PRINTED: 11/27/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315110	B. WING		C 09/10/2024
	ROVIDER OR SUPPLIER	LS REHAB & RESP CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 130 TERHUNE DRIVE WAYNE, NJ 07470	05/10/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
	Complaint #: NJ0017	76749			
	Survey Dates: 09/10/	2024			
	Census: 85				
	Sample Size: 4				
	THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.				
F 609 SS=D			F 609	9	10/7/24
		se to allegations of abuse, or mistreatment, the facility			
	involving abuse, negli mistreatment, includir source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not rest the administrator of the officials (including to adult protective service for jurisdiction in long	that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, ately, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if a the allegation do not involve all in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides term care facilities) in e law through established			
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE

Electronically Signed 10/07/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315110	B. WING _			C 09/10/2024		
	ROVIDER OR SUPPLIER E CARE AT WAYNE HIL	LS REHAB & RESP CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 130 TERHUNE DRIVE WAYNE, NJ 07470			10/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE	
F 609	designated represent accordance with Stat Survey Agency, within incident, and if the all appropriate corrective. This REQUIREMENT by: Complaint #: NJ001* Based on interviews records and other fact determined that the following that the following: The surveyor reviews record on 09/10/2022 reflected the Resident #2) and was following: The surveyor reviews record on 09/10/2022 reflected the Resider facility with medical control limited to: NJ Exercorder 10 (BIMS) score of less output on the surveyor reviews record on 09/10/2022 reflected the Resider facility with medical control limited to: NJ Exercorder 10 (BIMS) score of less output of limitated on	the results of all administrator or his or her tative and to other officials in the law, including to the State on 5 working days of the leged violation is verified the action must be taken. This not met as evidenced of 76749 and a review of the medical cility documentation, it was acility staff failed to report an made by a resident of the equired. This deficient of for 1 of 4 residents as evidenced by the seed Resident #2's medical of the Admission Record of the equired to the liagnoses which included but the equired to the equired the equired to the equired to the liagnoses which included but the equired to the eq	F 6	F609 1. Resident #2 deficient practice. Audit of events and allegations, not found to be not reported. 2. All residents with allegations with allegations of reportable events and profor reporting all allegations department of health, in-sconducted by regional state. 3. US FOIA (b)(6) Were re-educted reportable events and profor reporting all allegations department of health, in-sconducted by regional state. 4. Administrator/Design an audit to determine computable events and proform and the determine computable of the audits will be the monthly QAPI meeting.	gations of ab istreatment ffected by this ucated on per time fram s to the ervices ff. nee will condu pliance of events weekly months. The	use, s ne uct		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED		
		315110	B. WING _			09/10/2024		
	ROVIDER OR SUPPLIER	HILLS REHAB & RESP CENTER		STREET ADDRESS, CITY, STATE, ZIP C 130 TERHUNE DRIVE WAYNE, NJ 07470	CODE	03/10/2024		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 609	Review of residen revealed that resident's needs. Review of residen revealed that resident was provided and with the presence of the administrative staff rounds meeting of US FOIA (b)(6) at the presence of the while at the nursing the provided and the resident was not timeframe of the US FOIA (b)(6) at the resident was not timeframe of the US FOIA (b)(6) at the resident was not timeframe of the US FOIA (b)(6) at the resident was not timeframe, as per The US FOIA (b)(6) at the appropriate agency timeframe, as per The US FOIA (b)(6) at the provided the appropriate agency timeframe, as per The US FOIA (b)(6) at the provided the appropriate agency timeframe, as per The US FOIA (b)(6) at the provided the appropriate agency timeframe, as per The US FOIA (b)(6) at the provided the appropriate agency timeframe, as per The US FOIA (b)(6) at the provided the appropriate agency timeframe, as per The US FOIA (b)(6) at the provided the provided the appropriate agency timeframe, as per The US FOIA (b)(6) at the provided the provi	t #2's Progress Notes (PNs) dent #2 was admitted to the process with Nuexec Order 26.4b1 J Exec Order 26.4b1 The interview with the surveyor and Stated that the f was gathering for morning when the preceived a text from the the hospital stating that Resident we been Nuexec Order 26.4b1 g facility. The during the morning that after learning about the state us process the Nuexec Order 26.4b1 and the directly to report it, and the her directly to report it to the state and federal regulations. The cknowledged that they should NJ Exec Order 26.4b1 to the sites within the stipulated state and federal regulations. The cknowledged that their facility's policy for stigating NJ Exec Order 26.4b1.	F	609				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		315110	B. WING			C
NAME OF PE	ROVIDER OR SUPPLIER	313110	5:	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/10/2024
		LS REHAB & RESP CENTER		130 TERHUNE DRIVE WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFI TAG) BE	(X5) COMPLETION DATE
F 609	Continued From page 3 including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator or the facility and to other appropriate agencies in accordance with state and federal regulations within prescribed timeframes." The policy further states: 5. Alleged violation - A situation or occurrence that is observed or reported by staff, resident, relative, visitors or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. 6. Investigation - The facility will investigate all allegations and types of incidents as listed above in accordance with facility procedure for reporting/response as described below. 7. Reporting/Response - The facility will report all alleged allegations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.		F	609		
F 610 SS=D	CFR(s): 483.12(c)(2)-	Correct Alleged Violation (4) se to allegations of abuse,	F	610		10/7/24
	3 100.12(0) III 103polis	so to allogations of abuse,				

PRINTED: 11/27/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315110	B. WING _			C 09/10/2024	
	ROVIDER OR SUPPLIER	HILLS REHAB & RESP CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 130 TERHUNE DRIVE WAYNE, NJ 07470	ODE	03/10/2024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 610	neglect, exploitation must: §483.12(c)(2) Have violations are thore. §483.12(c)(3) Preveneglect, exploitation in investigation is in least second and investigations to the designated repressecord and if the appropriate correct accordance with Sourvey Agency, wincident, and if the appropriate correct This REQUIREME by: Complaint #: NJO Survey Dates: 09/ Census: 85 Sample Size: 4 Based on interview records and other determined that the investigate an NJ made by a resider Jersey Departmen required. This defined the surveyor reviews the survey that the surveyor reviews the surveyor revie	the evidence that all alleged oughly investigated. Went further potential abuse, on, or mistreatment while the progress. Fort the results of all the administrator or his or her entative and to other officials in state law, including to the State ithin 5 working days of the entative action must be taken. ENT is not met as evidenced	F 6	F610 1. Resident #2 deficient practice. Audit conevents and allegations and events found to be not inveus 2. All residents with alleganeglect, exploitation or mist the potential to be affected deficient practice. 3. US FOIA (b)(6) were re-educted proper investigation of allegabuse, neglect, exploitation mistreatment. In-services of the regional staff. 4. Administrator/ Designer and audit to determine that incidents are reviewed and weekly x 4 weeks, then more months. The results of the	nducted on no other estigated. ations of abuse, treatment have by this cated on ged incidents of nor conducted by the will conduct all alleged investigated onthly x 2		

Facility ID: NJ61610

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245440	B WINC				
		315110	B. WING			09/	10/2024
	ROVIDER OR SUPPLIER 'E CARE AT WAYNE HIL	LS REHAB & RESP CENTER		13	TREET ADDRESS, CITY, STATE, ZIP CODE 30 TERHUNE DRIVE VAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	most recent quarterly an assessment tool or resident had a Brief I (BIMS) score of Jan initiated on plan initiated on the care plan also indicated the care plan also indicated NJ Exec Order 26, resident's needs.	Review of the Minimum Data Set (MDS), lated Territory, reflected the Interview for Mental Status to f 15, which indicated 5.4b1. The resident's care and revised on the Resident #2 had a status towards staff. Resident #2's ted that Resident #2 utilized to NJ Exec Order 26.4b1	F	610	presented at the monthly QAPI meeting for review.	gs	
	nevealed that resident hospital on and NJE. During the entrance if on 09/10/2024, the Uthe presence of the administrative staff wrounds meeting on NJE.	nterview with the surveyor IS FOIA (b)(6) JS FOIA (b)(6) stated that the ras gathering for morning Exec Order 25.451 when the					
	US FOIA (b)(6) at the h # 2 reported to have while at the nursing fa The stated that NJ Exec Order 26.4b1 meeting, she did not	after learning about the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315110	B. WING			C 09/10/2024		
	ROVIDER OR SUPPLIER	ILLS REHAB & RESP CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 130 TERHUNE DRIVE WAYNE, NJ 07470				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 610	the resident was not timeframe the NJ Exappropriate agencie timeframe, as per some The US FOIA (b) (6) they did not follow to reporting and investing an interview 09/10/2024 at 12:50 stated that the NJ Exappropriate the NJ Exappropriate to her, but the information did stated that it is the US FOIA (b) (6) and the information did stated that it is the US FOIA (b) (6) and the information did stated that it is the US FOIA (b) (6) and the information did stated that it is the US FOIA (b) (6) and the information did stated that it is the US FOIA (b) (6) and the information did stated that it is the US FOIA (b) (6) and the information did stated that it is the US FOIA (b) (6) and the information of the safety of the safety of this facility to repabuse/neglect/exploincluding injuries of misappropriation of immediately to the safety of th	ther directly to report it, and to in the facility during the xec Order 26.4b1. The sedged that they should have ec Order 26.4b1 to the es within the stipulated tate and federal regulations. If further acknowledged that heir facility's policy for tigating Secondar 26.4b1. With the surveyor on 3 P.M., the Secondar 26.4b1 was not she heard about the siring morning rounds meeting. It is that the did not exec Order 26.4b1 because not come to her directly. She responsibility of the he secondary is to report any she heard about the responsibility of the he secondary is to report any she heard as a US FOIA (b)(6) did her role as a US FOIA (b)(6) is to find the residents and she should have taken the investigate the street should "Compliance" investigate the should "Compliance" investigate "Compliance" investigate "Compliance" investigate "Compliance" in the should should be should should should should should be should	F 61					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		315110	B. WING			C		
	ROVIDER OR SUPPLIER	LS REHAB & RESP CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 130 TERHUNE DRIVE	09	/10/2024		
				WAYNE, NJ 07470				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 610	Continued From page	e 7	F 61	0				
	that is observed or re relative, visitors or oth investigated and, if ve noncompliance with t related to mistreatme abuse, including injur misappropriation of ref. 6. Investigation - The	A situation or occurrence ported by staff, resident, ners but has not yet been erified, could be he Federal requirements nt, exploitation, neglect, or ies of unknown source, and esident property. The facility will investigate all of incidents as listed above cility procedure for						
	NJAC 8:39-9.4(f)							

PRINTED: 11/27/2024 FORM APPROVED

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BUILDING: _			、
		61610		B. WING		09/1	, 0/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COMPLET	E CARE AT WAYNE HIL	LS REHAB & RESP	130 TERHU WAYNE, NJ				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Initial Comments			S 000			
S 560	8:39, standards for lic Facilities. The facility Correction, including deficiency and ensure implemented. Failure result in enforcement the provisions of the Code, Title 8, chapter licensure regulations. 8:39-5.1(a) Mandator	densure of Long-Term Comust submit a Plan of a completion date for eathat the plan is to correct deficiencies action in accordance when Jersey Administrator 43E, enforcement of	Care ach may vith tive	S 560			10/7/24
	by: Complaint #: NJ0017 Based on interviews a documents on 09/04/ the facility failed to er met for 13 of 14-day a deficient practice had residents. Findings include: Reference: New Jers (NJDOH) memo, date with N.J.S.A. (New Jers Jers Jers (NJDOH) memo, date with N.J.S.A. (New Jers Jers Jers Jers (NJDOH) memo, date with N.J.S.A. (New Jers Jers Jers Jers (NJDOH) memo, date with N.J.S.A. (New Jers Jers Jers Jers Jers Jers Jers Jers	and review of facility 2024, it was determined resure staffing ratios were shifts reviewed. This I the potential to affect a sey Department of Heal and 101/28/2021, "Complied of the completed of the complete sey Statutes Annotate um staffing requirement	d that re all Ith ance ed)		S560 1. No Residents were affected by the deficient practice 2. All Residents have the potential to affected by this deficient practice. 3. Additional per diem, part time and fulltime were scheduled to meet minime staff to resident ratios. Licenses/certifications were verified by the staff manager/ Human Resources for currelicensed certified staff. DON / Designation-service Staffing Coordinator on appropriate staffing levels. The facility advertised open jobs through online recruitment platforms as well as traditioned.	o be d num ing ent ee to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

10/07/24

STATE FORM 6899 B66X11 If continuation sheet 1 of 3

TITLE

(X6) DATE

PRINTED: 11/27/2024 FORM APPROVED

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		61610		B. WING		C 00/40/2024			
		01010				09/10/2024			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
COMPLET	E CARE AT WAYNE HILI	LS REHAB & RESP	130 TERHU WAYNE, NJ						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
S 560	60 Continued From page 1			S 560					
5 500	Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to survey from 08/25/2024 to 09/07/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -08/25/24 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs08/26/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.		5 500	The facility has conducted job fairs ar has contracts with nursing staffing agencies. 4. The Scheduling manager or designial audit weekly x4 weeks and month months to ensure staffing levels are with the mandated ratios. All identified concerns will be corrected immediate. The results of the audits will be review in QAPI monthly.	gnee ly x2 vithin y.				
	day shift, required at 1-08/29/24 had 9 CNA	S for 86 residents on th least 11 CNAs. s for 87 residents on th							
	shift, required at least	s for 83 residents on th t 10 CNAs. s for 83 residents on th	·						
	-09/01/24 had 9 CNA shift, required at least	s for 82 residents on th t 10 CNAs.	e day						

PRINTED: 11/27/2024 FORM APPROVED

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		61610	B. WING			C 09/10/2024	
					I	09/10/2024	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	ATE, ZIP CODE			
COMPLET	E CARE AT WAYNE HILL	LS REHAB & RESP (RHUNE DRIVE , NJ 07470				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
S 560	-09/02/24 had 9 CNA: shift, required at least -09/03/24 had 9 CNA: shift, required at least -09/04/24 had 9 CNA: shift, required at least -09/05/24 had 9 CNA: shift, required at least	s for 82 residents on the day to 10 CNAs. s for 82 residents on the day to 10 CNAs. s for 82 residents on the day to 10 CNAs. s for 82 residents on the day to 10 CNAs. s for 88 residents on the day to 11 CNAs. As for 85 residents on the	S 560				

POST-CERTIFICATION REVISIT REPORT

PROVIDEI IDENTIFIC			A. Building	CONSTRUCTION	ii ioAiioi	VICEVIOIT ICE			DATE OF	
NAME OF COMPLE			Y1 B. Wing AYNE HILLS REHAE	3 & RESP CENTE	R	STREET ADDRESS, CIT 130 TERHUNE DRIVE WAYNE, NJ 07470	Y, STATE, ZIP CODE	12	10/11/20	24 _{Y3}
program, corrected	to show and the number	those d date su and the	eficiencies previousl ch corrective action	y reported on the was accomplished	CMS-2567, Staten d. Each deficiency	and/or Clinical Laborato nent of Deficiencies and r should be fully identifie 2567 (prefix codes show	Plan of Correction dusing either the r	n, that have b regulation or	LSC	
ITE	И		DATE	ITEM		DATE	ITEM			DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix	F0609		Correction	on ID Prefix	F0610	Correction	ID Prefix			Correction
Reg.#	483.12(l) (1)(4))(5)(i)(A)	(B)(c) Complete	ed Reg.#	483.12(c)(2)-(4)	Completed	Reg. #			Completed
LSC			10/07/202	LSC		10/07/2024	LSC			
ID Prefix			Correction	on ID Prefix		Correction	ID Prefix			Correction
Reg.#			Complete	ed Reg.#		Completed	Reg. #			Completed
LSC				LSC			LSC			
ID Prefix			Correctio	on ID Prefix		Correction	ID Prefix			Correction
Reg.#			Complete	ed Reg. #		Completed	Reg. #			Completed
LSC				LSC			LSC			
ID Prefix			Correction	on ID Prefix		Correction	ID Prefix			Correction
Reg.#			Complete	ed Reg. #		Completed	Reg. #			Completed
LSC				LSC			LSC			
ID Prefix			Correctio	on ID Prefix		Correction	ID Prefix			Correction
Reg.#			Complete	ed Reg.#		Completed	Reg. #			Completed
LSC				LSC			LSC			
REVIEWE			REVIEWED BY (INITIALS)	DATE	SIGNATUR	RE OF SURVEYOR	<u>I</u>	I	DATE	
REVIEWE CMS RO	D BY		REVIEWED BY (INITIALS)	DATE	TITLE	400000			DATE	
	FOLLOWUP TO SURVEY COMPLETED ON 9/10/2024				RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN			YES	□ по	

STATE FORM: REVISIT REPORT									
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 61610 MULTIPLE CONSTRUCTION A. Building B. Wing						Y2	DATE OF REVISIT 10/11/2024 _{Y3}		
NAME OF FACILITY COMPLETE CARE AT WAYNE HILLS REHAB & RESP CENTER 130 TERM					TREET ADDRESS, CITY, STATE, ZIP CODE 30 TERHUNE DRIVE WAYNE, NJ 07470				
This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).									
ITEM		DATE	ITEM		DATE	ITEM		DAT	E
Y4		Y5	Y4		Y5	Y4		Y5	5
ID Prefix	S0560	Correction	ID Prefix		Correction	ID Prefix		Corre	ection
Reg. #	8:39-5.1(a)	Completed	Reg. #		Completed	Reg.#		Comp	oleted
LSC		10/07/2024	LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Corre	ection