2nd. floor [redacted] " Residents shower room one sprinkler that was missing an escheon cap. This left an approximately 1/2 gap in the ceiling tile. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 02/14/2024 and 02/15/2024, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 12 electrical outlets	K 911	1. The duplex electrical outlets in the maintenance shop and 2nd floor unit managers office that were within 6 feet of a sink and did not de-energize when	3/23/24

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PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE** **BRIDGETON, NJ 08302**

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K 911	Continued From page 7 located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 02/14/2024 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the U.S. FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3)building with eleven (11) smoke zones.	K 911	tested were immediately replaced. 2. All residents have the potential to be affected by this deficient practice. The facility was inspected to ensure that there are no electrical outlets within 6 feet of a water source. 3. All maintenance staff were re-in-serviced on life safety and the importance of outlets de-energizing when tested, when located within 6 feet of a sink. The education was provided by the administrator. 4. The maintenance director/designee will audit outlets within 6 feet of sink for any issues weekly times four weeks and then monthly times three months and ensure proper functioning -and ensure that they are GFI outlets. All findings will be reported to the quarterly QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315396	A. BUILDING **01** B. WING _____	**02/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE** **BRIDGETON, NJ 08302**

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K 911	Continued From page 8 There are 91 Resident sleeping rooms and common areas. Starting at approximately 10:10 AM on 02/14/2024 and continued on 02/15/2024 in the presence of the facility [U.S. FOIA (b)] an inspection tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested twelve (12) electrical outlets in wet (with-in 6 feet of a sink) locations with two (2) electrical outlet that failed to de-energize when tested in the following location, On 02/14/2024: 1. At approximately 11:21 AM, inside the Maintenance Shop area, the surveyor observed, measured and recorded one (1) Duplex electrical outlet located 3'- 6" to the right of a sink when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. On 02/15/2024: 2. At approximately 11:37 AM, inside the 2nd. floor Unit Managers office the surveyor observed, measured and recorded one (1) Duplex electrical outlet located 4'- 2" to the right of a sink when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The [U.S. FOIA (b)] confirmed the findings at the time of observations. The Administrator was informed of the deficiency during the Life Safety Code survey exit on	K 911		

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	315396	A. BUILDING **01** B. WING _____	**02/23/2024**

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PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE** **BRIDGETON, NJ 08302**

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K 911	Continued From page 9 02/15/2024 at approximately 1:45 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	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. 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	K 918		3/23/24

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	315396	A. BUILDING 01 B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE BRIDGETON, NJ 08302**

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K 918	Continued From page 10 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 interview and document review on 02/14/2024 and 02/15/2024, it was determined the facility failed to: - Exercise the Emergency Generator for at least 30 minutes in 20- to 40-day intervals; and - Document the time needed by the generator to transfer power to the building was within the 10-second time frame, accordance National Fire Protection Association (NFPA) 99 and 110. Findings included: On 02/14/2024 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the U.S. FOIA (b)(6) if the facility had an emergency generator, what type of fuel and how often does the facility run the emergency generator. The U.S. FOIA (b)(6) told the surveyor, yes we have a New Diesel Emergency Generator, we run it weekly and we run under a load monthly and keep a logbook. The surveyor asked the U.S. FOIA to provide the logs for the last 25 months (January, February, March, April, May, June, July, August, September, October, November and December 2022, 2023 and January 2024) for review later. Later at approximately 12:15 PM a review of the "Emergency Generator Monthly Log" for the previous 12 months identified the following documented monthly load dates,	K 918	1. The US FOIA (b)(6) was immediately re-in-serviced on the importance of documenting monthly generator load tests. 2. All residents have the potential to be affected by this deficient practice. 3. All maintenance staff were re-in-serviced on life safety and the importance of conducting and documenting the monthly generator load tests. The education was provided by the administrator. 4. The maintenance director/designee will audit the generator log book weekly times four weeks and then monthly times three months and ensure proper documentation of the monthly load test. All findings will be reported to the quarterly QAPI committee.	

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K 918	Continued From page 11 01/03/2022, Transfer Time to Emergency Power: 3 seconds. 02/07/2022, Transfer Time to Emergency Power: 3 seconds. 03/07/2022, Transfer Time to Emergency Power: 3 seconds. 04/04/2022, Transfer Time to Emergency Power: 3 seconds. 05/02/2022, Transfer Time to Emergency Power: 3 seconds. 06/06/2022, Transfer Time to Emergency Power: 3 seconds. 02/02/2023, Transfer Time to Emergency Power: 3 seconds. 03/06/2023, Transfer Time to Emergency Power: 3 seconds. 04/03/2023, Transfer Time to Emergency Power: 3 seconds. 05/01/2023, Transfer Time to Emergency Power: 3 seconds. 06/05/2023, Transfer Time to Emergency Power: 3 seconds. 07/03/2023, Transfer Time to Emergency Power: 3 seconds. 07/09/2023, Transfer Time to Emergency Power: 3 seconds. 08/08/2023, Transfer Time to Emergency Power: 3 seconds. 09/05/2023, Transfer Time to Emergency Power: 3 seconds. 10/02/2023, Transfer Time to Emergency Power: 3 seconds. 11/06/2023, Transfer Time to Emergency Power: 3 seconds. 12/04/2023, Transfer Time to Emergency Power: 3 seconds. 01/02/2024, Transfer Time to Emergency Power:	K 918		

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K 918	Continued From page 12 3 seconds. 01/07/2024, Transfer Time to Emergency Power: 3 seconds. There were no documented monthly load test for: July, August, September, October, November and December 2022 and January 2023. On 02/15/2024 at approximately 10:28 AM, the surveyor made a request to the [redacted] if he could provide any additional emergency generator monthly log for July, August, September, October, November and December 2022 and January 2023. The MD could not provide any monthly load test for seven (7) months. There was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load tests were conducted every 20 to 40 days under load for 30 minutes for July, August, September, October, November and December 2022 and January 2023. The [redacted] confirmed the finding at the time of review and interview. The [redacted] was informed of the deficiency during the Life Safety Code survey exit on 02/15/2024 at approximately 1:45 PM. NFPA 110. NJAC 8:39-31.2(g)	K 918		

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
315396 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	154 SUNNY SLOPE DRIVE BRIDGETON, NJ 08302

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 K0345	03/23/2024	LSC K0351	03/23/2024	LSC K0911	03/23/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	03/23/2024	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	
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	
2/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO