STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315314	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR CARE AND REHABILITATION CENTER	3325 HIGHWAY 35 HAZLET, NJ 07730

(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 000	INITIAL COMMENTS Complaint # NJ 177500 and 172217 Census: 152 Sample Size: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		1/24/25

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

Electronically Signed | 01/14/2025

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F 842	Continued From page 1	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 2 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C #: NJ177500 Based on interviews, medical record review, and review of other pertinent facility documents on 12/04/24 and 12/05/24, it was determined that the facility staff failed to consistently document in the "Resident CNA (Certified Nursing Assistant) Documentation Record (RCDR)" on care provided to the resident according to the facility policy and protocol for 3 of 5 residents (Resident #2, Resident #3, and Resident #5) reviewed for documentation. This deficient practice was evidenced by the following: 1. According to the "Resident Face Sheet" (RFS), Resident #5 was admitted with diagnoses including but 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). A review of the Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4, revealed that Resident #5 had a Brief Interview of Mental Status (BIMS) score of NJ Ex indicating that Resident #5 had NJ Ex Order 26.4(b)(1) and was dependent on staff with Activities of Daily Living (ADLs). Resident #5's CP (Care Plan) initiated on NJ Ex Order 26.4 indicated that Resident #5 had a focus for NJ Ex Or as evidenced by an NJ Ex Order 26.4(b)(1) upon admission. Interventions included but were not	F 842	I. Immediate action a) We respectfully submit that resident #2 and #3 are NJ Ex Order 26.4(b)(1) the facility b) Resident #5 was seen by NJ Ex Order 26.4(b)(1) center on NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) without any complications. Continue with current plan of care. c) Resident assessed by Dietician and no significant NJ Ex Order 2 changes noted. Resident NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) d) Seen by primary MD on NJ Ex Order 26.4(b) d) Inservice regarding policy and procedure for charting and documentation was done facility wide and is ongoing. II. Identification of others: a) An audit was completed for all residents. All negative findings were brought to the Administrator's and Director of Nursing's attention immediately. b) All residents have the potential of being affected Completion date: 1/24/2025 III. Systemic Changes: a) The Policy and Procedure titled Charting and documentation was reviewed by Director of nursing and Administrator on 12/5/2024 and found to be in compliance b) Facility wide education for Charting and documentation is conducted by Assistant Director of nursing/Designee	

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F 842	Continued From page 3 limited to: providing [redacted] care and once a week with [redacted] providing [redacted] as ordered: [redacted], [redacted] and [redacted]. Additionally, Resident #5 had a focus for [redacted] with a goal to [redacted]. Interventions included but were not limited to [redacted] and encouraging [redacted]. Review of the RCDR (ADL Record), dated [redacted] for completion of ADL under "Task" did not indicate that [redacted], [redacted] and [redacted] were provided to the Resident at the following times: [redacted]: During the 7:00 a.m. to 3:00 p.m. shift, 22 out of 23 days did not have documentation. During the 3:00 p.m. to 11:00 p.m. shift, 12 out of 23 days did not have documentation. During 11:00 p.m. to 7:00 a.m. shift, 16 out of 24 days did not have documentation. [redacted]: At 12:00 a.m., 16 out of 23 days did not have documentation. At 2:00 a.m., 16 out of 23 days did not have documentation. At 4:00 a.m., 15 out of 23 days did not have documentation. At 6:00 a.m., 16 out of 23 days did not have documentation.	F 842	Completion date: 1/24/2025 IV. Quality Assurance: a) This audit will be done by Unit Manager/Supervisor daily. b) An audit form has been created to ensure that documentation is completed in a timely manner. c) Any negative findings will be corrected immediately and brought to the Director of Nursing'/Designee's attention. d) The results of all audits will be brought to the QAPI committee quarterly x 4	

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F 842	Continued From page 4 At 6:00 p.m., 16 out of 23 days did not have documentation. At 8:00 p.m., 16 out of 23 days did not have documentation. At 10:00 p.m., 15 out of 23 days did not have documentation. NJ Ex Order 26 During 7:00 a.m. to 9:00 a.m., 22 out of 23 days did not have documentation. During 11:00 a.m. to 1:00 p.m., 23 out of 23 days did not have documentation. During 4:00 p.m. to 6:00 p.m., 16 out of 23 days did not have documentation. NJ Ex Order 26.4(b) At 10 a.m., 23 out of 23 days did not have documentation. At 2 p.m., 23 out of 23 days did not have documentation. At 8:00 p.m., 16 out of 23 days did not have documentation. Review of the RCDR, dated NJ Ex Order 26.4(b)(1) for completion of ADL under "Task" did not indicate that NJ Ex Order 26.4(b)(1), NJ Ex Order 26 and NJ Ex Order 26.4(b) were provided to the Resident at the following times: NJ Ex Order 26.4(b)(1): During the 7:00 a.m. to 3:00 p.m. shift, 24 out of	F 842		

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F 842	Continued From page 5 30 days did not have documentation. During the 3:00 p.m. to 11:00 p.m. shift, 3 out of 30 days did not have documentation. During the 11:00 p.m. to 7:00 a.m. shift, 29 out of 30 days did not have documentation. NJ Ex Order 26.4(b)(1): At 12:00 a.m., 28 out of 30 days did not have documentation. At 2:00 a.m., 29 out of 30 days did not have documentation. At 4:00 a.m., 26 out of 30 days did not have documentation. At 6:00 a.m., 29 out of 30 days did not have documentation. At 6:00 p.m., 10 out of 30 days did not have documentation. At 8:00 p.m., 16 out of 30 days did not have documentation. At 10:00 p.m., 20 out of 30 days did not have documentation. NJ Ex Order 26 During 7:00 a.m. to 9:00 a.m. meal, 25 out of 30 days did not have documentation. During 11:00 a.m. to 1:00 p.m. meal, 23 out of 30 days did not have documentation.	F 842		

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F 842	Continued From page 6	F 842		

During 4:00 p.m. to 6:00 p.m. meal, 4 out of 30 days did not have documentation.

NJ Ex Order 26.4(b)

At 10 a.m., 24 out of 30 days did not have documentation.

At 2 p.m., 25 out of 30 days did not have documentation.

At 8:00 p.m., 15 out of 30 days did not have documentation.

2. According to the "Resident Face Sheet" (RFS), Resident #2 was admitted with diagnoses including but 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) .

A review of the Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4, revealed that Resident #2 had a Brief Interview of Mental Status (BIMS) score of NJ Ex [redacted] indicating that Resident #2 had NJ Ex Order 26.4(b)(1) and was independent with ADLs.

Review of the RCDR, dated NJ Ex Order 26.4(b)(1) for completion of ADL under "Task" did not indicate that NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 were provided to the Resident at the following times:

NJ Ex Order 26.4(b)(1)

During 7:00 a.m. to 3:00 p.m. shift, 8 out of 30 days did not have documentation.

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F 842	Continued From page 7	F 842		

During the 3:00 p.m. to 11:00 p.m. shift, 30 out of 30 days did not have documentation.

During the 11:00 p.m. to 7:00 a.m. shift, 30 out of 30 days did not have documentation.

NJ Ex Order 26

During the 7:00 a.m. to 9:00 a.m. meal, 8 out of 30 days did not have documentation.

During the 11:00 a.m. to 1:00 p.m. meal, 8 out of 30 days did not have documentation.

During 4:00 p.m. to 6:00 p.m. meal, 30 out of 30 days did not have documentation.

3. According to the RFS, Resident #3 was admitted with diagnoses that 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) NJ Ex).

The MDS, dated NJ Ex Order 26.4(b indicated that Resident #3 had a BIMS of NJ Ex indicating NJ Ex Order 26.4(b)(1) , and was NJ Ex Order 26.4(b)(1) for all ADLs.

Resident #3's CP (Care Plan) initiated on NJ Ex Order 26.4(b indicated that Resident #3 had a focus for ADLs. Interventions included but not limited to: NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with NJ Ex Order 26

Review of the RCDR, dated NJ Ex Order 26.4(b)(1) for completion of ADL under "Task" did not indicate

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F 842	Continued From page 8 that [redacted], [redacted] and [redacted] were provided to the Resident at the following times: [redacted]: During 7:00 a.m. to 3:00 p.m. shift, 2 out of 30 days did not have documentation. During 11:00 p.m. to 7:00 a.m. shift, 2 out of 30 days did not have documentation. [redacted]: At 12:00 a.m., 13 out of 30 days did not have documentation. At 2:00 a.m., 13 out of 30 days did not have documentation. At 4:00 a.m., 12 out of 30 days did not have documentation. At 6:00 a.m., 12 out of 30 days did not have documentation. At 6:00 p.m., 6 out of 30 days did not have documentation. At 8:00 p.m., 8 out of 30 days did not have documentation. At 10:00 p.m., 7 out of 30 days did not have documentation. [redacted] During 7:00 a.m. to 9:00 a.m. meal, 3 out of 30 days did not have documentation.	F 842		

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F 842	Continued From page 9 During 11:00 a.m. to 1:00 p.m. meal, 2 out of 30 days did not have documentation. [redacted] At 10 a.m., 2 out of 30 days did not have documentation. At 2 p.m., 3 out of 30 days did not have documentation. At 8:00 p.m., 1 out of 30 days did not have documentation. . During an interview with the surveyors on 12/05/24 at 9:35 a.m., the CNA, stated that CNAs were responsible for the primary care of the residents, and for documenting the ADLs on the kiosk (a computer that is located on each hall on the units that link to the residents' medical chart). She further stated that documentation includes [redacted] residents, and if [redacted] and [redacted] were performed. When the CNAs documented, they were to select performed or not performed, and if the CNA selected not performed, then a reason for the task not being completed needed to be entered. For example, a reason for a task not being completed would be, a resident out of the building for an appointment. The CNA further stated that the documentation needs to be completed by the end of the shift. During an interview with the surveyors on 12/05/245 at 10:46 a.m., the Unit Manager/Registered Nurse, stated that CNAs were responsible for ADL care on the unit. She stated that the CNAs have their own assignments	F 842		

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F 842	Continued From page 10	F 842		

and were responsible for documenting the care on the kiosk. She stated that ADL care should be documented by the end of their shift. She explained that the documentation must be completed in the residents' chart by the end of each shift to show that the care was provided to the residents, and to identify changes with residents.

During an interview with surveyors on 12/05/24 at 1:23 p.m., the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), both stated that CNAs were responsible for ADL care on the floors, and that care is documented in the kiosk. U.S. FOIA states that documentation is important to show that care has been completed.

Review of the facility policy titled "Charting and Documentation," dated October 2018, and reviewed October 2024, reflected "POLICY Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care...1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record...c. Treatment or services performed...3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate ..."

NJAC: 8:39-35.2 (d)(6)

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S 000	Initial Comments Complaint #: NJ00172217 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 26 day shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	I. Immediate Action: 1. The Administrator and Director of Nursing met with the Staffing Coordinator to determine current staffing vacancies in the nursing department to ensure accuracy of facility needs. 2. The facility has reviewed current salaries in comparison to other facilities in the immediate area to ensure salary competitiveness within the community. 3. The facility works with a full-time recruiter whose responsibility is to recruit nurses and C.N.A.s.	1/14/25

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

Electronically Signed | 01/14/25

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S 560	Continued From page 1 codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 03/17/2024 to 03/23/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -03/17/24 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -03/18/24 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -03/19/24 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -03/20/24 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -03/23/24 had 14 CNAs for 147 residents on the day shift, required at least 18 CNAs. 2. For the week of Complaint staffing from 09/15/2024 to 09/21/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:	S 560	4. The facility maintains contact with the company recruiters on a weekly basis and provide updates on current staffing needs. 5. Nursing Administration is available for interviews, hiring and training as needed to ensure allpotential candidates are interviewed, evaluated and offe red positions if appropriate. 6. The facility continues to offer incentives 7. The facility advertises on various platforms such as social media, posted flyers in various community establishments, colleges and schools. 8. Signs placed across facility property to enhance our recruitment efforts. II. Identification of Others: The facility respectfully submits that all residents may be affected by this practice. III. Systemic Changes 1. The Administrator, Director of Nursing, Human Resource Director and the Staffing Coordinator have reviewed the facility staffing ratios to ensure the facility meets the par levels. 1. Human Resource Director will complete exit interviews for all nursing employees who have vacated their positions in an attempt to address any issues which could be affecting retention of employees. 2. Orientation frequency will be increased to ensure that all potential candidates for employment will have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061303	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR CARE AND REHABILITATION CENTER	3325 HIGHWAY 35 HAZLET, NJ 07730

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S 560	Continued From page 2 -09/15/24 had 16 CNAs for 151 residents on the day shift, required at least 19 CNAs. -09/16/24 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs. -09/17/24 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs. -09/18/24 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs. -09/19/24 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs. -09/20/24 had 16 CNAs for 156 residents on the day shift, required at least 19 CNAs. -09/21/24 had 16 CNAs for 156 residents on the day shift, required at least 19 CNAs. 3. For the 2 weeks of Complaint staffing from 11/17/2024 to 11/30/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -11/17/24 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/18/24 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/19/24 had 16 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/20/24 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/21/24 had 16 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/22/24 had 16 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/23/24 had 16 CNAs for 148 residents on the day shift, required at least 18 CNAs. -11/24/24 had 16 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/25/24 had 16 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/26/24 had 16 CNAs for 144 residents on the	S 560	opportunities to complete the orientation soon after accepting a facility offer. IV. Quality Assurance 1. A tracking log will be maintained for all communication with recruiters, referrals, applicants, interviews, newly hired, orientation completion and success of recruitment efforts and will be reviewed monthly by Director of Nursing, Administrator and Human Resource Director. 2. All findings will be reviewed by the Quality Assurance Team at least quarterly and changes made as needed to improve facility ratios. V. Responsibility: Administrator, Director of Nursing, Staffing Coordinator and Human Resource Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 day shift, required at least 18 CNAs. -11/27/24 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/28/24 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/29/24 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/30/24 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315314	A. Building B. Wing	1/27/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR CARE AND REHABILITATION CENTER	3325 HIGHWAY 35 HAZLET, NJ 07730

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 F0842 Reg. # 483.20(f)(5), 483.70(h)(1)-(5) LSC	Correction Completed 01/14/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/5/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
061303 Y1	Y2	1/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR CARE AND REHABILITATION CENTER	3325 HIGHWAY 35 HAZLET, NJ 07730

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/14/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO