STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING _____ B. WING _____	C 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	**1801 OAK TREE ROAD EDISON, NJ 08820**

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F 000	INITIAL COMMENTS Complaint #: NJ177556 Survey Date: 10/10/24 to 10/16/24 Census: 22 Sample: 14 + 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 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 607		11/25/24

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

Electronically Signed | 11/07/2024

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F 607	Continued From page 1 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to complete reference checks on employees before their start date. The deficient practice was identified for 5 of 6 employees reference checks reviewed under Sufficient and Competent Nurse Staffing task. The deficient practice was evidenced by the following: On 10/15//24, the surveyor reviewed six employee files of employees hired since the last standard survey which revealed that five of the six did not have reference checks done prior to the start of employment. RN #1, date of hire [redacted] LPN (Licensed Practical Nurse) #1, date of hire [redacted] LPN #2, date of hire [redacted] LPN #3, date of hire [redacted] Housekeeper#1, date of hire [redacted] On 10/15/24, the surveyor requested the reference checks on the above employees. On 10/16/24 at 12:30 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that he was unable to provide the	F 607	1.Immediate action(s) taken for the resident(s) found to have been affected. The Human Resource Director immediately began to source and obtain the absent reference checks from the 7 employees files that were identified on 10/16/2024. As of 11/4/2024 the reference checks have been verified and completed on the identified employees. 2.Identification of other resident(s) having the potential to be affected was accomplished by: Current residents have the potential to be affected. An audit for currently employed community staff to validate reference check has been completed. Identified employee files have been updated with current reference checks.	

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F 607	Continued From page 2 reference checks at this time. He further stated that they used to be handwritten but now are on an electronic system. He acknowledged that the reference checks should be readily available. On 10/16/24 at 12:32 PM, the surveyor interviewed the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) who stated that they do reference checks on newly hired employees. They use a software program that requests electronically references from the previous places of employment. They were stored in one software program but were moved to another software program. They stated that was why they couldn't retrieve the reference checks. The U.S. FOIA (b) (6) further stated that she understood and stated "we should be able to print them out." A review of the facility's policy "Employment Verifications and Backround checks" reviewed 5/16/24, revealed: "4.1 Background Check Components:...Prior Employment Verificaition confirms applicant's employment with the provided companies, includeing dates of employments, position held...performance ratings, reason for departure and eligibility for rehire. This generally will be run on past two employers or past five years, which ever is most recent." N.J.A.C. § 8:39-9.3(b)	F 607	3.Action(s) taken/system put into place to reduce the risk of future occurrence include: On 10/17/2024 the Human Resource Director and the Licensed Nursing Home Administrator attended a training course by NJ Ex Order 26.4(b)(1), on NJ Ex Order 26.4 Reference Training, which provided re-education on the reference verification process. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning on 11/4/2024, for a period of 90 days, the Administrator and/or designee, will conduct a weekly record audit of all new hires to visually verify that their two reference checks are in the employee file. This plan of correction will be monitored at the monthly Quality Assurance meeting and at the conclusion of the 90-day period, the Committee will reevaluate and initiate any necessary action(s) or extend the review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing	

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F 607	Continued From page 3	F 607	and resolving any variances that may occur.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		12/15/24

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F 623	Continued From page 4 under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder	F 623		

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F 623	Continued From page 5 established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to notify the resident and or resident representative in writing of the reason for transfer or discharge to the hospital for 2 of 2 residents (Resident #8 and Resident #173) reviewed for hospitalization. This deficient practice was evidenced by the following: 1.) On 10/11/24 at 9:52 AM, the surveyor observed Resident #8 out of bed in a NJ Ex Order 26.4(b)(1) wheelchair in the common area with activities. On 10/11/24, the surveyor reviewed the Electronic Medical Record (EMR) which indicated that	F 623	1.Immediate action(s) taken for the resident(s) found to have been affected. Family/POA for resident #8 and resident #173 were provided with a copy of the written notification of transfer/discharge per regulation. Nurses, U.S. FOIA (b) (6) U.S. FOIA (b) (6) and business office were in-serviced by Executive Director/DON regarding the need for a written notification and process of notifying family/POA upon transfer/discharge	

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F 623	Continued From page 6 Resident #8 was admitted to the facility for [redacted]. Further review showed there was a Discharge/Return Anticipated MDS completed on [redacted] following a transfer to the hospital for treatment of [redacted]. The surveyor review of the Admission Record indicated Resident #8 had medical diagnosis which included but were not limited to; [redacted] and [redacted]). A review of the annual Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed a Brief Interview for Mental Status (BIMS) score of [redacted] out 15, indicating [redacted] The surveyor reviewed the progress notes which revealed that on [redacted] at 7:30PM, Resident #8 was transferred to the Hospital. On 10/15/24 at 10:13AM, the surveyor asked the [redacted]) for the location of the family and ombudsman notification of hospitalization. He stated the family notification is in the progress notes. On 10/16/24 at 9:17AM, the surveyor was unable to locate written notifications to the resident or family for the reason of transfer in the medical records. On 10/16/24 at 9:51 AM, in the presence of the survey team, the [redacted], and the [redacted]), the [redacted] stated when a resident was hospitalized, a written notice goes to the hospital with the resident's transfer paperwork. The [redacted]	F 623	2.Identification of other resident(s) having the potential to be affected was accomplished by: Current residents that are discharged/transferred were identified as having the potential of being affected. All recent discharges/transfers within the past 30 days were audited and found to be in compliance with regulations. 3.Action(s) taken/system put into place to reduce the risk of future occurrence include: Nurses and [redacted] were in-serviced-by the Executive Director/DON regarding filling out the notice of transfer/discharge at the time of transfer/discharge. A copy will be retained for records in the patient chart. Social worker and/or designee to mail/email copy of notice of transfer/discharge to family/POA. DON and/or designee will review all discharges/transfers for compliance weekly for the next 90 days.	

