STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE LAKEWOOD, NJ 08701**

(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 #: NJ172160, 172982, 173219, 173478, 173507, 174176, 174647, 175407 Survey Date: 10/11/2024 Census: 175 Sample: 35 +1 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 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition	F 803		11/30/24

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

Electronically Signed | 10/28/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE LAKEWOOD, NJ 08701**

(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 803	Continued From page 1 professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: C# NJ172982 Based on observation, interview, and record review, it was determined that the facility failed to provide all the items that were on the menu. This deficient practice occurred during one lunch meal that was observed in the conference room of the facility during a test tray evaluation by the survey team and was evidenced by the following: On 10/08/2024 at 11:28 AM, the surveyor requested the main and alternate meal for lunch on 10/8/2024. According to the [facility name] Week at a Glance - New Menu 2020 the main entree for week 4 consisted of creamy carrot soup, cheese quesadilla, zucchini stuffed tomato, and cinnamon rice pudding. The alternate meal at lunch according to the menu consisted of grilled eggplant and roasted pepper sandwich, and potato salad, in addition the creamy carrot soup. The US FOIA (b)(6) delivered the lunch meal trays to the facility conference room for the surveyors to sample as there had been resident complaints concerning residents not receiving items at meals that were listed on the menu. Observation of the main entree revealed that no zucchini stuffed tomato and the vegetable provided was yellow squash with diced tomato. The alternate meal consisted of grilled eggplant and roasted pepper sandwich with yellow squash and diced tomato as the vegetable. There was no	F 803	Leisure Chateau will ensure that the Menus Meet Resident Nutritional Needs in accordance with established national guidelines, be prepared in advance, be followed, reflect- based on a facility's reasonable efforts the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; updated periodically, reviewed by dietician. To address survey concerns the facility has done/will do the following: 1) The US FOIA (b) responsible for the preparing potato salad was disciplined and re-educated on carefully checking and preparing all menu items. 2) All residents who receive food from the kitchen can be affected by this practice 3) A policy on Following Menus will be reviewed and revised by the FSD to reflect the importance of following ALL items on the menu, including alternates. The FSD will in-service ALL cooks and supervisors on the policy for following the Menu. The FSD will revise the supervisor work flows to include that they check daily for all menu items to be prepared by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE LAKEWOOD, NJ 08701**

(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 803	Continued From page 2 zucchini stuffed tomato or potato salad as the menu indicated. During an interview with the surveyor on 10/08/2024 at 11:51 AM, the surveyor asked the [US FOIA (b)] if the kitchen staff had potato salad available as it was a listed item on the lunch menu for Tuesday week 4 according to the facility menu. The [US FOIA (b)] stated, "Ill check with the cook." The [US FOIA (b)] asked the cook who was serving on the tray line if they had potato salad available and the cook responded, "No. I didn't see it on the sheets, so we didn't make any today." The surveyor also pointed out to the [US FOIA (b)] that the vegetable served consisted of yellow squash and diced tomato and not a tomato stuffed zucchini. The [US FOIA (b)] agreed that the vegetable served was not a tomato stuffed with zucchini, as indicated on the lunch menu. The [US FOIA (b)] on interview agreed potato salad should be on the menu. The [US FOIA (b)] further stated, "I'll get some made now. We don't want any complaints from residents. We missed it, I don't want to lie." A review the facility policy titled Garbage Storage Area, dated September 2023, revealed under the policy title: "A garbage storage area is a necessity to provide a safe and sanitary environment for residents. It provides a specific place for the disposal of garbage and must be maintained properly to prevent the spread of bacteria, pests, and odor." In addition, the policy reveled the following at and 4. and 6. Garbage storage area must be maintained in a sanitary condition to prevent the harboring and feeding of pests. "Dumpsters must be covered and gates closed when the garbage storage area is not being utilized."	F 803	cooks. The FSD will in-service the supervisors on the revised work flow. If a substitution is needed due to unavailability, a comparable nutritional menu substitution will be provided with the approval of the Registered Dietitian. Menu will be updated to reflect the change and Menu board will be updated as well. 4) The FSD will develop a QAPI to ensure that the POC is effective. The FSD will audit weekly for 4 weeks then monthly for 2 months and then quarterly for 2 quarters to ensure compliance. FSD will monitor the production/menu and the supervisors work flow compliance for checking that the production matches the menu. The FSD will do audit production menus. Finding of the audit will be presented at the Quarterly/ QAPI meeting for the next 3 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE LAKEWOOD, NJ 08701**

(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 803	Continued From page 3 The facility did not provide a policy concerning menus. NJAC 8:39-17.2(b)	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 10/01/2024 from 9:29 to 10:14 AM, the surveyor, accompanied by the US FOIA (b)(6)	F 812	Leisure Chateau Care & Rehabilitation will :a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of foodborne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination To address survey concerns the facility has done and will do the following:	11/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE LAKEWOOD, NJ 08701**

(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 812	Continued From page 4 US FOIA (b)(6) observed the following in the kitchen: 1. In the dry storage area on a lower rack of a multi-tiered, wheeled, can storage rack, a can of vegetarian beans had a significant dent on the side of the can. The US FOIA (b) removed the can to the designated dented can area after agreeing that it was significantly dented. 2. In the meat walk-in on a middle shelf, a previously opened package of sliced turkey was wrapped in plastic wrap. The package had no dates. In addition, a clear plastic bag contained sliced bread. The bag of bread had no dates. The US FOIA (b) removed the undated foods from the meat walk-in in the presence of the surveyor. 3. The Meat Pot/Pan Storage Drying Rack had six (6) stacks of plates used to serve resident meals were stored on an upper shelf. The plates were not inverted or covered, and the eating surface was exposed. In addition, a red plastic dish rack contained silverware that was cleaned and sanitized. The silverware was not covered and exposed to contamination. Next to the red plastic dish rack two (2) metal, perforated half pans contained various kitchen utensils, including scoops and tongs used to serve food, amongst other utensils. The pans were not covered, and the utensils were exposed to contamination. The US FOIA (b) stated that the utensils and dishes should be inverted or covered when not in use to prevent contamination. On 10/08/2024 from 10:57 to 11:13 AM, the surveyor, accompanied by the US FOIA (b) observed the following in the kitchen:	F 812	1) 1. The dented can was removed by the FSD and discareded 2. The undated foods were removed from the Walk-In by the FSD and discarded 3. The exposed silverware, utensils and the uninverted/exposed plates were removed from service by the FSD and placed through another wash and then re-stored properly; unexposed and inverted. 4. The dishes that were stacked while still wet were removed by the cook. The dishes were re-washed, air dried & re-stored properly to avoid wet nesting. 2) All residents that are not strictly receiving their nourishment from a feeding tube can be affected by this deficient practice. 3) 1. FSD will in-service All dietary staff were on policy of storage of cans and dented can area. The opening and closing supervisors will audit the can storage on a daily basis for dented cans. FSD will in-service opening and closing supervisors on the auditing of can storage rack. 2. FSD will in-service ALL dietary staff on Policy for Proper Labeling & Dating of ALL food items and storage. The opening and closing supervisors will audit the kitchen food storage areas on a daily basis for compliance. FSD will in-service opening and closing supervisors on the auditing of food storage areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE LAKEWOOD, NJ 08701**

(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 812	Continued From page 5 1. During an observation of the Dish room Storage Rack, the surveyor observed that all dishware was inverted. The surveyor lifted the top plate on a stack of plates used to serve resident meals. The surveyor observed a wet and clear liquid on the plate just below the top plate. The surveyor lifted the next plate on the stack and observed a wet, clear liquid substance. Mike Cottrell/Cook. The [redacted] on interview stated that he had just washed the plates and agreed that he should have air dried the plates prior to stacking. The [redacted] removed the stack of plates to be cleaned and sanitized. The [redacted] on interview agreed that the cook should have allowed the cleaned and sanitized dish ware to be completely air dried before stacking the plates, a condition known as "wet nesting" (the practice of stacking wet dishes, pots, or pans together, which prevents them from drying and can lead to bacterial growth). The multiple stacks of plates were to be re-washed, sanitized and air dried according to the [redacted] who directed the cook to remove the dishes from the storage rack. A review of the facility policy titled Label and Dating, updated 6.22.23, revealed under the heading POLICY: All food items being received or prepared will have a standard label to identify the product name, the received date, the prepared date or the pull date from freezer date, and the expiration or cook by date. All products will be sealed or wrapped tightly with proper labels. All received products will be securely wrapped. In addition, the following was revealed under PROCEDURE: 4. All products that are "opened" (mayo, dressing, etc.,) are to be labeled with a new expiration date. (please follow label and dating chart system protocol) example-dressing container is opened. It now has a new expiration	F 812	3. FSD will in-service ALL Dietary staff on Policy for proper ware washing and storage of plates, utensils and wares to prevent wet nesting. The opening and closing supervisors will audit Dish and Pot/Utensil storage racks on a daily basis for compliance. FSD will in-service opening and closing supervisors on the auditing of Dish and Pot/Utensil storage racks. 4) The FSD will perform weekly audits for a minimum of 3 months to ensure compliance with the above. The FSD will then audit Monthly for the next 2 quarters. Audit will include a review of the Opening and Closing Supervisor checklist and a review of compliance with the policies referenced above. The findings of the audit will be presented at the Quarterly/QAPI meeting for 3 Quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE LAKEWOOD, NJ 08701**

(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 812	Continued From page 6	F 812		

date of 30 days from open date, Opened on 6.20.23 will be written on the "open date" on the label, as well as 7.20.23 written in the "use by" section on the label. All products will be wrapped securely.

A review of the facility policy titled Dry Storage and Receiving Foods Policy, undated, revealed under POLICY: Dietary will receive and deliver dry foods in a timely fashion ensuring quality of products and packaging. In addition, the following was revealed under PROCEDURE: 1. All receiving personnel are to check all dry food items upon delivery. Ensure that all packing is intact and marked off against the packing slip. Check all packages for any tears, stains, leaks, missing labels, shortages of order or over deliveries. Ensure product packing is in good condition.

A review of the facility policy titled Cleaning Dishes - Manual Dishwashing, 2013, [company name], revealed the following at POLICY: Dishes and cookware will be washed after each meal to assure that all dishes are clean and sanitary. In addition, the following was revealed under Sink 3: Sanitize: 4. Allow dishes to air dry. Invert dishes in a single layer to air dry. Check all dishes to be sure they are clean and dry prior to storing.

A review of the facility provided policy titled Handling Clean Equipment and Utensils, 2013 [company name], revealed under POLICY: Clean equipment and utensils will be handled to prevent contamination. In addition, the following was observed under Procedure: 2. Clean equipment and utensils will be stored in a clean, dry location in a way that protects them from splashes, dust, or other contamination. Stationary equipment will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE LAKEWOOD, NJ 08701**

(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 812	Continued From page 7 also be protected from contamination. A review of the facility policy titled Dented Can Policy, undated, revealed under PROCEDURE: 1) All receiving personnel are to check canned items dents, bulging or rust (sic). If a can is identified with these defects, place the can on the "dented can section." This section is in the vestibule locker section and labeled as such. Cans are to be returned to the purveyor for credit. Supervisors to check with weekly audits. NJAC 8:39-17.2(g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to have a cover over the opening of 1 of 2 garbage dumpsters. This deficient practice was evidenced by the following: On 10/03/2024 at 09:07 AM, the surveyor observed the facilities designated garbage area. The surveyor observed two (2) trash only dumpsters in the facility parking lot in an opened but fenced in area. The dumpsters were three (3) yard dumpsters and had two (2) separate black plastic lids to enclose the trash in the dumpster. The front dumpster contained bagged trash/garbage and 2 of 2 lids were open and left the bagged trash exposed. A residential housing	F 814	1) As soon as the deficient practice was discovered the Director of Housekeeping closed the lids and the gate. The Housekeeping Director continued to monitor the Garbage disposal area for compliance as an immediate corrective action. 2) Improper disposal of Garbage and Refuse can affect all residents and staff, as well as the members of the residential housing community that lives behind the dumpster. 3) The FSD and the Housekeeping Director will in-service their respective departments on the Leisure Chateau Policy that Garbage storage area must be	11/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE LAKEWOOD, NJ 08701**

(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 814	Continued From page 8 complex is located directly behind the designated garbage area. During an interview on 10/03/2024 at 09:11 AM, the surveyor asked who was responsible for the maintenance of the facility designated garbage area the [US FOIA (b)(6) redacted]) told the surveyor, "It's a joint effort between dietary, maintenance and housekeeping." On further interview the [US FOIA (b) redacted] stated that, "I agree with you 100%. The doors should be closed." A review of the facility policy titled Garbage Storage Area, September 2023, revealed the following under the policy title: A garbage storage area is a necessity to provide a safe and sanitary environment for residents. It provides a specific place for the disposal of garbage and must be maintained properly to prevent the spread of bacteria, pests and odor." The following was revealed at 4. "Garbage storage area must be maintained in a sanitary condition to prevent the harboring and feeding of pests. In addition, the following was revealed at 6. "Dumpsters must be covered and gates closed when the garbage storage area is not being utilized." NJHAC 18:39-19.3(b)	F 814	maintained in a sanitary condition to prevent the harboring and feeding of pests. In addition, Dumpsters must be covered and gates closed when the garbage storage area is not being utilized. 4) The Housekeeping Director will develop a QAPI to ensure that compliance is met. The Housekeeping Director will audit 2 times a week for 1 month and then weekly for 3 months and then quarterly for 2 quarters to ensure compliance. The Housekeeping Director will report results of the audits/QAPI to our QAPI committee meeting. Findings of the audit will be presented at the Quarterly/ QAPI meeting for 3 quarters.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061515	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey for 1.) 11/19/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shift 2.) 12/24/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts 3.) 01/28/2024 to 02/03/2024, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts 4.) 03/03/2024 to 03/09/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts 5.) 04/28/2024 to 05/04/2024, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts 6.)	S 560	1. Inadequate number of Certified Nursing Assistants due to call-offs and staff not showing off to work for the following number of shifts. 14 day shifts out of 56 day shifts. The Administrator immediately assigned the Assistant Administrator to supervise the Staffing Coordinator and ensure that required staffing are in place for CNA. The DON immediately reviewed the call out or not showing up to work among the in-house CNA and there were no pattern 2. All the residents may be affected by	11/30/24

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

Electronically Signed — 10/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061515	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 05/26/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts and 7.) 09/15/2024 to 0928/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts. Findings include: 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, codified at 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. As per the Nurse Staffing Report (AAS-11) completed by the facility, the staffing to resident ratios that did not meet the requirements of 1 CNA to 8 residents for the day shift as documented below: 1. For the week of Complaint staffing from 11/19/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows:	S 560	the short staff as required by NJ DOH. 3. The Administrator will in-service the Assistant Administrator and Staffing Coordinator in reference to the state guideline on S 560 related to mandatory staffing requirement. The Assistant Administrator and or designee will review the staffing one week ahead to ensure that there adequate number of Certified Nursing Assistants on staff. The Director of Human Resources will continue to post the vacancies in all 3 shifts. The Director of Human Resources/ designee will be attending a very large local job fair next month. The Assistant Administrator and/or designee will post and/or offer an OT pay to in-house staff. The Administrator, DON, Assistant Administrator and/or designee will offer a bonus on top of the overtime and/or regular hourly pay. The staffing agency will block a schedule for the open position to cover for the vacancies. The ownership will continue to offer local housing to recruit and maintain agency CNA's. 4. The Assistant Administrator and/or designee will audit the staffing weekly for 4 weeks then monthly for 3 months. The Assistant Administrator and the DON will submit the audit report to the Quality Assurance Improvement Committee monthly for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061515	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 -11/24/23 had 20 CNAs for 170 residents on the day shift, required at least 21 CNAs. -11/25/23 had 20 CNAs for 170 residents on the day shift, required at least 21 CNAs. 2. For the week of Complaint staffing from 12/24/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -12/24/23 had 17 CNAs for 163 residents on the day shift, required at least 20 CNAs. -12/25/23 had 17 CNAs for 163 residents on the day shift, required at least 20 CNAs. 3. For the week of Complaint staffing from 01/28/2024 to 02/03/2024, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -01/28/24 had 18 CNAs for 175 residents on the day shift, required at least 22 CNAs. -012/03/24 had 21 CNAs for 176 residents on the day shift, required at least 22 CNAs. 4. For the week of Complaint staffing from 03/03/2024 to 03/09/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -03/03/24 had 18 CNAs for 179 residents on the day shift, required at least 22 CNAs. 5. For the week of Complaint staffing from 04/28/2024 to 05/04/2024, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -04/28/24 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs. -05/04/24 had 21 CNAs for 176 residents on the	S 560	4 months to ensure the solutions implemented are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061515	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 day shift, required at least 22 CNAs. 6. For the week of Complaint staffing from 05/26/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -05/26/24 had 19 CNAs for 168 residents on the day shift, required at least 21 CNAs. -06/01/24 had 19 CNAs for 168 residents on the day shift, required at least 21 CNAs. 7. For the 2 weeks of staffing prior to survey from 09/15/2024 to 0928/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -09/15/24 had 16 CNAs for 174 residents on the day shift, required at least 22 CNAs. -09/22/24 had 17 CNAs for 173 residents on the day shift, required at least 22 CNAs. -09/28/24 had 20 CNAs for 174 residents on the day shift, required at least 22 CNAs. During an interview with the surveyors on 10/08/2024 at 12:05 PM, the Director of Nursing (DON) stated that she was aware of the staffing ratio requirements. When asked if she was consistently meeting the requirements, the DON stated, "For the most part, yes." A review of facility policy titled Direct Care Staff-to-Resident Ratios, with review date of January 20, 2023, revealed the facility will abide by the bill requiring nursing homes to maintain certain minimum direct care staff-to-resident ratios to the best of their ability. Specifically, the bill will require: 1) one certified nurse aide to every eight residents for the day shift,	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061515	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members are to be certified nurse aides, and each staff member will sign in to work as a certified nurse aide and will perform certified nurse aide duties; and 3) one direct care staff member to every 14 residents for the night shift, provided that each direct acre staff member is to sign in to work as a certified nurse aide and perform certified nurse aide duties.	S 560		

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
315190 Y1	A. Building B. Wing Y2	12/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

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 F0803	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(c)(1)-(7)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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?
10/11/2024	☐ YES ☐ NO

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
315190 Y1	A. Building B. Wing Y2	12/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

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 F0803	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.60(c)(1)-(7)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	11/30/2024	LSC	11/30/2024	LSC	11/30/2024
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	
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?
10/11/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061515 Y1	A. Building B. Wing Y2	12/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 10/11/2024

☐ 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	DATE OF REVISIT
061515 Y1	A. Building B. Wing Y2	12/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 10/11/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 10/11/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 10/11/24 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Leisure Chateau is a two-story building with a partial basement constructed in 1982. It is composed of Type II (000) construction and is divided into twelve smoke compartments. The facility has a complete automatic sprinkler system (wet). The diesel generator powers 100% of the building. The number of occupied beds was 172 out of 243.	K 000		
K 224 SS=F	Horizontal Sliding Doors CFR(s): NFPA 101 Horizontal-Sliding Doors Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound.	K 224		11/30/24

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

Electronically Signed | 10/28/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 224	Continued From page 1 Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: o Area served by the door has no high hazard contents. o Door is operable from either side without special knowledge or effort. o Force required to operate the door in the direction of travel is less than or equal to 30 lbf to set the door in motion and less than or equal to 15 lbf to close or open to the required width. o Assembly is appropriately fire rated, and where rated, is self-closing or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. o Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 19.2.2.2.10 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to meet the requirements for horizontal sliding doors of NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.14. This deficient practice had the potential to affect staff and 30 residents. Findings include: Observations on 10/11/24 at 1:36 PM of the designated exit by room 95 revealed horizontal sliding doors that were not functioning. The door leaf was not readily operable from either side horizontally. When a force was applied in the direction of egress, the door leaf only partially opened and did not meet the minimum width required for egress. The leaf popped out of its bottom track and got stuck between the floor and door frame. A sign on the door indicated the	K 224	1) The Maintenance Director examined the problem and was able to determine that the pin that kept the door suspended off of the floor needed adjustment. The Maintenance Director adjusted the pin and the suspension was corrected. As a result of the pin being adjusted, the door was suspended off of the floor, thereby allowing for a full opening when pushed manually. 2) All residents residing in the area of room 95 and those spending time in the lounge accross the hall can be affected in the event of an emergency requiring a nemergency exit from the building. 3) The assistant administrator contacted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 224	Continued From page 2 following: "These doors no longer work, please use main entrance" During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and stated the facility was waiting for a service technician to come out and fix the doors. NJAC 8:39-31.1(c), 31.2(e)	K 224	the Automatic door company,"Eastern Door Company" to come in and do a complete service on these automatic doors. Eastern Door Company will check the entire operation of the door, Lubricate and change parts as neccessary. The Administrator will in-service the Maintenance department on checking the door for proper function and proper manual opening during emergencies. The Maintenance Director will assign his staff to check this door on a monthly basis as part of the facility preventative maintenance program. 4) The Maintenance Director will develop a QAPI to check for compliance weekly for one month and then monthly for 3 months. Maintenance Director will submit his findings to the QAPI committee meeting which meets quarterly	
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	K 321		11/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 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) 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 interview, the facility failed to separate hazardous areas from other parts of the facility in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 8.4. This deficient practice had the potential to affect staff and 65 residents. Findings include: Observations on 10/11/24 at 10:59 AM revealed Room 97 had been turned into a combustible storage room. A self-closing device was missing from the door separating it from the corridor. The room measured over 50 square feet (sf) in size and contained stored combustibles (paper products, cleaning supplies). Observations on 10/11/24 at 1:27 PM of the dry storage room, located in the Kitchen, revealed a self-closing device was missing from the door	K 321	1) a self closing door device will be placed on the door of room 97 and on the Dry Storage room doors separating the Dry Storage Room from the Dining Room. 2)All residents on the Washington Unit by room 97 and all residents who spend any time in the dining room can be affected by this deficient practice. 3) The Administrator will in-service the Maintenance Department on the requirement for hazardous areas to have a self closing device on the doors. The Maintenance Director will in-service and assign his staff to add these doors on their monthly preventative maintenance checks to make sure that the devices are in place and operational. 4) The Maintenance Director will develop a QAPI to ensure compliance with this requirement. He will audit the doors	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 4 separating it from the Dining Room. The room measured over 50 square feet (sf) in size and contained stored combustibles (oil, paper products). During an interview at the time of the observations, the US FOIA (b)(6) confirmed the findings and revealed the facility was unaware that a self-closing device was required on the door. NJAC 8:39-31.2(e)	K 321	weekly for 1 month and then monhly for 2 additional months. The results of the QAPI will be reviewed by the QAPI committee at he quarterly QAPI meeting	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 9.6.1.3 and NFPA 72 (2010) Chapter 14. This deficient practice had the potential to affect all 172 residents. Findings include: A review of the facility's "Fire Alarm Inspection & Test Reports" for the previous two years revealed	K 345	1) The Fire Alarm Company, Affiliated Electric will do a complete annual inspection of the entire fire alarm system. The test will include documentation of every magnetic hold open device to ensure that they are ALL closing in the event of an alarm. 2) This deficient practice can affect all residents and staff 3)The Administrator will educate the Fire	11/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING 01 B. WING _____	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 5 only quarterly visual inspections were conducted. There was no documented evidence that an annual test of the entire system was conducted. The forms were also incomplete and did not identify the magnetic hold open devices and locks that are connected to the fire alarm. Visual and functional checkboxes were not checked off. The list of each device inspected, their location, and whether they passed or failed was not filled out. During an interview on 10/11/24 at 5:00 PM, the US FOIA (b)(6) confirmed the finding and stated the facility was unable to locate the missing documentation of the annual test of the entire fire alarm system. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 345	Alram company and the MAintenance Director as to the requirement for a complete annual test on the alarm system and that the form must be completed entirely. The Manitenance Director will make sure that there are 3 quarterlies and 1 annual test per year. 4) the Maintenance Director will develop a QAPI to ensure compliance. MAintenance Director will check the completion of the documentation of the alarm tests on a quarterly basis for one year. The results of the QAPI will be reviewed with the QAPI Committee at the QAPI meeting which takes place at a minimum on a quarterly basis.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		11/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING 01 B. WING _____	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 6 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all 172 residents. Findings include: An observation on 10/11/24 at 11:05 AM of the sprinkler head located in the Soiled Linen Room by Room 99 revealed the escutcheon plate was missing. An observation on 10/11/24 at 1:25 PM of the sprinkler head located in the Kitchen by the ice machine revealed the escutcheon plate was missing. During an interview at the time of each observation, the US FOIA (b)(6) confirmed the findings and stated the facility was unaware the escutcheon plates were missing. A review of the facility's sprinkler inspection and test reports revealed the quarterly inspection for the second quarter of 2024 was missing. Quarterly inspections conducted on 09/10/24, 03/15/24 and 12/19/23 by [Contract Company] were available for review. During an interview on 10/11/24 at 4:45 PM, the US FOIA (b)(6) confirmed the findings and stated the facility was unable to locate the	K 353	1) The Maintenance Director will replace the missing escutcheon plate in soiled linen room by room 99 and in the kitchen by the ice machine. The Maintenance Director has located the missing 2nd Quarter sprinkler Inspection documentation and has filed it in the Inspection book which is kept in the Maintenance Shop. A monthly monitoring tool was set up to document monthly inspections of sprinkler gauges. 2) All residents and staff can be affected by this deficient practice 3) The administrator will in-service the Maintenance Department about the requirement to have monthly inspections of the sprinkler gauges and to maintain the sprinkler system in accordance with NFPA 25. Included in the in-service will be specific instructions on checking and ensuring that the Escutcheon plates are in place and that there a 4 quarterly tests on the sprinkler system and that documentation is kept in an accessible binder for immediate inspection. The Maintenance Director will add the inspection of this documentation and the Escutcheon Plates to the preventative Maintenance program monthly and will assign a technician from the maintenance department to check the sprinkler heads monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 7 missing quarterly inspection. A review of the facility's sprinkler maintenance records revealed no documented evidence of the monthly inspections of the sprinkler gauges. During an interview on 10/11/24 at 4:45 PM, the US FOIA (b)(6) confirmed the finding and stated the facility did not conduct monthly inspection of the gauges. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	4)The Maintenance Director will develop a QAPI to monitor/audit compliance. The Maintenance Director will audit weekly for one month and then monthly for six months to ensure that the facility is compliant. The results of the QAPI will be reviewed at the Quarterly/QAPI Committee meeting.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		12/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 8 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 19.3.6.3. The deficient practice had the potential to affect 172 residents. Findings include: Observations on 10/11/24 between 11:07 AM and 11:22 AM revealed the following corridor doors on the second level were hitting the door frame and failed to latch: Room 106 Staff Break Room Room 119 Observations on 10/11/24 between 12:00 PM and 1:17 PM revealed the following corridor doors on the first level were hitting the door frame and failed to positive latch:	K 363	1) All of the rooms noted in the deficiency will be equipped with doors that close and latch properly. Each one of the doors will be worked on by the maintenance team being led by the Maintenance Director. The TEAM will attempt to fix every door noted to close and latch properly. In the event that a door is in disrepair, Leisure Chateau will purchase a new door for that room. The assistant administrator has already contacted a door vendor to ascertain the availiblity and procedure for ordering new doors if necessary. The vendor is MD Door out of Brooklyn NY. The vendor sent the Assistant Administrator exact measuring instructions for accurate ordering. 2) All residents residing on these affected units can be affected by this deficient practice. 3) The Administrator will In-Service the Maintenance Department about the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 9 Room 38 Room 40 Room 53 Room 56 Room 59 Room 70 Room 80 Room 88 Room 89 Room 92 Rehab Door in California Wing Room 203 Room 205 Room 229 Room 239 Room 241 Room 243 Room 251 During an interview at the time of the observations, the US FOIA (b)(6) confirmed the doors failed to close and latch. He stated the facility was unaware the doors were hitting the door frame prior to the survey. NJAC 8:39-31.2(e)	K 363	requirement that a facility must ensure that corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 19.3.6.3. The Maintenance Director will Add this to the monthly Preventative Maintenance checklist and will inservice the Maintenance Staff on the updated checklist. 4) The Maintenance Director will AUDIT the above for compliance. The Maintenance Director will Audit monthly for 6 months by checking that ALL corridor doors are being checked on a monthly basis by the maintenance department. The Maintenance Director will also randomly select 10 doors on a monthly basis for 6 months to check that they are closing properly. The results of the Audits will be reviewed at the QAPI Committee meetings held at a minimum on a quarterly basis.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for	K 372		11/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 10 smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 172 residents who resided at the facility. Findings include: An observation on 10/11/24 at 10:53 AM of the smoke barrier located by Room 104 revealed a two-inch unsealed gap in the top of the wall at the metal deck joint above the corridor smoke doors. Also observed in this area was an unsealed five-inch overcut around a group of wires. An observation on 10/11/24 at 12:05 PM of the smoke barrier located by the Dayroom near Room 69 revealed an unsealed three-inch overcut around a conduit penetration. Observations on 10/11/24 at 12:16 PM of the smoke barrier located by the Lobby and Physician's Office revealed the following: - Five-inch overcut around a conduit penetration above the ceiling and pull station. - Eight-inch overcut around a conduit penetration above the ceiling and strobe light.	K 372	Leisure Chateau Maintenance Department will ensure that penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101Life Safety Code (2012 Edition) Sections8.5.6.1 and 8.5.6. 2. 1) The Assistant Administrator consulted with a technician in the maintenance department trained in the use of Fire Stop Systems. The technician advised the Assistant Administrator on the Correct Fire Block material foam spray to properly block all the noted penetrations cited in this deficiency. The assistant administrator purchased the materials necessary for the blocking of all the noted penetrations. 2) All residents residing in the facility can be affected by this deficient practice. 3) the Administrator will In-Service the Maintenance Department on the importance of ensuring that smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 11 - In the corner of the wall by the Lobby and smoke doors, an unsealed ten-inch gap in the wall was observed above the ceiling. - Three-inch overcut around a wire penetration located above the ceiling and smoke doors. - Two-inch overcut around a pipe penetration above the ceiling and smoke doors. An observation on 10/11/24 at 12:25 PM of the smoke barrier located between the Conference Room and Courtyard revealed a two-inch unsealed overcut around a conduit penetration above the ceiling. An observation on 10/11/24 at 12:31 PM of the smoke barrier located at Room 64 revealed an eight-inch overcut left of the ductwork penetration. Also observed was a fire damper, not a smoke damper, located above the ceiling tile. The duct was open to the corridor on both sides of the smoke wall. The doors did not have fire rated door hardware but were smoke resistant. An observation on 02/09/24 at 12:46 PM of the smoke barrier located by Room 50 revealed a two-inch unsealed gap along the top of the wall at the metal deck above the corridor smoke doors and ceiling tile. An observation on 02/09/24 at 12:53 PM of the smoke barrier located by the Nurses' Station by the 700 Hall revealed a four-inch unsealed overcut around wire penetrations above the corridor smoke doors and ceiling tile. An observation on 02/09/24 at 1:06 PM of the smoke barrier located by Room 235 revealed a two-inch unsealed gap along the top of the wall at the metal deck above the corridor smoke doors	K 372	8.5.6.1 and8.5.6. 2. - The In-service will include a specific requirement that when outside vendors are called in to do electrical work or low voltage work such as fire alarms or telephone or internet, the MaintenanceK37211 Department must immediately follow the vendors work and ensure that any penetrations left are corrected with the proper fire block system. 4) The Maintenance Director will keep a log of all such work that is done either by the maintenance department of an outside vendor. The maintenance director will Audit this log on a monthly basis for 6 months and check that penetrations were properly blocked. The Results of these Audits will be reviewed by the QAPI committee on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 12 and ceiling tile. During an interview at the time of the observations, the [US FOIA (b)(6)] confirmed the findings and stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers prior to the survey.	K 372		
K 918 SS=F	NJAC 8:39-31.1(c), 31.2(e) Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		11/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING 01 B. WING _____	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 13 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the generator in accordance with NFPA 110 Emergency Power and Standby Power Systems (2010 Edition), Section 8. This deficient practice had the potential to affect all 172 residents. Findings include: A review of the facility's "Generator Inspection & Testing Records" revealed documentation of the monthly tests under load of the diesel generator were missing for September 2024. The most recent generator test was conducted on 08/17/24. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and stated the facility was unaware of they had missed the monthly test prior to the survey. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	1) The US FOIA (b)(6) will be disciplined and re-educated on the requirement to properly test under load and properly document that the generator transfers power within the 10 seconds. The tests must take place within the required time frame 12 times a year in 20-40 day intervals. 2) all residents can be affected by thisdeficient practice 3) The administrator will in-service the US FOIA (b)(6) and the mainenace director will inservice the entire maintenance department about the requirement to exercise the emergency generator 12 times each year for at least 30 minutes in 20- to 40-day intervals; and document the time needed by the generator to transfer power to the building was within the 10-second time frame inaccordance National Fire Protection Association (NFPA)110. 4) The Assistant Administrator or his designee will conduct monthly audits of the generator testing documentation for 6 months to ensure compliance and will submit the audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**10/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 14	K 918	made regarding any adjustments and the need for continued submission and reporting	

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
315190 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

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 K0224	11/30/2024	LSC K0321	11/30/2024	LSC K0345	11/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	11/30/2024	LSC K0363	12/20/2024	LSC K0372	11/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	11/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
10/11/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO