STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING _____ B. WING _____	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 12/6/2022 Census:107 Sample: 27 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		12/12/22

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

Electronically Signed | 12/30/2022

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

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. 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 ensure that the residents' dining experience was provided in a manner to promote the dignity and respect of the residents, by a) staff not sitting while feeding a resident and b) residents who were not served their meal at the same time while seated at the same table. This deficient practice was observed for 7 of 27 residents reviewed for dining (Resident # 56, Resident #91 and 5 unsampled Residents). This deficient practice was evidenced by the following: On 11/16/2022 at 12:45 PM, during the initial	F 550	The RN was educated on the proper way of feeding residents, ensuring she is at eye level with the resident. All staff that have the potential to pass out meal trays were educated to ensure all participants at each table are given meal at the same time. A seating chart was created to make sure the trays from each table are delivered together. All residents have the potential to be affected. All staff including nursing, activities, and administration were educated on the	

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F 550	Continued From page 2 lunch meal observation on the 3rd floor dining room, the surveyor observed the following: 1. A staff member who identified herself as a Registered Nurse (RN) #1, was observed standing over an unsampled resident while assisting him/her to eat. The RN was not at eye level with the resident while assisting him/her to eat. RN #1 was also overheard to call the resident "honey" while assisting with eating. 2. The surveyor observed a table of four residents in the back of the dining area. One of the residents had completed their lunch meal, one resident was actively eating. Resident # 56 and Resident #91 were sitting at the same table talking to each other without a lunch meal or fluids in front of them. When questioned by the surveyor if they had eaten their lunch, Resident # 56 and Resident # 91 said they had not yet received their meal. Resident # 91 said everybody else is eating except us. The residents received their tray's 15 minutes later. On 11/16/2022 at 1:01 PM, a staff was observed to pour Resident #56 and Resident #91 water and both the residents were heard complaining that "they are always last to be served." On 11/17/2022 at 1:12 PM, during the 3rd floor lunch meal observation, the surveyor observed a table in middle room with five residents seated at the table. One resident (unsampled) had his/her tray and was actively eating, and the other 4 residents had not been served their lunch meal. An unsampled resident who was not eating was observed to be looking at the resident who was eating and asked, "When am I going to eat."	F 550	proper way to serve and feed residents in a dignified manner. Ensuring when you are feeding a resident that you are at eye level with the resident and not standing above. Ensuring all participants at each table are given meal at the same time. The administrator or designee will do weekly audits x12weeks ensuring all residents are being served in a dignified manner. The contents of the audit above will be reported by the administrator or his designee and reviewed at the quarterly QA meeting with suggested recommendations made by the committee. It will be determined if the need for continuing auditing is warranted.	

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F 550	Continued From page 3 On 11/17/2022 at 1:15 PM, the 2nd of 3 food carts arrived, and the other residents were served their meal. During an interview with the surveyor on 11/22/2022 at 9:23 AM, Licensed Practical Nurse (LPN #1) said it is nursing's opinion and resident right if they want to eat with others in the dining room or in their rooms. Residents at higher risk for altered diets, aspiration or assist with feeding eat in the dining room. LPN #1 went on to say the family is included in the decision where it is best for residents to eat their meals. LPN#1 further explained that the process was nursing will notify dietary if a resident wants to change where they eat. When questioned by the surveyor on how trays are set up on the carts LPN #1 said, "The trays are set up on carts based on whether the resident eats in the dining room or chooses to eat in their room." During an interview with the surveyor on 11/22/2022 at 11:03 AM, the Food Service Director (FSD) said "We have been doing tray service on the 3rd floor for approximately 7 months. Nursing and the Registered Dietician are responsible for alerting the FSD of changes in resident attendance and changing/manipulating tickets for the dining room. The FSD went on to say that "two services in advance would be the best timeframe to be notified but that's not always the case. We adjust as needed. " During an interview with the surveyor on 11/23/2022 at 10:10 AM, the Unit Manager/Licensed Practical Nurse (UM/LPN #1) said, "Ideally a resident can eat where they want, and I keep those that need to be fed together. We as a team pass trays in the dining room. We try to	F 550		

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F 550	Continued From page 4	F 550		

serve everybody at same table together and the dining room trays come to the unit before the room trays." UM/LPN #1 said "No, there was never a time that residents who sit at same table are not fed at the same time." She went on to say the kitchen has a list of who sits at which table and send trays accordingly. All residents' trays for the same table should come on the same food truck. If they don't come on the same truck, and ideally, they should come together, we don't hold the tray's that have come as we don't want the food to get cold. We would serve trays that are on the first truck to residents who are sitting at the table and after the 2nd truck we would serve the others seated at the table.

During an interview with the surveyor on 11/23/22 at 10:58 AM, the Registered Dietician (RD) said, "We try our very best to put trays in an order to be given out table by table. There is a list and the person I have puts the trays in order based on the list. The RD went on to say that all the tables meal trays ideally are on the same truck but are probably not always on the same truck. The RD went on to say dietary is notified through the unit manager or activity staff if residents change tables. The RD said, "Yes all residents at same table should be served at same time."

During an interview with the surveyor on 11/28/2022 at 1:19 PM, the facility Administrator said everyone at the table should be fed their meal at the same time. The surveyor then asked what if the table has resident trays split between carts? The Administrator said, "we should make sure that the trays for a full table are on the same food truck."

The facility was unable to provide a dining policy.

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F 550	Continued From page 5 8:39-4.1(a)(12)	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to: a.) obtain a physician's order for a resident to self-administer medication, and b.) periodically assess the resident's ability to safely self-administer medication. This deficient practice was identified for 1 of 27 sampled residents, (Resident #69) and was evidenced by the following: On 11/16/2022 at 10:10 AM, the surveyor observed Resident #69 sitting on the edge of the bed. The surveyor observed an [redacted] on the resident's bed. Resident #69 confirmed that the they are permitted to keep the [redacted] with them at all times. On 11/21/2022 at 11:57 AM, the surveyor interviewed Resident #69 regarding the [redacted] usage. When asked if the facility completed any assessment for determine if she was able to keep the medication, Resident #69 responded, I don't remember if they did any type of an assessment. On 11/23/2022 at 10:12 AM, the surveyor observed Resident #69 seated at the edge of the	F 554	A self-administration of medication evaluation was completed, IDT met to review and determined the resident was clinically appropriate to self-administer the albuterol inhaler. Order received from the doctor and care plan updated to reflect the above. All residents have the potential to be affected. An audit was completed for all resident who are self-administering medication with no additional concerns. Education completed with all nurses on proper determination for residents to self-administer medication. The Director of Nursing or designee will audit quarterly all residents that are self-administering medication. The contents of the audit above will be reported by the Director of Nursing or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee. It will be determined if the need for continuing auditing is warranted.	12/12/22

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F 554	Continued From page 6	F 554		

bed with [redacted] in hand.

According to the Admission Record, Resident #69 was admitted to the facility with diagnoses which included but were not limited to; [redacted]

A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 10/27/2022, revealed a Brief Interview for Mental Status score of [redacted]/15, indicating Resident #69 is [redacted].

A review of the physician orders on 11/17/2022 at 1:07 PM, did not include any physician orders that the medication was to remain at bedside and that the resident is approved to self administer.

A review of the Medication Administration Record (MAR) dated 11/1/2022- 11/30/2022, revealed the physician order for [redacted] one time a day for [redacted] the mouth after each use, with initials indicating the medication had been administered.

A review of the resident's care plan with an initiated date of 6/10/2022, indicated Resident #69 had had [redacted] related to [redacted], sitting still, and cannot lay flat. Interventions included, but were not limited to, administer my medications per physicians order, and provide me with [redacted] or [redacted] per physicians orders. The care plan did not identify the resident as safe and approved to self-administer medications or keep medication

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F 554	Continued From page 7 at bedside. During an interview with the surveyor on 11/23/2022 at 09:57 AM, Certified Nursing Assistant (CNA #2) stated that bedside medications are not permitted and the nurse is supposed to take it. During an interview with the surveyor on 11/23/2022 at 10:20 AM, the assigned Registered Nurse (RN #2) stated that bedside medications are not permitted, unless it states that they self-administered in the orders (physician) itself. It would be in the care plan as well. RN #2 went on to say I do not see it on the orders. I'm curious if it is on her care plan. RN #2 then reviewed the resident's care plan and said It's not there either. During an interview with the surveyor on 11/23/2022 at 10:56 AM, the assigned Unit Manager/Licensed Practical Nurse (UM/LPN #2) stated that bedside medications, have to have a doctor's order and a care plan. I will check to see if there is an assessment. When asked if the orders are missing for self administration, UMLPN#2 responded, it's...yea. During an interview with the surveyor on 11/28/2022 at 1:05 PM, the Director of Nursing (DON) reported that medications at bedside are permitted if there is a care plan and doctor orders. When asked what steps are required for a resident to be deemed safe to self administer and the DON responded, an evaluation. When asked how the medication is to be stored at beside, the DON responded, probably locked. When asked if an Interdisciplinary Team meeting is required according to the policy, the DON responded, I would have to look at the policy.	F 554		

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F 554	Continued From page 8 A review of an undated Facility Policy titled Administering Medication-Version 2.0 (H5MAPL0028), revealed under the Policy Interpretation and Implementation section: #27- Residents may self-administer their own medication only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. A review of an undated Facility Policy titled Self-Administration of Medications Version 2.0 (H5MAPL0812), revealed under the Policy Interpretation and Implementation section: #2. The IDT considers the following following factors when determining whether self-administration of medications is safe and appropriate for the resident: a. The medication is appropriate for self-administration. b. The resident is able to read and understand medications labels. c. The resident can follow directions and tell time to know when to take the medication d. The resident comprehends the medication's purpose, proper dosage, timing, signs of the side effects and when to report these to the staff. e. The resident has the physical capacity to open medication bottles, remove medications from a container and to ingest and swallow (or otherwise administer) the medication and f. The resident is able to safely and securely store the medication 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely	F 554		

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F 554	Continued From page 9 self-administer medications is assessed periodically based on changes in the resident's medical and/or decision-making status. 7. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medication of residents permitted to self-administer are stored on a central medication cart or in the medications room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. 8. Any medications found at the beside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible.	F 554		
F 623 SS=C	NJAC 8:39-29.2(c), 6(d) Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		12/12/22

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F 623	Continued From page 10 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623		

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F 623	Continued From page 11 completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §	F 623		

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F 623	Continued From page 12 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to notify in writing the representative of the New Jersey Long-Term Care Ombudsman's office of emergency transfers to the hospital, when practicable, as mandated by Federal law. This deficient practice was evidenced by the following: During an interview with the surveyor on 11/28/2022 at 9:41 AM, the Director of Admission when asked who is responsible for notifying the ombudsman of a facility-initiated emergency transfer to the hospital stated, "not sure, I would think the social worker." During an interview with the surveyor on 11/28/2022 at 9:46 AM, the social worker when asked who is responsible for notifying the ombudsman of a facility-initiated emergency transfer to the hospital, stated, "I'm not sure. I have to double check on that." During an interview with the surveyor on 11/28/2022 1:01 PM, the Administrator stated, "It should have been done, there may have been a gap." He further stated, "I do not know how long it has not been done." During a follow up interview with the surveyor on 11/29/22 at 10:31 AM, the Administrator stated that as far as I know, it hasn't been done since December of 2021. He further said that the social worker is responsible for notifying the ombudsman and she was educated regarding	F 623	A list of all transfers and discharges dating 12/1/21 to current, was faxed over to the Office of the Long-Term Care Ombudsman. All residents can be affected. The Social Worker was educated on proper notification to the Office of the Long-Term Care Ombudsman. The administrator or designee will audit 5 (or all if less than 5) transfer/discharges per week x4 weeks to ensure proper notifications were made to the appropriate parties. Then monthly x4 months. The contents of the audit above will be reported by the administrator or his designee and reviewed at the quarterly QA meeting with suggested recommendations made by the committee.	

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	315218	A. BUILDING _____ B. WING _____	12/06/2022

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F 623	Continued From page 13 that process. A review of an undated facility policy titled Transfer or Discharge Notice, revealed under "Policy Statement" Residents and/or representatives are notified in writing ... Under the Policy Interpretation and Implementation heading ...6. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman. ..."	F 623		
F 656 SS=D	NJAC 8:39-4.1(a) 32 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		12/12/22

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F 656	Continued From page 14 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to develop a person-centered comprehensive care plan to address the use of Ex Order 26. 4B1 Ex Order 26. 4B1 for 1 of 5 Residents (Resident #102) reviewed for unnecessary medication. This deficient practice was evidenced by the following: On 11/17/2022 at 12:51 PM, Resident # 102 was observed in his/her room sitting in a chair and was non-verbal.	F 656	Resident #102 comprehensive care plan was updated to include her/his plan of care regarding her/his diagnosis of Ex Order 26. 4B1 and Ex Order 26. 4B1. All residents can be affected. The nursing staff was educated on implementing and maintaining a comprehensive care plan for all residents. Facility completed a facility wide audit to determine if any other Ex Order 26. 4B1 residents were missing a comprehensive plan of care regarding their diagnosis of Ex Order 26. 4B1 and Ex Order 26. 4B1, with no negative findings. The Director of Nursing or designee will audit x4 residents monthly x 3 months,	

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F 656	Continued From page 15 A review of the Admission Record revealed Resident # 102 was admitted to the facility with diagnoses including but not limited to; Ex Order 26. 4B1 [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate care dated 10/27/2022, revealed Resident # 102 had a Brief Interview for Mental Status score of Ex.Ord/15 indicating Resident # 102 had Ex Order 26. 4B1 [redacted]. Further review revealed Resident # 102 received Ex Order 26. 4B1 [redacted] of the prior [redacted]. A review of the current Order Summary Report on 11/17/2022 revealed an order for Ex Order 26. 4B1 [redacted] two times a day for Ex Order 26. 4B1. An additional order for Ex Order 26. 4B1 medication was listed as follows: Ex.Order 26.4(b)(1) [redacted] FOR Ex Order 26. [redacted] GREATER THEN Ex.Order 26.4(b)(1) [redacted] A review of Resident # 102's care plan on 11/17/2022 revealed that there was no care plan in place regarding Resident # 102's Ex Order 26. 4B1 and Ex Order 26. 4B1. During an interview with the surveyor on 11/22/2022 at 9:15 AM, Licensed Practical Nurse (LPN) #1 said that nursing does the care plans,	F 656	ensuring they have a comprehensive care plan. The contents of the audit above will be reported by the Director of Nursing or designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee. It will be determined if the need for continuing auditing is warranted	

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F 656	Continued From page 16	F 656		

and during care conference Social Services, dietary and nursing update care plans. LPN #1 went on to say that the initial care plan includes skin, pain, falls, risk for rehospitalization, and code status. LPN #1 further said that any major co-morbidities (a disease or medical condition that is simultaneously present with another or others) would also be on the care plan. When asked what the expectation would be for a resident with diabetes, LPN #1 said, "Yes, if the resident is diabetic the expectation would be to have a care plan in place for diabetes." The surveyor requested LPN #1 to review Resident # 102's care plan for a diabetes/insulin Focus area. LPN #1 reviewed the care plan and she stated, "No but he/she will."

During an interview with the Director of Nursing (DON) on 11/28/2022 at 1:23 PM, the DON said I believe the MDS coordinator and Unit Managers initiate the baseline care plan upon admission. The DON further said that the baseline care plan would include falls, skin, pain, Activities of Daily Living, and advanced directive. When asked what the expectation is if a resident is diabetic and on insulin the DON said, "I would expect to see a care plan for a resident who is diabetic and on insulin."

A review of a facility policy with a Version date of October 2022, titled Care Plans, Comprehensive Person-Centered, revealed the following under the Policy Interpretation and Implementation section 3:
"The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy also indicated 7. ...e. "reflects currently recognized standards of practices for problem

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F 656	Continued From page 17 areas and conditions." 8:39-11.2(d)	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to promote an accident free environment by not conducting quarterly smoking assessments. This deficient practice was identified for 1 of 1 resident reviewed for smoking, (Residents #50). This deficient practice was evidenced by the following: On 11/16/2022 at 12:27 PM, the surveyor observed Resident #50 sitting outside on the second floor balcony smoking area with staff nearby observing. On 11/17/2022 at 12:14 PM, the surveyor observed Resident #50 standing outside with cigarette. Resident independently extinguished cigarette and placed in proper receptacle. According to the Admission Record, Resident # 50 was admitted to the facility with diagnoses which included but were not limited to; [redacted]	F 689	Resident #50 last received a smoking evaluation and assessment on [redacted], the resident is currently up to date with a smoking evaluation and assessment. All nursing staff were educated on ensuring a smoking evaluation and assessment is completed quarterly. All residents that smoke can be affected. Facility completed a facility wide audit to determine if any other smoking residents were missing quarterly assessments. No negative findings. The administrator or designee will conduct quarterly audits will be conducted on all resident that smoke ensuring a proper evaluation and assessment. The contents of the audit above will be reported by the administrator or his designee and reviewed at the quarterly QA meeting recommendations made by the committee. It will be determined if the need for continuing auditing is warranted	12/12/22

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F 689	Continued From page 18 Ex Order 26. 4B1 and Ex Order 26. 4B1 following Ex Order 26. 4B1 . A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 7/27/2022, identified the resident as tobacco user. A review of Resident #50's care plan identified a smoking safety concern. Interventions included but were not limited to, adhering to smoking policy and smoking in designated smoking area. A review of Resident #50's medical record revealed a completed: Ex.Order 26.4(b)(1) During an interview with the surveyor on 11/23/2022 at 10:20 AM, the assigned Registered Nurse (RN #2) stated residents should have smoking assessments upon admission and care planned accordingly. When asked if there is a routine assessment for smoking safety, RN#2 responded the Unit Manager completes the assessment. During an interview with the surveyor on 11/23/2022 at 10:56 AM, the assigned Unit Manager/Licensed Practical Nurse (UM/LPN #2) confirmed that the two latest smoking evaluations are 11/3/22 and 4/13/22. UM/LPN#2 stated that smoking assessments are required upon admission and quarterly. During an interview with the surveyor on 11/28/2022 at 1:05 PM, the Director of Nursing	F 689		

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F 689	Continued From page 19 (DON) reported that smoking assessments are to be conducted in a timely manner upon admission, every quarter, and as needed. The DON also confirmed that there should have more than two assessments completed within 2022. A review of two facility undated policies titled Smoking Policy-Residents Version 2.0 (H5MAPI0828) revealed under Policy #8 and #9, that, a resident's ability to smoke safely will be re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff. NJAC 8:39-33.1(d)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		12/12/22

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F 690	Continued From page 20 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to to ensure the *Ex Order 26. 4B1* did not come into contact of the floor. The deficient practice was observed for 1 (Resident #7) of 2 residents reviewed for *Ex Order 26. 4B1*. This deficient practice was evidenced by the following: On 11/16/2022 at 9:50 AM during the initial tour of the facility, the surveyor observed Resident #7 in their wheelchair. Underneath the wheelchair was a *Ex Order 26. 4B1* and *Ex Order 26. 4B1* attached to the wheelchair. The *Ex Order 26. 4B1* was in contact with the floor as Resident #7 propelled themselves in the *Ex Order 26. 4B1*. On 11/17/2022 at 12:38 PM, during an interview with the surveyor, Resident #7 confirmed they had a *Ex Order 26. 4B1*. At that time, the surveyor observed the *Ex Order 26. 4B1* and *Ex Order 26. 4B1* in	F 690	Resident #7 *Ex Order 26. 4B1* was placed higher on the wheelchair to avoid coming in contact with the floor. All residents with *Ex Order 26. 4B1* can be affected. All nursing staff was educated on ensuring proper placement of *Ex Order 26. 4B1*. Facility completed a facility wide audit of all residents utilizing a *Ex Order 26. 4B1*, ensuring proper placement. The administrator or designee will conduct weekly audits x12 weeks on x4 residents, utilizing urinary drainage collection bags, ensuring proper placement. The contents of the audit above will be reported by the administrator or his designee and reviewed at the quarterly QA meeting with suggested recommendations by the committee. It will be determined if the need for continuing auditing is warranted	

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F 690	Continued From page 21 contact with the floor. On 11/18/22 at 8:57 AM, the surveyor observed Resident #7's Ex Order 26. 4B1 Ex Order 26. 4B1 in contact with the floor as it hung from their wheelchair. A review of the Electronic Medical Record (EMR) revealed that Resident #7 had a diagnosis of but not limited to Ex Order 26. 4B1 and Ex Order 26. 4B1 . A review of the 9/25/2022 quarterly Minimum Data Set (an assessment tool) in the electronic medical record (EMR) revealed the Resident #7 had a Brief Interview for Mental Status (cognitive assessment score) of Ex.Ord, indicating Resident #7 had Ex.Orde Ex Order 26. 4B1 . A review of the EMR under "Orders" revealed a physician's order for catheter care. A review of the EMR under "Care Plan" confirmed Resident #7 had a Ex Order 26. 4B1 . On 11/28/22 at 1:01 PM, during an interview with the surveyor, the Director of Risk Management stated the Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) should be off the floor. A review of an undated facility policy titled, "Catheter Care, Urinary" under section "Infection Control" number 2 revealed, "Be sure the catheter tubing and drainage bag are kept off the floor."	F 690		
F 812 SS=E	NJAC 8:39-19.4(a) Food Procurement,Store/Prepare/Serve-Sanitary	F 812		1/5/23

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F 812	Continued From page 22 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 other facility documentation, it was determined that the facility failed to maintain the kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 11/16/2022 from 9:03 to 9:43 AM the surveyor's, accompanied by the facility Food Service Director (FSD) and Registered Dietitian (RD) observed the following in the kitchen: 1. On a lower shelf, a plastic container contained bags of individually opened pasta. (3) individual bags of opened pasta wrapped in plastic wrap had no open or use by dates. (1) bag of pasta	F 812	The open bag of pasta was discarded. The open box of plastic forks exposed to possible contamination was discarded. The open bag of shredded cheese dated 11/9/22 was discarded. The deli turkey received on 11/2 with no use by date was discarded. The open container of beans with open date of 11/9 and use by 11/12, was discarded. The open container of black olives that was exposed to possible contamination was discarded. The frozen spinach and the frozen corn that was not dated were discarded. The ice machine in the 3rd floor nourishment room was thoroughly cleaned ensuring not dirt. The red bucket next to the 3 compartment was	

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F 812	Continued From page 23 was opened and exposed to the air. On interview the FSD stated "They should be labeled with an opened and use by date." 2. On a middle shelf in the designated dry storage room, an opened cardboard box of plastic forks used to serve resident's meals was opened and the plastic bag that contained the forks on the interior of the box was also open. The forks were exposed to the air and contamination. When interviewed the FSD was unaware that the opened and exposed forks were an issue. 3. On a middle shelf of the walk-in refrigerator an opened bag of shredded cheese was wrapped in plastic wrap and had an open date of "11/9/22." The FSD stated that shredded cheese, once opened, was good for 3 days. The FSD removed the cheese to the trash. On a top shelf, an opened deli turkey wrapped in plastic wrap had a received by date of 11/02/2022. The turkey had no open or use by date. On interview the FSD said, "That should be dated for opened and use by." The FSD removed the deli turkey to the trash. On a middle shelf a clear, plastic container with a plastic lid contained beans. The container had an opened date on "11/09/2022" and used by "11/12/2022." The FSD stated, "It should have been thrown away on the 12th." The beans were removed to the trash. On an upper shelf a plastic container contained black olives. The container lid was open and allowed the olives to be exposed to the air. 4. In the walk-in freezer on a middle shelf a bag of frozen spinach was removed from its original container. The bag had no dates. The FSD said, "That should be dated." On a lower shelf an opened bag of frozen corn was wrapped in plastic	F 812	immediately removed and taken out of service. The bowls and plates that were exposed were rewashed and stored properly. The pan with west nesting was immediately rewashed. The 2 dietary aides and 1 cook, readjusted their hairnets immediately to include all the hairs on their head. The All residents can be affected. The Food Service Director and dietary staff were educated on proper labeling and dating of food items. The Food Service Director and dietary staff were educated on prospering storing of open items ensuring they are not exposed to possible contamination. The Food Service Director was educated on proper cleaning of the ice machine and maintaining a regular cleaning schedule. The Food Service Director and dietary staff were educated on the proper sanitization of dishes with the use of sanitization liquid. The Food Service Director and dietary staff were educated on utilization of hair nets ensuring all hair is properly covered. The Food Service Director and dietary staff were educated on safe serving temperatures for resident food. The purchasing department is actively working on an order for Pellet Warmers that would ensure the food that is leaving the main kitchen is holding the correct temperatures throughout the process. In the interim the facility will be returning to a previous applied process of point of service dining to ensure proper serving temperatures. Meals will be delivered to all residents directly from each unit's	

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F 812	Continued From page 24 wrap. The bag had no open or use by dates. The FSD stated, "It's garbage." On 11/18/2022 from 11:55 AM to 12:16 PM the surveyors, accompanied by the Licensed Practical Nurse (LPN#2), observed the following on the 3rd floor Nourishment Room: 1. The surveyor observed the ice machine in the 3rd floor nourishment room. The machine was observed to be dripping from the ice dispenser into the drip pan below where cups or containers would be placed to collect ice. The drip pan and drip pan grate were coated with a white unidentified substance. The wall/backsplash of the ice machine just above the drip pan was observed to be coated with a brownish/white unidentified substance. The surveyor grabbed a hand towel from the available dispenser and proceeded to wipe the wall/backsplash of the ice machine above the drip pan in the presence of LPN #2. The hand towel was observed to be covered with a light brown, slimy substance. LPN#2 stated that maintenance cleans the ice machine monthly and the schedule attached to the ice machine revealed that the machine was due for service on 11/25/2022 and was last serviced on 10/23/2022. LPN#2 further stated that residents come into the nourishment room to get ice. LPN#2 then asked the surveyor if she wanted the surveyor to have somebody come and clean the machine. LPN#2 said that she thought housekeeping was responsible for the cleaning of the ice machine daily. A maintenance staff arrived at 12:10 PM and stated "This machine drips into the drip pan because it does not have an external hose to drain the condensate, so it drips into the drip pan. I'm going to do the maintenance cleaning today since it's close to the due date	F 812	kitchenettes located in the dining rooms. The Food Service Director will temp trays x2 daily and the facility administrator will conduct a questionnaire daily x2 resident regarding the temperature and quality of food. The Food Service Director or designee will audit weekly x12, all the above items ensuring accuracy. The contents of the audit above will be reported by the Food Service Director or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations. It will be determined if the need for continuing auditing is warranted.	

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F 812	Continued From page 25 anyway. We (maintenance) don't clean it on a daily basis. That should be done by staff or housekeeping." On 11/22/2022 from 10:28 to 1105 AM the surveyors, accompanied by the FSD, observed the following in the kitchen: 1. A red bucket located on the shelf of 3 the compartment sink was identified by the FSD as being used for sanitizing work surfaces and various kitchen equipment and utilized quaternary ammonium compound (a class of chemicals with disinfecting properties to kill bacteria, viruses, and fungi). The bucket was 1/2 full of a clear liquid and contained a blue wash rag. The surveyor requested the FSD to obtain a test strip to measure for proper sanitizer chemical level. The FSD proceeded to obtain and tear off an approximate 2-inch strip of Hydrion (a simple, reliable, and economical means to measure the concentration of Quaternary sanitizers) test strip. The FSD inserted the test strip in the sanitizer for 10 seconds, as per manufacturer instructions. After 10 seconds the test strip was removed and compared to the colored chart on the test strip plastic container. The surveyors and FSD noted that the level was 0-100 PPM (parts per million). The FSD replied, "We usually change the buckets every 2 hours." The surveyor requested that the FSD perform a second test of the sanitizer for accuracy. The FSD again tore off an approximate 2-inch piece of test strip and dipped it into the sanitizer for 10 seconds, as per manufacturer instructions. The FSD removed the test strip after 10 seconds and again the test strip read between 0-100 ppm. The surveyor questioned the FSD if the sanitizer was at the appropriate recommended concentration to effectively	F 812		

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sanitize kitchen surfaces and equipment. The FSD responded, "No the sanitizer is not at the correct level for proper sanitizing. This was probably left out." The FSD agreed that the bucket of sanitizing solution needs to be at the proper ppm to be an effective sanitizer. A label attached to the red sanitizer bucket revealed that the sanitizer bucket was prepared on "8/22/2022" at "8:39 AM."

2. In the dessert prep area the surveyors observed a 3-level wire storage rack. The top and middle shelf were observed to have various stacks of small and large plates and small and medium bowls used for resident desserts, per staff. The bowls and plates were stored with the eating surface exposed and were not inverted or covered. The FSD stated, "They should be covered or inverted."

3. In the designated pot storage rack area of the kitchen the surveyors observed 2 stacks of 1/4 pans on an upper shelf were stacked on top of each other. The surveyor removed a top 1/4 pan off each of 2 stacks of 1/4 pans and observed a wet, watery substance in the presence of the FSD and Regional Director of Dining (RDOD). The surveyor and FSD agreed after touching the surface of the 1/4 pans that they were wet to the touch. This is known as wet nesting, which occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow. The RDOD removed the pans to be rewashed.

On 11/23/2022 from 12:34 to approximately 1:10 PM the surveyors, accompanied by the FSD and RDOD observed the following in and out of the

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F 812	Continued From page 27 kitchen: 1. Upon entry to the kitchen the surveyors observed the dessert position employee/dietary aide (DA) walk past the surveyors in the kitchen. The DA walked past, and the surveyors noticed that the staff had her hair in a bun and had braids extending down to the shoulder area. The DA then proceeded to go to the dessert prep area and prep food. The surveyor questioned the staff if she had a hairnet on. The staff stated, "I do have one." The DA then proceeded to say that it was on her "bun." The surveyor then explained that all the hair on the head must be encompassed within the hair net. The staff responded, "Ok" and proceeded to go to the front door to the kitchen and obtain a hair net. In addition, the staff at the starter position on the lunch tray-line had lengthy hair that extended down to the shoulders. The starter had a hair net that covered their hair and pony tail. The staff had hair that was not encompassed in the hair net that extended to the shoulder area and was unprotected from the hair net. Additional observation during the lunch tray line revealed that the cook had a baseball style hat on while plating resident meals. Closer observation revealed he had no hair net and had a lengthy portion of hair extend out of the back of the hat that was exposed. 2. The surveyor conducted a resident council meeting with 6 facility residents on 11/21/2022. During the meeting the 4 out of 6 residents present complained that they received cold food at mealtime. As a result of the resident's complaint on 11/23/2022 the surveyors conducted a test tray during the lunch meal to assess meal temperatures upon arrival to facility residents. At	F 812		

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F 812	Continued From page 28 12:59 PM, upon completion of the lunch tray line, the surveyors requested that the tray line starter assemble one additional regular meal tray that was to be put on the same meal delivery cart with the other resident trays and was designated to go to the 3rd floor. The test tray consisted of raviolis with vodka sauce, roasted carrots, garlic bread, and apple juice. This was the main meal for the lunch served on 11/23/2022. The surveyors had previously obtained food temperatures prior to tray line and the following temperatures were observed: Ravioli: 193 F Roasted Carrots: 163 F Vodka Sauce: 166 F The juice and coffee temperatures were not taken prior secondary to the juices observed to be kept on ice and coffee was observed to be poured directly from coffee machine. The requested the test tray was placed on the cart with the other resident lunch meals for the 3rd floor at 1:04 PM. This meal cart is the last meal cart to be delivered to residents at the lunch meal. The surveyors, accompanied by the FSD and RDOD escorted the meal cart from the kitchen at 1:04 PM and after utilizing the elevator the meal cart arrived on the 3rd floor at 1:07 PM. Upon arrival to the 3rd floor at 1:07 PM the 3rd floor staff immediately began to deliver resident meal trays and the last meal tray was delivered at 1:20 PM. At 1:20 PM the surveyors requested the FSD and RDOD remove the test tray from the meal cart and bring to the nursing station counter to take food temperatures. The RDOD utilized a digital thermometer to take food temperatures, the same thermometer that was utilized to take	F 812		

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food temperatures prior to the start of the lunch meal, as observed by the surveyor. The following food temperatures were observed:

Raviolis with Vodka Sauce: 118 F
Roasted Carrots: 109.6 F
Apple Juice: 54 F

The surveyor, after completion of the test tray food temperatures, asked the RDOD if he was familiar with the minimum serving temperatures for hot and cold foods. The RDOD said, "Hot food is 135 degrees and above and cold food should be 45 degrees or below." The "Danger Zone" for food temperatures is defined as between above 41 F and below 135 F, this is the temperature range in which disease causing bacteria grow best. While standing at the 3rd floor nursing station with the RDOD and FSD the surveyor asked the RDOD and FSD if they observed any issues with the assembled lunch meal tray. The RDOD stated, "The obvious problem is that we do not have the inserts for the pellets to help keep the food warm." The surveyor asked the RDOD if he meant the heated metal insert that is a component of the pellet system. The RDOD stated, "Yes." The RDOD further explained that they do not have the metal inserts at this facility but other sister facilities do have them. The RDOD explained that previously the facility served meals from the kitchenettes located on the floors and the food would be plated in the kitchenette and distributed to residents in the dining room. In addition, residents who chose to eat in their rooms would have their tray assembled in the kitchenette and then immediately distributed to resident rooms via tray. The RDOD explained that they had no previous need for the metal inserts because the food was

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being immediately delivered to residents with minimal delay. The RDOD and FSD agreed that it was possible that food would lose heat from time of being assembled in the main kitchen and the time the tray is received by residents on the floors due to the unavailability of the heated metal insert for the pellet system. The pellet system holds heat at its core to keep hot foods at safe temperatures for over an hour.

The surveyor reviewed a facility policy titled Preventing Foodborne Illness - Food Handling, undated. The following was revealed under the heading Policy Interpretation and Implementation section:

1. This facility recognizes that the critical factors implicated in foodborne illness are:

b. inadequate cooking and proper holding temperatures.

The surveyor reviewed a facility policy titled Food Receiving and Storage, undated. The following was revealed under the heading Policy Interpretation and Implementation section:

8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date).

The surveyor reviewed a facility policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, undated. The following was revealed under the heading Policy Interpretation and Implementation section:

12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed

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F 812	Continued From page 31 food, clean equipment, utensils, and linens. The surveyor reviewed a facility policy titled Sanitization, undated. The following was revealed under the heading Policy Interpretation and Implementation section: 4. Sanitizing of the environmental surfaces and utensils must be performed with one of the following solutions: b. 150-200 ppm quaternary ammonium compound (QAC). NJAC 8:39-17.2(g)	F 812		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to monitor antibiotic use for 1 of 2 residents (Resident #59) reviewed for antibiotic use and Antibiotic Stewardship. This deficient practice was evidenced by the following: According to the Admission record, Resident #59 was admitted to the facility with diagnoses that	F 881	The [redacted] that was being given to resident #59 was reviewed with the doctor and discontinued. All residents can be affected. The Infection Prevention Nurse was educated on Ex.Order 26.4(b)(1) and monitoring all residents prescribed Ex.Order 26.4(b)(1) A audit was completed on all residents	12/12/22

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F 881	Continued From page 32 included but were not limited to: Ex Order 26. 4B1 [redacted], and Ex Order 26. 4B1 [redacted]. A review of Resident #59's Order Summary Report revealed that Resident #59 had the following order: Ex Order 26. 4B1 [redacted]. It is often caused by Ex.Order 26.4(b)(1) and is usually accompanied by Ex Order 26. 4B1 [redacted] with an order date of Ex Order 26. 4B1. According to the Significant Change in Status Minimum Data Set (MDS), an assessment tool, dated 11/7/2022 Resident #59 had a Brief Interview for Mental Status score of [redacted], indicating Ex Order 26. 4B1 [redacted]. Section H of the MDS revealed Resident #59 was frequently Ex Order 26. 4B1 [redacted]. Section I of the MDS revealed that Resident #59 had no Ex Order 26. 4B1 [redacted] in the past 30 days and section N revealed that Resident #59 had received Ex Order 26. 4B1 [redacted] 3 times in the last 7 days of the assessment period. A review of Resident #59's comprehensive care plan with an initiated date of 5/24/2022 revealed under "Focus" that Ex Order 26. 4B1 [redacted] Under the "Interventions" section was, "Administer medication check for effectiveness and side effects. Administer Ex Order 26. 4B1 [redacted]	F 881	prescribed Ex Order 26. 4B1 [redacted] with no negative findings. The director of nursing or designee will conduct Monthly audits x3months on residents prescribed Ex.Order 26.4(b)(1) [redacted], ensuring appropriate monitoring and usage of the Ex.Order 26.4(b)(1) [redacted] The contents of the audit above will be reported by the director of nursing or his designee and reviewed at the quarterly QA meeting with suggested recommendations by the committee. It will be determined if the need for continuing auditing is warranted	

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Ex Order 26. 4B1 [redacted] as ordered."

On 11/23/2022 at 9:01 AM the surveyor conducted an interview with the 3rd floor Unit Manager/Licensed Practical Nurse (UM/LPN #1) The surveyor asked UM/LPN #1 if the facility had and utilized an *Ex Order 26. 4B1* [redacted]

UM/LPN #1 stated, "We do follow *Ex Order 26. 4B1* [redacted] at this facility. We follow the [name of the criteria] *Ex Order 26. 4B1* [redacted] and we have used those criteria with both ownership groups. UM/LPN #1 further stated that if we receive a *Ex Order 26. 4B1* [redacted] for *Ex Order 26. 4B1* [redacted], I will discuss the order with the nurse practitioner or physician to discuss what other options there may be and then the Infection Preventionist (IP) will follow up. UM/LPN #1 also stated that if someone has *Ex Order 26. 4B1* [redacted] *Ex Order 26. 4B1* [redacted] in their urine I believe that it is more the responsibility of the physician or IP to make that decision. I would not time frame how long to use a *Ex Order 26. 4B1* [redacted] without symptoms, I would let the IP handle that.

On 11/28/22 at 10:43 AM the surveyor reviewed the past 60-day copy (9/20/2022 to 11/21/2022) of the antibiotic surveillance tracking form provided and used by the facility for resident's receiving

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F 881	Continued From page 34 Ex Order 26. 4B1 . A review of the surveillance tracking form revealed that Resident #59 was not included on the Ex Order 26. 4B1 tracking sheet for the Ex Order 26. 4B1 of Ex Order 26. 4B1 for Ex Order 26. 4B1. On 11/28/2022 at 10:45 AM the surveyor interviewed the facility IP. The surveyor asked the facility IP what the purpose of the facility Ex Order 26. 4B1 program was. The IP stated, "The purpose of the program is to get away from the rising resistance to Ex Order 26. 4B1 and reduce the use of Ex Order 26. 4B1 inappropriately. I don't 100% know about that use of the Ex Order 26. 4B1 with Resident#59 because it (the Ex Order 26. 4B1) started before I started as the IP. The IP further explained, "I mean I would have to reach out to the doctor and see why it was ordered. I have no recollection of discussing this with the primary physician since I have taken the position. On 11/28/2022 at 1:15 PM the surveyor interviewed the facility administrative staff which included the Licensed Nursing Home Administrator, Director of Nursing, Regional Director of Risk Management (RDRM)and Regional Director of Operations (RDO). The surveyor asked the administrative staff whether resident #59 should be included on the facility Ex Order 26. 4B1 surveillance tracking form. The RDO responded, Ex Order 26. 4B1 On 11/29/2022 at 10:31 AM the survey team met with the facility administrative staff. The RDO explained to the surveyor that, " We did a thorough investigation and in-service with our IP who is kind of new to the position. He/she (Resident #59) was on the Ex Order 26. 4B1 since	F 881		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 35 admission in 2019. In addition, the RDRM explained, *Ex Order 26. 4B1* [redacted] On 11/29/2022 at 11:44 AM the surveyor conducted an additional interview with the facility IP. The surveyor asked if any other staff were responsible for tracking antibiotic use on the antibiotic surveillance tracking record. The IP responded, "I am the only one responsible for adding residents and their antibiotic use on the surveillance form." The surveyor reviewed a facility policy titled Antibiotic Stewardship, undated. The Policy Statement revealed that "Antibiotics will be prescribed under the guidance of the facility's antibiotic stewardship program." The policy further revealed under the heading Policy Interpretation and Implementation that: 1. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. 2. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. The surveyor reviewed a facility policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, undated. The following was revealed under the Policy Statement heading: "Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING _____ B. WING _____	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	**1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087**

(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 881	Continued From page 36 tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship." The following was revealed under the heading Policy Interpretation and Implementation: 1. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee. 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. NJAC 8:39-19.1	F 881		

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
	061522	A. BUILDING: _____ B. WING _____	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCA	1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087

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S 000	Initial Comments 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 deficieny 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 a) failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 14 of 14-day shifts reviewed and b) facility failed to ensure all staff members were up to date with their first COVID-19 (a potentially deadly respiratory virus) booster vaccination in accordance with New Jersey Executive Directive 294. Findings include: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	Facility will continue its best faith effort to remain in compliance with mandatory access to care. No residents were identified Residents of the facility have the potential to be affected Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. The facility has developed a Culture Committee focused on recruitment. and retention of staff along with customer service and the employee experience. The facility has implemented the Care Champion Program to mentor new employees which has been proven to	12/12/22

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

Electronically Signed | 12/30/22

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 1 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 "Nursing Staffing Report" completed by the facility for the weeks of 10/3/21 and 10/10/21, the staffing to residents' ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/30/22 had 10 CNAs for 114 residents on the day shift, required 14 CNAs. -10/31/22 had 10 CNAs for 114 residents on the day shift, required 14 CNAs. -11/01/22 had 9 CNAs for 114 residents on the day shift, required 14 CNAs. -11/02/22 had 9 CNAs for 114 residents on the day shift, required 14 CNAs. -11/03/22 had 11 CNAs for 114 residents on the day shift, required 14 CNAs. -11/04/22 had 13 CNAs for 116 residents	S 560	raise retention rates. The facility participates in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. Contract staff utilization is reviewed bi- weekly to identify trends and opportunities. The facility has contracts in place with multiple staffing agencies as an effort to provide additional staff when needed. The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Implementation of OnShift, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Contract staff utilization, Implementation of Temporary Nurse Aide program, Text message campaigns. The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for two months and then quarterly. The results of Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting.	

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S 560	Continued From page 2	S 560		

on the day shift, required 14 CNAs.
-11/05/22 had 8 CNAs for 114 residents on the day shift, required 14 CNAs.
-11/06/22 had 8 CNAs for 114 residents on the day shift, required 14 CNAs.
-11/07/22 had 12 CNAs for 113 residents on the day shift, required 14 CNAs.
-11/08/22 had 12 CNAs for 112 residents on the day shift, required 14 CNAs.
-11/09/22 had 12 CNAs for 111 residents on the day shift, required 14 CNAs.
-11/10/22 had 12 CNAs for 110 residents on the day shift, required 14 CNAs.
-11/11/22 had 10 CNAs for 107 residents on the day shift, required 13 CNAs.
-11/12/22 had 12 CNAs for 105 residents on the day shift, required 13 CNAs.

During an interview with the Staffing Coordinator (SC) on 11/28/2022 at 9:32 AM, the SC stated that it was her responsibility to staff the facility. The SC stated that the facility was meeting the staffing requirements.

During an interview with the surveyor on 11/28/2022 at 1:28 PM, the facility Administrator stated that they try to meet the requirements however sometimes they cannot.

A review of an undated facility policy titled Staffing did not include information regarding the state mandated minimum direct care staff (CNA) to resident ratio.

2. Reference: New Jersey Executive Directive 294, dated 4/13/22: All covered workers must provide adequate proof that they have received their first booster dose by April 11, 2022, or within 3 weeks of becoming eligible for their first booster

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S 560	Continued From page 3 dose, whichever is later. A review of the facility's Staff COVID Vaccination list revealed that 11 staff members did not receive their first COVID-19 booster vaccination by April 11, 2022, or within 3 weeks of becoming eligible for their first booster dose, whichever is later. During an interview with the surveyor on 11/28/2022 at 1:01 PM, the Licensed Nursing Home Administrator stated, "It was new staff that haven't gotten through the vaccination process early. As of now, it has been corrected." A review of the facility's policy titled, "Center for Medicare and Medicaid Services - Omnibus COVID-19 Health Care Staff Vaccination Policy" updated, June 2022, did not include information about staff receiving their first COVID-19 booster vaccination in accordance with New Jersey Executive Directive 294. N.J.A.C. 8:39-5.1(a)	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment.	S1405		12/12/22

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S1405	Continued From page 4 The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of five recently hired employee files, it was determined that the facility failed to ensure that 2 of 5 newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. The deficient practice was evidenced as follows: On 11/22/2022 at 11:00 AM, the surveyor reviewed the employee files of five random recently hired individuals. Employee #1 was hired on 10/25/2022 and the physical was done on 8/16/22. Employee #1 received their physical 8 weeks prior to hire. Employee #2 was hired 10/19/2022 and there was no employee health certificate/employee physical exam signed by a physician. On 11/22/2022 at 11:03 AM, the surveyor asked the Human Resources Manager (HRM) when the physical was required for a new employee and she replied she did not know. The HRM also said	S1405	Both employees received a health examination by a physician and a health history completed. All residents can be affected. The Human Resource Director was educated on the requirements for all new employees to have a health history and to receive an examination within 2 weeks of higher. Quarterly audits will be conducted ensuring all new employee are up to date with the appropriated documentation. The contents of the audit above will be reported by the Human Resources Director or her designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations. It will be determined if the need for continuing auditing is warranted.	

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S1405	Continued From page 5 that she wasn't aware that the facility's procedure was not in compliance with state regulations.	S1405		

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
315218 Y1	A. Building B. Wing Y2	2/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087

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 F0550	Correction	ID Prefix F0554	Correction	ID Prefix F0623	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(c)(7)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed
LSC	12/12/2022	LSC	12/12/2022	LSC	12/12/2022
ID Prefix F0656	Correction	ID Prefix F0689	Correction	ID Prefix F0690	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	12/12/2022	LSC	12/12/2022	LSC	12/12/2022
ID Prefix F0812	Correction	ID Prefix F0881	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(3)	Completed	Reg. #	Completed
LSC	01/05/2023	LSC	12/12/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
12/6/2022	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061522 Y1	A. Building B. Wing Y2	2/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1405	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. #	Completed
LSC	12/12/2022	LSC	12/12/2022	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?
12/6/2022	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING **01** B. WING _____	**12/06/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	**1001 CENTER ST** **LITTLE EGG HARBOR TW, NJ 08087**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/05/2022 and 12/06/2022 and Seacrest Rehabilitation and Healthcare 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Seacrest Rehabilitation and Healthcare National is a Three-story, Type II Un-Protected building that was built in January 1985. The facility is divided into 10 smoke zones.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS	K 222		12/12/22

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

Electronically Signed | 12/25/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.	K 222		

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SEACREST REHABILITATION AND HEALTHCARE CENTER	**1001 CENTER ST** **LITTLE EGG HARBOR TW, NJ 08087**

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of other facility documentation on 12/5/2022 and 12/6/2022, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was identified for 2 of 13 designated exit discharge doors. Findings include: During the survey entrance on 12/5/2022 (day one of survey) at 8:53 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are thirteen (13) designated exit discharge doors (illuminated exit signs above doors) in the facility. Starting on 12/5/2022 at approximately 9:16 AM and continued on 12/6/2022, in the presence of the facility's MD a tour of the building was conducted. The surveyor observed the following, 1) On 12/6/2022 at approximately 10:36 AM, the surveyor observed the main entrance two sets of automatic sliding exit discharge doors (internal and external) revealed thumb turn locks on the	K 222	The thumb locks on the 2 sliding doors by each main entrance were immediately disabled and removed. All residents have the potential to be affected. Plant Operation Manager was educated on maintaining exit doors to ensure no restricted use in an emergency. Facility completed a facility wide audit to determine if any other exit door had a lock that would restrict emergency use of the exit. The audit yielded no additional findings. The Plant Operation Manager will audit quarterly ensuring all exit doors are not restricted in an emergency. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee.	

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	315218	A. BUILDING **01** B. WING _____	**12/06/2022**

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K 222	Continued From page 3 egress side. The thumb turn locks and fastening device on the door could restrict emergency use of the exit. 2) On 12/6/2022 at approximately 11:30 AM, the surveyor observed the Sub-Acute Rehabilitation main entrance two sets of sliding exit discharge doors (internal and external) revealed thumb turn locks on the egress side. The thumb turn locks and fastening device on the door could restrict emergency use of the exit. The MD confirmed the finding at the time. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 12/06/2022 at approximately 1:56 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 12/05/2022 and 12/06/2022, in the presence of facility management, it was determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps	K 281	The Physical Therapy exit discharge doors was fixed with a two-lamp fixture outside the exit. All residents have the potential to be affected. All other 12 exit discharge doors have a	12/20/22

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K 281	Continued From page 4 for 1 of 13 exit discharge doors. This deficient practice was evidenced by the following: During the survey entrance on 12/05/2022 (day one of survey) at 8:53 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are thirteen (13) designated exit discharge doors (illuminated exit signs above doors) in the facility. Starting on 12/05/2022 at approximately 9:16 AM and continued on 12/06/2022, in the presence of the facility's MD a tour of the building was conducted. On 12/06/2022 at approximately 11:03 AM, the surveyor observed outside the Physical Therapy designated exit discharge door (illuminated exit sign above the door) failed to be equipped with two lamps. The surveyor observed no evidence of a light fixture in the area. The MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 12/06/2022 at approximately 1:56 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281	two-lamp fixture outside the exit. Education completed with Plant Operations Manager on requirements of NFPA 101 7.8. The Plant Operation Manager will audit monthly quarterly all light fixtures are in working order. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee.	

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K 355	Continued From page 5	K 355		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 12/05/2022 and 12/06/2022, in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination 3 of 23 portable fire extinguishers, 2) Install portable fire extinguishers with-in the required height for 2 of 23 fire extinguishers 3) Maintain one (1) portable fire extinguisher in proper working condition, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 7.3 Maintenance. - 7.3.1.1 All Fire Extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross	K 355	3 Fire extinguisher in the following locations were immediately replaced, the first-floor activity room, the first-floor copy room, and one in the corridor near the generator annunciator panel. 2 Fire extinguishers in the following locations, the first-floor copy room and inside the main electric room, were lowered to below 5 feet. 1 Fire extinguisher near the Business office on the Sub-Acute unit with the pressure indicating needle in the red discharge zone on the gauge, was immediately replaced. All residents can be affected. The Plant Operation Manager and Assistant were educated on proper monthly fire extinguisher checks, the proper placement, and identifying when a extinguisher would need to be replaced. Facility completed a facility wide audit to determine if any other fire extinguishers were determined faulty. Monthly checks will be completed on all fire extinguishers ensuring working order and proper placement. The contents of the audit above will be reported by the Plant Operation Manager	12/12/22

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K 355	Continued From page 6 weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. According to NFPA 10- 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. During the building tour on 12/05/2022 and 12/06/2022 in the presence of the facility Maintenance Director (MD) the surveyor observed and inspected Twenty Three (23) portable fire extinguishers in various locations with the following finding; 1) On 12/06/2022 at approximately 10:35 AM, the surveyor observed inside the first floor Activity room one (1) ABC Type fire extinguisher was last annually inspected May 2022 and, with no evidence of a monthly visual examination being performed and documented on the inspection tag attached to the extinguisher for June and July 2022. 2) On 12/06/2022 at approximately 11:09 AM, the surveyor observed inside the first floor copy room one (1) ABC Type fire extinguisher was last annually inspected May 2022 and with no evidence of a monthly visual examination being performed and documented on the inspection tag attached to the extinguisher for June and July 2022. This fire extinguisher appeared to be mounted	K 355	or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee.	

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K 355	Continued From page 7 too high. The surveyor measured and recorded the fire extinguisher was mounted at 5 feet 7 inches to the center of the pressure indicating needle. 3) On 12/06/2022 at approximately 11:46 AM, the surveyor observed in the corridor near the Business office on the Sub-Acute unit one (1) ABC Type fire extinguisher pressure indicating needle was in the Red discharge zone on the gauge. At that time the surveyor made a request to the MD if they had a spare fire extinguisher and exchange with this extinguisher. The MD said yes and complied with the request. 4) On 12/06/2022 at approximately 11:47 AM, the surveyor observed one (1) ABC Type fire extinguisher inside the Main Electric room one (1) ABC Type fire extinguisher. This fire extinguisher appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at 5 feet 10 inches to the center of the pressure indicating needle. 5) On 12/06/2022 at approximately 12:02 PM, the surveyor observed in the corridor near the generator annunciator panel one (1) ABC Type fire extinguisher last annually inspected May 2022 and with no evidence of a monthly visual examination being performed and documented on the inspection tag attached to the extinguisher for June and July 2022. The MD confirmed the finding at the time. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 12?06/2022 at approximately 1:56 PM.	K 355		

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K 355	Continued From page 8 NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 372 SS=E	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 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 observations and review of facility provided documentation on 12/05/2022 and 12/06/2022, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for four (4) of nine (9) smoke barrier walls as evidenced by the following: During the survey entrance on 12/05/2022 (day one of survey) at 8:53 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are three (3) smoke barrier walls on the	K 372	The 1" penetration through the smoke barrier walls next to the following resident rooms, #302, #212, #202, #223, were corrected and all holes filled up. All residents can be affected. The Plant Operation Manager was educated on smoke barriers and ensuring there is no gap for penetration. Facility completed a facility wide audit to determine if any other smoke barriers had any penetration. The Plant Operation Manager or designee will audit quarterly all Smoke Barriers ensuring no penetration. The contents of the audit above will be reported by the Plant Operations Manager	12/12/22

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K 372	Continued From page 9 third floor, Three (3) smoke barrier walls on the second floor, three (3) smoke barrier walls on the first floor. Starting on 12/05/2022 at approximately 9:16 AM and continued on 12/06/2022, in the presence of the facility's MD a tour of the building was conducted. During the two day tour the surveyor observed the following smoke barrier walls that failed to maintain the 1/2 hour fire rated construction as required by code in the following locations on 12/05/2022; 1) At approximately 10:30 AM,the surveyor observed above the corridor double smoke doors ceiling tiles next to Resident room #302 had one (1) 1" penetration with a electrical cable running through the smoke barrier wall. 2) At approximately 10:55 AM,the surveyor observed above the corridor double smoke doors ceiling tiles next to Resident room #212 had one (1) 1" penetration with a electrical cable running through the smoke barrier wall. 3) At approximately 11:12 AM,the surveyor observed above the corridor double smoke doors ceiling tiles next to Resident room #202 had one (1) 1" penetration with a electrical cable running through the smoke barrier wall. 4) At approximately 11:42 AM,the surveyor observed above the corridor double smoke doors ceiling tiles next to Resident room #223 had one (1) 1" penetration with a electrical cable running through the smoke barrier wall.	K 372	or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee.	

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K 372	Continued From page 10 These penetrations was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The MD confirmed the finding at the time. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 12?06/2022 at approximately 1:56 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and review of other facility documentation on 12/05/2022 and 12/06/2022, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 4 of 11 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A.	K 521	The exhaust fans in the bathrooms of rooms, 322, 312, 314, and 200 were fixed and were function properly. All residents can be affected. The Plant Operation Manager was educated on ensuring working exhaust fans in all bathrooms. Facility completed a facility wide audit to determine if any other exhaust fans were	12/12/22

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K 521	Continued From page 11 This deficient practice was evidenced by the following: During the survey entrance on 12/05/2022 (day one of survey) at 8:53 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are, twenty-Six (26) Resident sleeping rooms on the first floor, Thirty-Two (32) Resident sleeping rooms on the second floor and Thirty-Two (32) Resident sleeping rooms on the third floor. Starting on 12/05/2022 at approximately 9:16 AM and continued on 12/06/2022, in the presence of the facility's MD during the building tour, the surveyor inspected 11 Resident sleeping rooms and 3 unisex bathrooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 4 of 11 resident bathrooms in the following locations: 1. At approximately 9:51 AM, inside the 3rd. floor unisex bathroom, across near Resident room #322, when tested the exhaust system did not function properly. The surveyor observed that there was air back pressure blowing the tissue inward into the bathroom. At that time, the surveyor informed the MD that	K 521	not working. Quarterly audits will be conducted on all exhaust fans ensuring proper functioning. The contents of the audit above will be reported by the Plant Operation Manager or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee.	

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K 521	Continued From page 12 the exhaust system did not function properly. 2. At approximately 10:01 AM, inside Resident room #312 bathroom, when tested the exhaust system did not function properly. 3. At approximately 10:06 AM, inside Resident room #314 bathroom, when tested the exhaust system did not function properly. 4. At approximately 11:10 AM, inside Resident room #200 bathroom, when tested the exhaust system did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The MD confirmed the finding at the time. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 12?06/2022 at approximately 1:56 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced	K 911		12/12/22

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K 911	Continued From page 13 by: Based on observation and review of other facility documentation on 12/05/2022 and 12/06/2022, in the presence of facility management, it was determined that the facility failed to ensure that 3 of 16 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: During the survey entrance on 12/05/2022 (day one of survey) at 8:53 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are on the first floor Sub-Acute unit there are Twenty-Six (26) Resident sleeping rooms. On the second floor Long Term Care unit there are Thirty-Two (32) Resident sleeping rooms. On the third floor Long Term Care unit there are Thirty-Two (32) Resident sleeping rooms. Starting on 12/05/2022 at approximately 9:16 AM and continued on 12/06/2022, in the presence of the facility's MD a tour of the building was conducted. During the two day tour of the facility, the surveyor observed and tested sixteen (16) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following,	K 911	2 GFCI outlets located in Sub-Acute Resident dining room #1 and 1 GFCI outlet located in Sub-Acute dining room #2 were replaced with functioning GFCI outlets. All residents can be affected. The Plant Operation Manager was educated on ensuring functioning GFCI outlets. Facility completed a facility wide audit to determine if any other GFCI outlets did not deenergize as required. Quarterly audits will be conducted on all new GFCI outlets ensuring they are properly working. The contents of the audit above will be reported by the maintenance director or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations.	

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K 911	Continued From page 14 1) On 12/06/2022 at approximately 11:30 AM, the surveyor observed in the Sub-Acute Resident dining room #1 located near Resident room #106, two (2) GFCI electrical outlets, one GFCI outlet 37 inches (3'-1") to the right and one GFCI outlet 8 inches directly behind the sink. When the surveyor tested the two (2) GFCI electrical outlets with a GFCI tester to de-energize, both GFCI electrical outlets did not de-energize as required by code. 2) On 12/06/2022 at approximately 11:36 AM, the surveyor observed in the Sub-Acute Resident dining room #2 located near Resident room #125, one (1) GFCI electrical outlets, one GFCI outlet 41 inches (3'-5") to the right of the sink. When the surveyor tested the one (1) GFCI electrical outlet with a GFCI tester to de-energize, the GFCI electrical outlets did not de-energize as required by code. The MD confirmed the finding at the time. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 12?06/2022 at approximately 1:56 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING 01 B. WING _____	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 15 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/05/2022 and 12/06/2022 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	A remote emergency shut off for the generator was installed. All residents can be affected. The Plant Operation Manager was educated on requirements for the generator to have a remote emergency shut off. Monthly audits will be conducted ensuring the remote emergency shut off is working	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING **01** B. WING _____	**12/06/2022**

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K 918	Continued From page 16 The deficient practice was evidenced by the following: On 12/05/2022 (day one of survey) at 8:53 AM, a request was made to the Maintenance Director (MD) if the facility had an emergency generator. The MD told the surveyor, yes we have a Diesel generator. Starting on 12/05/2022 at approximately 9:16 AM and continued on 12/06/2022, in the presence of the facility's MD a tour of the building was conducted. During the tour on 12/06/2022 at approximately 11:58 AM, an inspection inside the generator room where the emergency generator was located was performed. At that time, the surveyor asked the MD, "Do you have a remote emergency shut off for the generator?" The MD told the surveyor, There is no remote emergency shut off. I spoke with our generator vendor and it is coming in on this Thursday. The MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 12?06/2022 at approximately 1:56 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	properly. The contents of the audit above will be reported by the Plant Operation Manager or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315218 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087

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 K0222	12/12/2022	LSC K0281	12/12/2022	LSC K0355	12/12/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	12/12/2022	LSC K0521	12/12/2022	LSC K0911	12/12/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	01/05/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/6/2022	☐ YES ☐ NO