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F 623	Continued From page 7 further stated "in most cases the facility retains a copy; however, in this case they did not have a copy to provide to the surveyor." 2. On 10/10/24 at 11:19 AM, during the initial tour, the surveyor observed Resident #173 in bed with their eyes closed. The resident's family member was at the bedside and stated the resident had just been NJ Ex Order 26.4(b)(1) to the facility. The surveyor reviewed the electronic medical record (EMR) for Resident #173. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)). A review of the progress notes revealed: NJ Ex Order 26.4(b)(1) 08:01 COMMUNICATION - with US FOIA (b)(6) - Narrative Note Text: U.S. FOIA (b) (6) called at 7:30 AM NJ Ex Order 26.4(b)(1) ...requested that [identifier redacted] be sent to hospital for evaluation ...Dr. (doctor) and NJ Exec [name redacted] were both notified of the situation. Further review of the medical record, did not revealed written notification of reason for transfer to the resident or family. On 10/16/24 at 11:52 AM, the U.S. FOIA (b) (6) provided a copy of "Skilled Nursing Facility Notice of Transfer" for Resident # 173. The letter dated was NJ Ex Order 26.4(b). The U.S. FOIA (b stated the letter was sent with the resident to the hospital. He was unable to verify if a copy was sent to the family/representative or if a copy was given to the	F 623	4.How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning 11/4/2024, DON and/or designee will review all discharges /transfers for compliance weekly for the next 90 days. Administrator and/or designee will report findings of the above observations and audits to the monthly QAPI Committee. During and at the conclusion of the 90-day period, the Committee will reevaluate and initiate any necessary action(s) or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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F 623	Continued From page 8 resident. On 10/16/24 at 12:31 PM, in the presence of the survey team, the [redacted] confirmed a written copy of the notification of hospitalization was not sent to the family or given to Resident #173. Review of facility provided policy "Transfer, Discharge & Bed-Hold Notices" reviewed 5/16/24,included: 4. The Social Service Coordinator/designee will complete the following steps before the community transfers or discharges a resident (voluntary or involuntary): a. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move, in writing and in a language and manner they understand. NJAC 8:39-4.1(a) 31	F 623		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		11/21/24

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F 692	Continued From page 9 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to obtain an admission [redacted] for 1 of 3 residents, Resident # 173, reviewed for [redacted] This deficient practice was evidenced by the following: On 10/10/24 at 11:19 AM, during the initial tour, the surveyor observed Resident #173 in bed with their [redacted]. The resident's family member was at the bedside and stated the resident had just been readmitted to the facility. The surveyor reviewed the electronic medical record (EMR) for Resident #173. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted]. A review of the admission Minimum Data Set, an assessment tool, dated [redacted], revealed it was in progress. A review of the individual comprehensive care	F 692	1.Immediate action(s) taken for the resident(s) found to have been affected. [redacted] was immediately obtained for resident #173 and documented in the EHR. The registered dietician reviewed the [redacted] to ensure [redacted] status was maintained. The physician and responsible party was made aware with no adverse effects noted. On 10/16/2024 The [redacted] was reeducated by the director of nursing on the admitting weight policy and the need to obtain a new weight for the assessment. 2.Identification of other resident(s) having the potential to be affected was accomplished by: Current admissions were identified as having the potential to be affected.	

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F 692	Continued From page 10 plan (ICCP) revealed: "FOCUS: ...resident has NJ Exec Order 26.4b1 problem or potential NJ Ex Order 26.4(b)(1) problem r/t (related to) NJ Ex Order 26.4 and current dx. (diagnosis) Date Initiated NJ Ex Order 26.4(b)(1). Goal: [name redacted] will NJ Ex Order 26.4(b)(1) at leas NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) offered resulting in NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 improvement over next 30 days. Date Initiated: NJ Ex Order 26.4(b)(1)." The surveyor reviewed both the EMR and paper chart for the resident's admission NJ Ex Order 26.4 NJ Ex Order 26.4 There was no documented readmission taken by the facility in the resident's medical record. The last NJ Ex Order 26. entry was NJ Ex Order 26.4(b)(1) at 12:28 PM. A review of the progress notes revealed the U.S. FOIA (b) (6) progress note: NJ Ex Order 26.4(b)(1) 12:01 PM Type: NJ Ex Order 26.4(b)(1) Note ... Resident known from previous admission ...Updated NJ Exec Order 2 pending ... U.S. FO from NJ Exec Order 26 center to be in contact with community dietitian .. U.S. FO will continue to follow up." On 10/15/24 at 10:32 AM, the surveyor interviewed the U.S. FOI who stated a resident's weight should be obtained within 24 hours of admission. He stated he completes the NJ Ex Order 26.4(b) section on the Service Evaluation and Health Assessment (SEHA) for all new admissions. He stated the purpose of the admission NJ Ex Order 26.4(b) was for a NJ Ex Order 26.4(b)(1). The U.S. FO reviewed the SEHA for Resident #173 in the presence of the surveyor and acknowledged a new admission NJ Ex Order 26 was not used. He acknowledged the NJ Ex Order 26.4 from NJ Ex Order 26.4(b) was used. He further reviewed the EMR and confirmed he was unable to find a new admission NJ Ex Order 26 for the resident. He stated if there was not an admission NJ Ex Order 26.4 he would ask the nurse. He stated he had told the nurse but	F 692	An audit was completed of current residents including new admissions to ensure weights are current and updated in the electronic health record. 3.Action(s) taken/system put into place to reduce the risk of future occurrence include: Nurses and Certified nursing assistants were in-serviced by the DON beginning on 10/15/2024 regarding the importance of obtaining and documenting the admission weight for all admission within 24 hours of admission. Policy for weight was reviewed with nursing staff. Beginning on 11/4/2024, DON and/or designee will review all admission for compliance with admission weight weekly for 90 days. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning on 11/4/2024, DON and/or	

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F 692	Continued From page 11 was unable to say when or who he told. On 10/15/24 at 10:50 AM, the surveyor interviewed Resident #173's assigned U.S. FOIA (b) (6)), who stated the residents should have been NJ Ex Order 26.4(b)(yesterday (Monday) but the resident NJ Exec Order 26.4b1 of bed. On 10/15/24 at 10:53 AM, the surveyor interviewed Resident #173's assigned U.S. FOIA (b) (6) , who stated "new admission should be NJ Ex Order 26.4(b)(upon admission and then in 3 days." She stated NJ Ex Order 26.4(should be done usually within 24 hours so you "know the parameters." The U.S. FOIA reviewed the EMR in the presence of the surveyor and acknowledged the last entered NJ Ex Order 26. was NJ Ex Order 26.4(. On 10/15/24 at 11:10 AM, the surveyor interviewed the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)). The U.S. FOIA (b stated new admissions should be NJ Ex Order 26.4(b)(within 24 hours, and then weekly x 4 weeks. He then stated all NJ Exec Order 26.(would be in the EMR. The U.S. FOIA (b reviewed the EMR for Resident #173 in the presence of the surveyor. He acknowledged that a new admission NJ Exec Order 2 was not entered. He reviewed the SEHA, effective date NJ Ex Order 26.4(b), completed by the U.S. FO and acknowledged the U.S. FO should not have used the NJ Ex Order 26. from NJ Ex Order 26.4(. He then stated, "We missed the admission NJ Ex Order 26.4(b He stated our policy is to NJ Ex Order 2 them (the residents) ourselves and if a NJ Ex Order 26 was not obtained the reason should be documented. On 10/15/24 at 1:18 PM, in the presence of the survey team, the U.S. FOIA (b) (6) and the U.S. FOIA (b were made aware of	F 692	designee will review all admission for compliance with admission weight weekly for 90 days. Administrator and/or designee will report findings of the above observations and audits to the monthly QAPI Committee. During and at the conclusion of the 90-day period, the Committee will reevaluate and initiate any necessary action(s) or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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	315351	A. BUILDING _____ B. WING _____	C 10/16/2024

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F 692	Continued From page 12 the above concerns. A review of the facility's policy "Nutrition & Weight Management Program" reviewed 5/16/24, revealed: "Goal: The Goal of this program is to evaluate residents ...prevent unanticipated weight gain or loss ...Section 2: ...Weight Monitoring: Ongoing weight is integral to the plan to manage the resident's weight: Residents are upon admission, weekly for 4 weeks, then monthly to evaluate trends or in accordance with physician's orders ...All weights are recorded int the resident's electronic health record."	F 692		
F 759 SS=D	NJAC 8:39-11.2(e), 17.1(c), 27.1(a) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation performed on NJ Ex Order 26.4(b)(1) the surveyor observed two (2) nurses administer medications to four (4) residents. There were 27 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.41 %. This deficient practice was identified for two (2) of four (4) residents, (Resident #12 and #13), that were administered medications by one (1) of two (2) nurses	F 759	1.Immediate action(s) taken for the resident(s) found to have been affected. Upon notification of the medication error, resident #12 and resident #13 were notified of the medication error on NJ Ex Order 26.4(b)(1). Attending MDs for both residents were also notified and facility medication error reporting policy was followed on NJ Ex Order 26.4(b)(1).	11/25/24

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F 759	Continued From page 13 (Licensed Practial Nurse (LPN #1). The deficient practice was evidenced by the following: 1. On 10/11/24 at 9:27 AM, during the medication pass, the surveyor observed LPN #1 preparing to administer five (5) medications to Resident #12 which included one NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(LPN #1 stated that the resident had a physician's order (PO) for NJ Ex Order 26.4(b)(1) according to the electronic medication administration record (eMAR). LPN #1 also stated that the NJ Ex Order 26.4(b)(1) were a house stock over the counter (HS/OTC) medication, meaning that the facility purchased a bottle to be used for any resident that had a PO. LPN #1 stated that the NJ Ex Order 26.4 was a NJ Ex Order 26.4(b)(1) and was the only formulation of NJ Ex Order 26.4(b)(1) in the medication cart. On NJ Ex Order 26.4(b)(at 9:32 AM, the surveyor observed LPN #1 administer the NJ Ex Order 26.4(b)(1) to Resident #12 and told the resident to NJ Ex Order 26.4(b)(1 On NJ Ex Order 26.4(b)(at 9:46 AM, after the surveyor observed LPN #1 administer an NJ Ex Order 26.4(b)(1) to Resident #13, LPN #1, with the surveyor, reviewed the eMAR for Resident #12 which revealed a PO for ' NJ Ex Order 26.4 which was the same PO for Resident #13. LPN #1 explained that Resident #13 had their NJ Ex Order 26.4(b)(1) packaged by the provider pharmacy and labeled for them and had not had to use the HS/OTC. LPN #1 acknowledged that the PO for Resident #12 was for NJ Ex Order 26.4(b)(1) and that he had administered NJ Ex Order 26.4(b)(1) . (ERROR #1)	F 759	Beginning on 10/11/2024 the U.S. FOIA (E began immediate education on the need to notify MD/obtain new order prior to administering/changing drug formulation and on the following of manufacturer recommendations for proper dosage calculation when administering medications. Pharmacy consultant conducted a medication pass with LPN #1 on 10/13/2024 with no errors reported. 2.Identification of other resident(s) having the potential to be affected was accomplished by: Current residents receiving oral medications were identified as having the potential to be affected. An audit was completed of licensed nurses for administration of oral medication by the Director of Nursing Services and/or designee with no concerns noted.	

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F 759	Continued From page 14 On 10/11/24 at 10:33 AM, the surveyor interviewed LPN #1, in the presence of the U.S. FOIA (b) (6)). LPN #1 stated that there were no bottles of NJ Ex Order 26.4(b)(1) in the medication room where the backup supply of HS/OTC medications were stored. The U.S. FOIA (b) (6) stated that if the PO was for NJ Ex Order 26.4(b)(1) and there was not any available, then the physician had to be called and the order changed to NJ Ex Order 26.4(b)(1) LPN #1 stated, "It was already administered." The surveyor reviewed the medical record for Resident #12. A review of the Admission Record revealed diagnoses which included but not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)). A review of the NJ Ex Order 26.4(b)(1) Order Summary Report revealed a PO with an order date of NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b)(1)) Give 1 NJ Ex Order 2 by mouth one time a day for NJ Ex Order 26.4(b)(1))(NJ NJ Ex Order 26.4(b)(1)). A review of the NJ Ex Order 26.4(b)(1) electronic medication administration record (eMAR) revealed a PO with a start date of NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b)(1)) Give 1 NJ Ex Order 2 by mouth one time a day for NJ Ex Order 26 On 10/11/24 at 11:53 AM, the surveyor interviewed the U.S. FOIA (b) (6) , who stated she was responsible for	F 759	3.Action(s) taken/system put into place to reduce the risk of future occurrence include: Beginning on 10/17/2024 all nursing staff was Inservice by DON/Designee regarding the need to notify MD/obtain new order prior to administering/changing drug formulation and regarding following manufacturer recommendations for proper dosage calculation when administering medications and regarding the need to notify MD/obtain new order prior to administering/changing drug formulation. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning 11/4/2024, medication administration audits will be conducted by DON and/or designee for one nurse weekly on each shift for (2) weeks, then two nurses monthly for (3) months, then one nurse monthly on-going to ensure compliance with facility guidelines. This plan of correction will be monitored at the monthly Quality Assurance meeting and at the conclusion of the 90-day period, the Committee will reevaluate and initiate any necessary action(s) or extend	

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F 759	Continued From page 15 ordering the HS/OTC medications. The [U.S. FOIA] stated that she was aware of what had happened this morning, meaning that there were no [NJ Ex Order 26.4(] available. The [U.S. FOIA] stated that she usually ordered by visualizing what was low in the medication room where the HS/OTC medications were stored or what she was told by the nurses. The [U.S. FOIA] added that she was just given a list of what HS/OTC medications the facility were to keep on hand and would now check the list against what was on hand. A review of the facility Stock List provided by the U.S. FOIA (b) (6)) reflected that "[NJ Ex Order 26.4])" was on the list as a HS/OTC medication. On 10/11/24 at 2:00 PM, the surveyor interviewed the U.S. FOIA (b) (6)) via the telephone, who stated that [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4] were the same drug but not the same formulation and that one could not be substituted for the other. The [U.S. FO] added that the [NJ Ex Order 26.4(b)(1)] formulation is NJ Ex Order 26.4(b)(1) and that the [NJ Ex O] formulation was NJ Ex Order 26.4(b)(1) . The [U.S. FO] also stated that he had completed medication observations but had not completed an inservice on medication pass. On 10/15/24 at 9:08 AM, the surveyor interviewed the [U.S. FOIA (b)] who stated that he had completed a "Medication Skill Capability Evaluation Checklist" on [NJ Ex Order 26.4(b)(] for LPN #1 which was a comprehensive medication pass observation. The [U.S. FOIA (b] also stated that NJ Ex Order 26.4(b)(1) was a HS/OTC medication but was not available on [NJ Ex Order 26.4(b)(] and was obtained after the surveyor performed the medication administration observation. The [U.S. FOIA (b] acknowledged that if the	F 759	the review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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NJ Ex Order 26.4(b)(1) was not available then the physician was to be called and asked to switch to what was on hand. The U.S. FOIA (b added that the nurses were inserviced on the specific issue of what to do if a medication was not available and to make sure the correct HS/OTC was available.

On 10/15/24 at 1:29 PM, the survey team met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) The U.S. FOIA (b stated that the NJ Ex Order 26.4 tablets were obtained on 10/11/24 after the surveyor performed the medication administration observation.

A review of the manufacturer specifications for NJ Ex Order 26.4 included, but was not limited to, NJ Ex Order 26.4 is available in different formulations such as NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) In addition, the specifications reflected that NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), or NJ Ex Order 26.4(b)(1) may be associated with NJ Ex Order 26.4(b)(1) and/or symptomatic NJ Ex Order 26.4(b)(1) than NJ Ex Order 26.4(b)(1) ."

2. On 10/11/24 at 9:34 AM, during the medication pass, the surveyor observed LPN #1 preparing to administer nine (9) medications to Resident #13 which included NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). LPN #1 stated that according to the eMAR the dose of NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1) LPN #1 added that sometimes the provider pharmacy sen NJ Ex Order 26.4(b)(1), but that Resident #13 had a NJ Ex Order 26.4(b)(1) that was sent by the provider pharmacy and that he had to measure the NJ Ex Order 26.4(

At that time, the surveyor observed LPN #1 pour the NJ Ex Order 26.4(b)(1) into a NJ Ex Order 26.4(b)(1)

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F 759	Continued From page 17 medication cup. LPN #1 stated that he was filling the medication cup up to [redacted], which was an estimate between the [redacted] and the [redacted] on the medication cup. On 10/11/24 at 10:16 AM, the surveyor interviewed LPN #1, who stated that he thought [redacted] was the same as 17 ML. LPN #1 added that it was easier to use the 17 GM premade packets. LPN #1, in the presence of the surveyor, removed the resident's bulk bottle of [redacted] from the medication cart and reviewed the label which revealed the instructions for use were to "Use the measuring line on the bottle cap to measure a single dose (about 1[redacted]." (ERROR #2) At that time, LPN #1 removed the cap of the [redacted] bottle and stated that there was a designation for [redacted] to be measured in the cap. LPN #1 then stated that he was unsure if the [redacted] that he had measured in the medication cup would be the same as the [redacted] measurement indicated on the cap of the [redacted] bottle. On 10/11/24 at 10:19 AM, the surveyor observed LPN #1 measure NJ Ex Order 26.4(b)(1) from the resident's bulk bottle in a [redacted] medication cup as he had previously done by estimating [redacted] and poured the measured [redacted] into a NJ Ex Order 26.4(b)(1) . Then, LPN #1 poured a NJ Ex Order 26.4(b)(1) into another NJ Ex Order 26.4(b)(1) and put the two cups side by side. LPN #1 stated that he was unsure if they were the same but thought the two cups were "close" to the same amount. On 10/11/24 at 10:26 AM, the surveyor, in the presence of another surveyor, with LPN #1,	F 759		

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F 759	Continued From page 18 showed the two clear cups of NJ Ex Order 26.4(b)(1) that were measured by LPN #1 to the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) stated that the plastic cup with the NJ Ex Order 26.4(b)(1) measured a little more than the plastic cup with the NJ Ex Order 26 measured NJ Ex Order 26.4(b)(1). LPN #1 explained that he had measured NJ Ex Order 26.4(of the NJ Ex Order 26.4(b)(1) in a medication cup and had to make an estimation of NJ Ex Order 26 between the NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1). At that time, the surveyor with the U.S. FOIA (b) (6 reviewed the label on the NJ Ex Order 26.4(b)(1) bottle which revealed "Use the measuring line on the bottle cap to measure a single dose (about 1 heaping tablespoon)." The U.S. FOIA (b) (6 stated that the manufacturer instructions for measuring were to be followed for an accurate dose. The surveyor reviewed the medical record for Resident #13. A review of the Admission Record revealed diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the NJ Ex Order 26.4(b)(1) Order Summary Report reflected a PO with an order date of NJ Ex Order 26.4(NJ Ex Order 26.4(b)(1) Give NJ Ex Order 26.4 by mouth in the morning for NJ Ex Order 26.4(b)(1) A review of the NJ Ex Order 26.4(b)(1) eMAR revealed a PO with a start date of NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) Give NJ Ex Order 26.4 by mouth in the morning for NJ Ex Order 26.4(b)(1)	F 759		

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F 759	Continued From page 19 On 10/11/24 at 2:00 PM, the surveyor interviewed the NJ Ex Order 26.4(b)(1)) via the telephone, who stated that the manufacturer instructions should be followed for measuring NJ Ex Order 26.4(b)(1) from the bulk bottle for an accurate dose. On 10/15/24 at 9:08 AM, the surveyor interviewed the U.S. FOIA (b) who stated that he had completed a "Medication Skill Capability Evaluation Checklist" on NJ Ex Order 26.4(b)(1 for LPN #1 which was a comprehensive medication pass observation. The U.S. FOIA (b) also stated he was aware that the NJ Ex Order 26.4(b)(1) was inaccurately measured using a NJ Ex Order 26.4 medication cup. A review of the manufacturers' specifications for NJ Ex Order 26.4(b)(1) reflected to "Follow all directions on your prescription label." In addition, the specifications reflected to use the NJ Ex Order 26.4(b)(1) of this medicine, measure your dose with the medicine cap on the bottle. This cap should contain dose marks on the inside of it." A review of the facility policy titled "Medication Administration" dated January 2023 provided by the U.S. FOIA (b) revealed that "Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing and principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication." Also, the policy revealed for the medication administration procedure that "Medications are administered in accordance with written orders of the prescriber." In addition, the policy revealed for the medication administration	F 759		

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F 759	Continued From page 20 procedure that "Verify medication is correct three (3) times before administering the medication. a. When pulling medication package from med cart b. When dose is pulled c. Before dose is administered."	F 759		
F 812 SS=F	NJAC 8:39-11.2(b), 29.2(d), 29.4(c) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility documentation it was determined that the facility failed to a.) handle, clean and sanitize dishware in a manner to prevent microbial growth and cross contamination, and b.) wear hair restraints to maintain proper kitchen sanitation.	F 812	1.Immediate action(s) taken for the resident(s) found to have been affected. Immediately after the surveyor noticed the deficiency, the dishwasher put a hairnet on, washed his hands and put on gloves,	11/25/24

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F 812	Continued From page 21 This deficient practice was evidenced by the following: On 10/10/24 at 9:22 AM, the surveyor entered the kitchen with a second surveyor. The surveyors observed a staff member at the dish machine without a hair restraint. At 9:35 AM, the surveyors began the kitchen tour with the U.S. FOIA (b) (6). The surveyors observed the same staff member (now with a hair restraint worn) load the dish machine with soiled dishware and bare hands. He then removed clean bowls from the clean side of the dish machine without performing hand hygiene and glove application. The U.S. FOIA (b) (6) acknowledged that the staff member should have washed his hands and applied gloves prior to removing clean dishware from the dish machine to prevent cross contamination. She stated that there was usually one dishwasher that worked the soiled side and one dishwasher on the clean side of the dish machine. A review of the facility's policy "Food Safety and Seniors - Additional Food Safety Tips" dated 2015, included "Restrain hair in food preparation areas." A review of the facility's policy "Dishwashing Procedure" dated 11/19/2019, included "Objective: Participants will understand the correct dishwashing procedures ...;" "Either two people are in the dish room, one on the dirty side, one on the clean side. If one person does both, they must wash their hands between dirty and clean areas ..."	F 812	and all the contaminated dishes were placed back in the dishwasher to be washed again. Dishwashers and kitchen staff were in-serviced by ADON/Infection preventionist on 10/11/2024 regarding hand washing and use of hairnet in the kitchen area. Dishwashing procedure reviewed with dishwashers and other kitchen staff by Dining Service Coordinator on 10/31/2024. 2.Identification of other resident(s) having the potential to be affected was accomplished by: Current residents in the community were identified as having the potential to be affected. No observed/reported issues or concerns were noted. 3.Action(s) taken/system put into place to reduce the risk of future occurrence include: All of the dining and kitchen staff were re-in-serviced by the director of dining service beginning 11/20/2024 regarding dishwashing/unloading policy and	

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	315351	A. BUILDING _____ B. WING _____	C 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	**1801 OAK TREE ROAD EDISON, NJ 08820**

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F 812	Continued From page 22 A review of the facility's policy "Proper Handwashing" dated 8/16/23, included "Hands must be washed: ... After contact with unsanitary surfaces i.e. soiled dishes ..." A review of the facility's policy "Food Safety and Seniors - Facts About Handwashing" dated 2015, included "When to Wash Your Hands ... After washing dirty dishes." A review of the facility's policy "Food Safety and Seniors - Four Steps to Food Safety" dated 2015, included "Wash and sanitize ... to prevent cross contamination." A review of the facility's policy "Food Safety and Seniors" dated 2015, included "Objective: to recognize the consequences of unsafe food practices and identify ways to prevent foodborne illness." "Be sure to: ... Avoid cross contamination." A review of the Dishwasher Job Description, dated November 2023, included "The Dishwasher is responsible for cleaning and janitorial duties ... while adhering to all food safety and sanitation requirements and maintaining a safe and orderly kitchen." "Performs dishwashing tasks to properly wash and sanitize all dishes and china, silverware, glassware, utensils and cookware." N.J.A.C 18:39-17.2(g)	F 812	procedure, infection control and hand hygiene. Hairnet usage policy was also reviewed with the dinning/kitchen staff. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning on 11/4/2024, to ensure ongoing compliance with food safety practices, weekly breakfast, lunch and dinner audits will be conducted by Dinning Service Coordinator or designee, monitoring compliance with hand hygiene, hairnet use, glove use, and the proper handling of clean and dirty dishware in accordance with facility policy for the next 90 days. This plan of correction will be monitored at the monthly Quality Assurance meeting and at the conclusion of the 90-day period, the Committee will reevaluate and initiate any necessary action(s) or extend the review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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
315351 Y1	A. Building B. Wing Y2	12/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	1801 OAK TREE ROAD EDISON, NJ 08820

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 F0607	Correction	ID Prefix F0623	Correction	ID Prefix F0692	Correction
Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	11/25/2024	LSC	12/15/2024	LSC	11/21/2024
ID Prefix F0759	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	11/25/2024	LSC	11/25/2024	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	
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?
10/16/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING **01** B. WING _____	C **10/16/2024**

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BRIGHTON GARDENS OF EDISON	**1801 OAK TREE ROAD** **EDISON, NJ 08820**

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E 000	Initial Comments Brighton Gardens of Edison was in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/15/2024 and 10/16/2024, and Brighton Gardens of Edison was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Brighton Gardens of Edison is a Two-story building that was built in 1995. Acute care is in the West Wing. It is composed of Type II protected construction. The facility is divided into two - smoke zones. The generator does approximately 100% of the building as per the Maintenance Director.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.	K 211		12/15/24

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

Electronically Signed | 11/07/2024

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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K 211	Continued From page 1 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/15/2024 in the presence of the facility's U.S. FOIA (b) (6)), it was determined that the facility failed to ensure exits were maintained free of obstructions and impediments for full and instant use in accordance with NFPA 101:2012 Edition, Section 7.1.10.1. for 1 of 4 exits doors. This deficient practice had the potential to affect all 16 residents on that Wing and was evidenced by the following: An observation at 2:10 PM with the U.S. FOIA revealed the exit door by Room # NJ Ex C was blocked with Door Guard Stop Banner. In an interview at the time, U.S. FOI confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 10/16/2024 at 1:50 PM. N.J.A.C 8:39-31.2(e)	K 211	1.Immediate action(s) taken for the resident(s) found to have been affected. On 10/15/2024 the Maintenance Coordinator removed the mesh stop banner that was on the exit door by room NJ Ex C 2.With respect to what systemic measures have been put into place to address the stated concern: On 10/15/2024 The administrator discontinued the practice of utilizing mesh stop signs in front of exit doors as an elopement intervention. 3.With respect to how the plan of correction will be monitored: The maintenance coordinator or designee will monitor all exit doors for obstructions during daily rounds. 4. How the corrective action(s) will be monitored to ensure the practice will not recure In order to confirm that the processes outlined above are sustained: The MC will report the findings of the above audit to the QAPI committee monthly for the next 90- days. During and at the conclusion of the 90-day period the Committee will re-evaluate and initiate any necessary action or extend the review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	
K 291 SS=F	Emergency Lighting	K 291		12/15/24

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K 291	Continued From page 2 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/15/2024, in the presence of U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 Edition, Sections 7.9, 19.2.9.1 and NFPA 110:2010 Edition, Section 7.3. This deficient practice was identified for 1 of 1 transfer switches in the healthcare facility, had the potential to affect all residents and was evidenced by the following: Observations at 1:31 PM in the presence of the U.S. FOIA revealed in the closed fence where the Emergency generator transfer switch was located had no battery back-up emergency lighting. In an interview at that time, the U.S. FOI confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 10/16/2024 at 1:50 PM. NJAC 8:39-31.2(e)	K 291	1.Immediate action(s) taken for the resident(s) found to have been affected. On 10/15/2024 the electrician contractor was contacted to install a battery back-up emergency light above the transfer switch. 2.Identification of other resident(s) having the potential to be affected was accomplished by: All residents have the potential to be affected 3.Action(s) taken/system put into place to reduce the risk of future occurrence include: On 10/22/2024 the electrician contractor began the work on the installation of the battery back-up emergency light above the transfer switch install which was completed on 10/31/2024 4.How the corrective action(s) will be monitored to ensure the practice will not recure In order to confirm that the processes outlined above are sustained: The Maintenance Coordinator will report the findings of the above audit monthly to the	

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K 291	Continued From page 3	K 291	QAPI committee for the next 90- days. During and at the conclusion of the 90-day period the Committee will re-evaluate and initiate any necessary action or extend the review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		12/15/24

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K 321	Continued From page 4 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/15/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that hazardous areas were protected with self-closing doors in accordance with NFPA 101: 2012 Edition, Sections 19.3.2,19.3.5.9 and 8.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 2:19 PM with the U.S. FOIA [redacted] revealed shower room was being used as storage for combustibles. The room is 55 square feet (measured) and was not provide with self-closing door. In an interview at the time, U.S. FOI [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 10/16/2024 at 1:50 PM. NJAC 8:39-31.2(e)	K 321	1.Immediate action(s) taken for the resident(s) found to have been affected. On 10/16/2024 the Maintenance Coordinator installed a door closer on the shower room door. 2.Identification of other resident(s) having the potential to be affected was accomplished by: All residents have the potential to be affected 3.Action(s) taken/system put into place to reduce the risk of future occurrence include: Starting on 11/4/2024 Maintenance Coordinator/ Designee will continue to monitor all self-closing doors to ensure resident safety during monthly audit rounds. 4.How the corrective action(s) will be monitored to ensure the practice will not recure To confirm that the processes outlined above are sustained: The Maintenance Coordinator will report the findings of the above audit monthly to the QAPI committee for the next 90- days. During	

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K 321	Continued From page 5	K 321	and at the conclusion of the 90-day period the Committee will re-evaluate and initiate any necessary action or extend the review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	
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		12/15/24

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K 324	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/15/2024 in the presence of U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that 4 of 6 kitchen cooking equipment's wet chemical fire suppression systems nozzles were in the proper position to protect against fire in accordance with NFPA 101: 2012 Edition, Section 19.3.2.5.1 and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation in the facility kitchen at 3:01 PM, revealed that the wet chemical fire suppression system (over the cooking equipment) had four suppression spray nozzles not positioned to protect the cooking equipment. In an interview at that time, the U.S. FOI[redacted] confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 10/16/2024 at 1:50 PM. NJAC 8:39-31.2(e) NFPA 96	K 324	1. With respect to the specific resident/situation cited: On 10/18/2024 the Maintenance Coordinator reached out to NJ Ex Order 26.4(b)(1) [redacted] to have a technician come in and on 10/18/2024 the technician aliened and calibrate the nozzles 2. With respect to how the facility will identify residents/situations with the potential for the identified concerns: All residents have the potential to be affected 3. With respect to how the plan of correction will be monitored: The Nozzle placement was added to the closing check list. On 11/4/2024 a photo depicting proper Nozzle placement was framed and put on the wall by the system for reference during the closing checklist. 4. With respect to how the plan will be reported during QAPI and for how long: In order to confirm that the processes outlined above are sustained: The MC / DSC or designee will report the findings of the above audit monthly to the QAPI committee for the next 90-days. During and at the conclusion of the 90-day period the Committee will re-evaluate and initiate any necessary action or extend the review period.	

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K 324	Continued From page 7	K 324	Licensed Nursing Home administrator is responsible for complience.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/12/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 enclosed courtyard in accordance with NFPA 101: 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72: 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:06 PM in the presence of the	K 341	1. Immediate action(s) taken for the resident(s) found to have been affected. On 10/15/2024 the Maintenance coordinator reached out to NJ Ex Order 26.4(b)([redacted] to begin the process of having a new strobe and horn system installed in the courtyard. 2. Identification of other resident(s) having the potential to be affected was accomplished by: All residents have been identified as having the potential to be affected.	12/15/24

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K 341	Continued From page 8 U.S. FOIA revealed there was no fire alarm system horn/strobe installed in the enclosed courtyard. In an interview at the time, the U.S. FOI confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 10/16/2024 at 1:50 PM. N.J.A.C. 8:39-31.2(a) NFPA 72	K 341	3.Action(s) taken/system put into place to reduce the risk of future occurrence include: The courtyard equipment will be added to the inspection report and audited by the Maintenance Coordinator Monthly. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: To confirm that the processes outlined above are sustained: The MC / DSC or designee will report the findings of the above audit to the QAPI committee monthly for the next 90- days. During and at the conclusion of the 90-day period the Committee will re-evaluate and initiate any necessary action or extend the review The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	
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	K 353		12/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING 01 B. WING	C 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	1801 OAK TREE ROAD EDISON, NJ 08820

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K 353	Continued From page 9 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/15/24 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined the facility failed ensure fire sprinkler system sprinkler heads were maintained in accordance with NFPA 101: 2012 edition, Sections 9.7.5,19.3.5.1 and, NFPA 25: 2011 edition. This deficient practice had the potential to affect all 16 residents on the wing and was evidenced by the following: Observations during a tour of the facility on 10/15/24 between 9:25 AM and 3:20 PM revealed the following: 1. The sprinkler head in the sales office was covered with blue painter's tape. 2. The sprinkler head in the electrical room by room #122 was covered with blue painter's tape. In an interview at the time, the U.S. FOI [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 10/16/2024 at 1:50 PM N.J.A.C 8:39-31.2(e) NFPA 13,25	K 353	1.Immediate action(s) taken for the resident(s) found to have been affected. On 10.15.2024 the Maintenance Coordinator removed the tape that was covering the sprinkler in the sales office and in the electrical room by 122. 2.Identification of other resident(s) having the potential to be affected was accomplished by: All residents have the potential to be affected. 3.Action(s) taken/system put into place to reduce the risk of future occurrence include: Maintenance coordinator will monitor fire system equipment during daily rounds	

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	315351	A. BUILDING 01 B. WING _____	C 10/16/2024

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K 353	Continued From page 10	K 353	4.How the corrective action(s) will be monitored to ensure the practice will not recur: In order to confirm that the processes outlined above are sustained: The MC will report the findings of the above audit monthly to the QAPI committee for the next 90- days. During and at the conclusion of the 90-day period the Committee will re-evaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/15/24 in the presence of the U.S. FOIA (b) (6) [redacted], the facility failed to provide the required instructional placards near the Class K portable fire extinguisher in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10, 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 355	1.Immediate action(s) taken for the resident(s) found to have been affected. On 10.16. 2024 the Maintenance coordinator placed proper K placard over the K fire extinguisher. 2.Identification of other resident(s) having	12/15/24

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	315351	A. BUILDING 01 B. WING _____	C 10/16/2024

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K 355	Continued From page 11 At approximately 2:47 PM, an observation during the Kitchen tour revealed one K- Type fire extinguisher that did not have the required instructional placard indicating the fire protection system must be activated prior to using the fire extinguisher. In an interview at the time, the U.S. FOI confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 10/16/2024 at 1:50 PM NJAC 8:39-31.2(e) NFPA 10	K 355	the potential to be affected was accomplished by: All residents have the potential to be affected. Facility will ensure that proper K fire extinguishers have placard in case of fire 3.Action(s) taken/system put into place to reduce the risk of future occurrence include: Maintenance coordinator will monitor monthly during fire extinguisher inspections. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: In order to confirm that the processes outlined above are sustained: The MC will report the findings of the above audit monthly to the QAPI committee for the next 90- days. During and at the conclusion of the 90-day period the Committee will re-evaluate and initiate any necessary action or extend the review period. The administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may	

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	315351	A. BUILDING 01 B. WING	C 10/16/2024

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K 355	Continued From page 12	K 355	occur.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/15/2024 in the presence of U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that 8 of 8 gas boilers were equipped with a remote manual stop station in accordance with NFPA 101:2012 Edition, Section 9.5,19.5.1. NFPA 54 National Fuel and Gas Code. NFPA 70 National Electric Code. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 2:40 PM in the boiler room, revealed that 8 of 8 boilers were not equipped with a Remote Manual Emergency Stop Switch remote from the unit. There was an emergency stop located on the boiler that was not remote from the units to shut down in a catastrophic failure. In an interview at the time of observation, the [redacted]	K 511	1. Immediate action(s) taken for the resident(s) found to have been affected. K511 On October 15, 2024, the Maintenance Coordinator reached out to NJ Ex Order 26.4(b)(1) [redacted] plumbing company to make an appointment to have the remote shutoff installed. On 11/5/2024 the plumber assessed the supplies need. 2. Identification of other resident(s) having the potential to be affected was accomplished by: All residents have been identified as having the potential to be affected. 3. Action(s) taken/system put into place to reduce the risk of future occurrence include:	11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING **01** B. WING _____	C **10/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	**1801 OAK TREE ROAD** **EDISON, NJ 08820**

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K 511	Continued From page 13 confirmed the boilers were not equipped with a manual stop station that was remote from the units. The facility's U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 10/16/2024 at 1:50 PM. N.J.A.C 8:39-31.2(e) NFPA 54, 70	K 511	On 11/15/2024 the remote manual stop was installed. The Maintenance Coordinator added the shut off to the monthly checklist to ensure continued operation. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: In order to confirm that the processes outlined above are sustained: The Maintenance Coordinator will report the findings of the above audit monthly to the QAPI committee for the next 90- days. During and at the conclusion of the 90-day period the Committee will re-evaluate and initiate any necessary action or extend the review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced	K 521		12/15/24

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	315351	A. BUILDING 01 B. WING	C 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	1801 OAK TREE ROAD EDISON, NJ 08820

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K 521	Continued From page 14 by: Based on observations and interview on 10/15/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure residents bathroom ventilation systems for rooms were functionally maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice had the potential to affect 2 of 21 residents and was evidenced by the following: Observations in the presence of the U.S. FOIA revealed the following: In Room #100 and Room #102 bathrooms, the ventilation systems were not functioning when tested by the U.S. FOIA In an interview at the time, the U.S. FOI confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 10/16/2024 at 1:50 PM. NJAC 8:39-31.2(e) NFPA 90A	K 521	1. Immediate action(s) taken for the resident(s) found to have been affected. On 10/15 /2024 the Maintenance coordinator reached out to HVAC company. The rooftop exhaust fan was replaced on 10/16/2024 2. Identification of other resident(s) having the potential to be affected was accomplished by: All residents in the community were identified as having the potential to be affected 3. Action(s) taken/system put into place to reduce the risk of future occurrence include: Beginning on November 2024, The Maintenance Coordinator will test the fans for proper operation monthly 4. How the corrective action(s) will be monitored to ensure the practice will not recur: In order to confirm that the processes outlined above are sustained: The Maintenance Coordinator will report the findings of the above audit monthly to the QAPI committee for the next 90- days. During and at the conclusion of the 90-day period the Committee will re-evaluate and initiate any necessary action or extend the	

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	315351	A. BUILDING **01** B. WING _____	C **10/16/2024**

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BRIGHTON GARDENS OF EDISON	**1801 OAK TREE ROAD** **EDISON, NJ 08820**

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K 521	Continued From page 15	K 521	review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	K 921		12/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING 01 B. WING _____	C 10/16/2024

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K 921	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 10/15/2024 and 10/16/2024 in the presence of the [U.S. FOIA (b) (6)], it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3,10.5.2.1,10.5.2.1.2,10.5.2.5, 10.5.3,10.5.6 and 10.5.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 10/15/2024 from 10:15 AM to 4:10 PM, revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility. In an interview at the time, the [U.S. FOI] confirmed the findings. Documentation review on 10/16/2024, revealed no policy on patient care related electrical equipment. An interview at that time, the [U.S. FOI] confirmed the finding and acknowledged that no policy was provided. The facility's [U.S. FOIA (b) (6)] was notified of the deficient practice at the Life Safety Code survey exit conference on 10/16/2024 at 1:50 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	1.K921 Immediate action(s) taken for the resident(s) found to have been affected. K921 On 10/26/2024 The Maintenance coordinate tagged each piece of patient care electrical with the date of inspection and his initials. 2. Identification of other resident(s) having the potential to be affected was accomplished by: All residents have the potential to be affected 3. Action(s) taken/system put into place to reduce the risk of future occurrence include: The Maintenance coordinator will inspect all resident care-related equipment monthly to monitor compliance. Newly introduced equipment will be reviewed in the daily stand-up meeting for to make the maintenance department aware of the need to inspect and tag. 4. How the corrective action(s) will be monitored to ensure the practice will not recure To confirm that the processes outlined above are sustained: The Maintenance Coordinator will report the findings of the above audit monthly to the QAPI committee for the next 90- days. During and at the conclusion of the 90-day period the Committee will re-evaluate and initiate	

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	315351	A. BUILDING **01** B. WING _____	C **10/16/2024**

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K 921	Continued From page 17	K 921	any necessary action or extend the review period. The Administrator is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur.	

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
315351 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	1801 OAK TREE ROAD EDISON, NJ 08820

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	12/15/2024	LSC K0291	12/15/2024	LSC K0321	12/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	12/15/2024	LSC K0341	12/15/2024	LSC K0353	12/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	12/15/2024	LSC K0511	11/21/2024	LSC K0521	12/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0921	12/15/2024	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
10/16/2024	