STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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: 11/23/22 Census: 106 Sample: 22 + 2 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 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		12/19/22

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

Electronically Signed | 12/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 755	Continued From page 1 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure that a.) an expired narcotic medication was removed from active inventory that resulted in repeated administration of an expired medication to Resident #93 for three months and b.) discontinued biologicals were removed from active inventory for 3 of 3 unsampled residents (Resident #6, #32, and #34). This deficient practice was identified during 1 of 1 medication rooms inspected NJ EX Orde-floor) and evidenced by the following: 1. On 11/16/22 at 10:23 AM, the surveyor inspected the NJ EX Or-floor medication room in the presence of Licensed Practical Nurse/Unit Manager (LPN/UM). The surveyor observed an expired, opened bottle of NJ EX Order. 264b1 NJ E milligram (mg) NJ E milliliter (ml; a narcotic	F 755	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ Regarding "a) an expired narcotic medication was removed from active inventory that resulted in repeated administration of an expired medication to Resident #93 for three months", 1) The identified expired narcotic medication for resident #93 was immediately removed from active inventory. 2) All medications for resident #93 were immediately audited to ensure no medications with past shelf-life expiration date were present. Regarding "b.) discontinued biologicals were removed from active inventory for 3 of 3 unsampled residents (Resident #6, #32, and #34)", The identified discontinued biologicals from residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 755	Continued From page 2 medication used for anxiety) labeled with Resident #93's name. The LPN/UM confirmed the seal was broken on the bottle. At that time, the surveyor and the LPN/UM reviewed the manufacturer's package that reflected "Discard opened bottle after 90 days". The resident's label revealed a pharmacy dispense date of [redacted]. A review of Resident #93's Controlled Drug Record (a narcotic inventory log) revealed [redacted] was signed received on [redacted], and the first dose was deducted from the inventory on [redacted]. At that time, the LPN/UM confirmed the medication should have been discarded on [redacted]. A further review of Resident #93's Controlled Drug Record for [redacted] revealed doses on NJ EX Order. 264b1 and [redacted] were deducted from inventory after the expiration date. A review of the Resident #93's corresponding electronic Medication Administration Record for NJ EX Order. 264b1 revealed [redacted] was administered on NJ EX Order. 264b1 and [redacted]. On 11/16/22 at 10:52 AM, the surveyor interviewed the LPN/UM who stated it was important for expired medication to be discarded since the potency of the medication may be affected and the medication may not be as effective. On 11/16/22 at 11:21 AM, the surveyor	F 755	#6, #32, and #34 were immediately removed from active inventory. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ Regarding "a) an expired narcotic medication was removed from active inventory that resulted in repeated administration of an expired medication to Resident #93 for three months", All medications in active inventory were audited on [redacted] to ensure no medications with past shelf-life expiration date were present. Regarding "b.) discontinued biologicals were removed from active inventory for 3 of 3 unsampled residents (Resident #6, #32, and #34)", All medications in active inventory were audited on [redacted] to ensure no discontinued biologicals were present. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ Regarding "a) an expired narcotic medication was removed from active inventory that resulted in repeated administration of an expired medication to Resident #93 for three months", An	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 755	Continued From page 3 interviewed the Regional Clinical Nurse who confirmed expired medications should have been removed from active inventory. On 11/23/22 at 10:19 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Director of Operations, Regional Clinical Nurse, and survey team confirmed the expired [redacted] should have been removed from the active inventory. 2. On 11/16/22 at 10:23 AM, the surveyor inspected the [redacted]-floor medication room in the presence of the LPN/UM and observed the following: Unsampled Resident #6's sealed Basaglar ([redacted]) with a dispense date of [redacted] Unsampled Resident #32's sealed [redacted] with a dispense date of [redacted]. Unsampled Resident #34's sealed [redacted] with a dispense date of [redacted] On 11/16/22 at 11:55 AM, the LPN/UM reviewed the electronic Medical Record and confirmed the insulin found for unsampled Residents #6, #32 and #34 were discontinued. A review of Resident #6's Order Recap Report (ORR) dated [redacted] reflected that Basaglar was discontinued [redacted] A review of Resident #32's ORR dated 3/1/22 to [redacted], reflected that [redacted] was discontinued on [redacted] A review of Resident #34's ORR dated [redacted] to [redacted], reflected that Humalog was	F 755	in-service for nurses was initiated on 11/17/2022 with a target completion date of 11/25/2022 to check all medications for appropriate shelf-life requirements and expiration dates before administering and to immediately report any expired or expiring medications to Supervisor. Regarding "b.) discontinued biologicals were removed from active inventory for 3 of 3 unsampled residents (Resident #6, #32, and #34)", 1) An in-service for nurses was initiated on 11/17/2022 with a target completion date of 11/25/2022 on responsibility and requirement that when manually discontinuing a medication in the eMAR the nurse must also remove the medication from active inventory. 2) The facility has implemented on 12/19/2022 that each day the 3-11 supervisor (alternatively the DON or her designee) will run the "Order Listing Report" in the facility eMAR software system for "Completed" and "Discontinued" medications. The supervisor will then remove any extra medications from the identified "completed" orders, and will also audit that the identified "discontinued" medications were already removed by the nurse who put in the discontinue order. 3) Any discontinued medications found to still be in active inventory will be investigated and the nurse who entered the discontinue order will be disciplined appropriately. 4) On 12/19/2022 the "Order listing report" audit will be added to the 3-11 supervisor's daily tasks and will be added to the "End of Shift Checklist Report" completed by the 3-11 Supervisor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 755	Continued From page 4 discontinued on [redacted] On 11/16/22 at 11:21 AM, the surveyor interviewed the Regional Clinical Nurse who confirmed discontinued medications should have been removed from active inventory. On 11/23/22 at 10:19 AM, the DON in the presence of the LNHA, Regional Director of Operations, Regional Clinical Nurse, and survey team confirmed the discontinued insulin should have been removed from the active inventory. A review of the undated facility provided "Storage of Medications" policy included...Policy Interpretation and Implementation...4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed... NJAC 8:39- 29.2(d); 29.4(g)	F 755	daily, and which is sent by email to the DON and LNHA. The DON will review to ensure the task was completed and will follow up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ Regarding "a) an expired narcotic medication was removed from active inventory that resulted in repeated administration of an expired medication to Resident #93 for three months", 1) Starting on 12/19/2022 the DON or designee will audit 1 medication cart or storage area twice a week for 4 weeks and every week for an additional 8 weeks to ensure no expired /or shelf-life expired medications are present. 2) Results of audits will be submitted to, and reviewed by the Quality Assurance Performance Improvement Committee monthly and the committee will make recommendations to the Administrator for any further actions. Regarding "b.) discontinued biologicals were removed from active inventory for 3 of 3 unsampled residents (Resident #6, #32, and #34)", 1) Starting on 12/19/2022 the DON or designee will audit twice a week for 4 weeks and every week for an additional 8 weeks. The audit will consist of the following: The "Order listing report" in the facility eMAR software system for "Completed" and "Discontinued"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 755	Continued From page 5	F 755	medication orders will be ran for the past 24-hour period and the Active inventory will be audited to ensure that any identified "Completed" or "Discontinued" medications on the report have been removed. 2) Results of audits will be submitted to, and reviewed by the Quality Assurance Performance Improvement Committee monthly and the committee will make recommendations to the Administrator for any further actions.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		12/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 756	Continued From page 6 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and record review of facility documents, it was determined that the facility failed to ensure the Consultant Pharmacist identified and/or reported a medication interaction during the monthly medication regimen review from [redacted] to [redacted]. This deficient practice was identified for 1 of 4 residents (Resident #26) reviewed for medication administration [redacted] and was evidenced by the following: A review of the manufacturer's specifications for [redacted] under section 7.0 titled, Drug Interactions, Table 2. Drugs That May Decrease [redacted] included...Potential impact: Concurrent use may reduce the efficacy of [redacted] sodium by binding and delaying or preventing absorption, potentially resulting in [redacted]. [redacted] (e.g., [redacted] may bind to [redacted]. Administer levothyroxine sodium tablets at least 4 hours part from these agents.	F 756	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ A physician order was obtained on [redacted] for resident #26 to move the Administration time of the [redacted] and [redacted] to be 4 hours apart. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ On 11/18/2022 the DON conducted a facility wide audit of all resident's drug regimens and found 6 additional residents with an order for [redacted] but found that none of them had an order for [redacted] and that zero additional residents had the potential to be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 756	Continued From page 7 On 11/14/22 at 10:35 AM, during the initial tour, the surveyor observed Resident #26 sleeping, covered with a flat sheet. The bed was positioned at the lowest height and the resident was positioned at approximately a 30-degree incline with a [redacted] next to the bed. The surveyor reviewed the medical record for Resident #26. A review of the Admission Record face sheet (an admission summary) reflected the resident was originally admitted to the facility in [redacted] with diagnoses which included [redacted]. A review of the Order Summary Report (OSR) from admission included an initial physician's order (po) dated [redacted] for [redacted] microgram (mcg); give [redacted] tablet by mouth one time a day for [redacted], and a po dated [redacted] for [redacted] tablet [redacted] milligram (mg; medication for [redacted]); give [redacted] tablet [redacted] one time a day for [redacted]. A review of the corresponding [redacted] and [redacted] electronic Medication Administration Record (eMAR) revealed [redacted] were scheduled to be administered both at 9:00 AM daily from [redacted] to present. This was not in accordance with manufacturer's recommendations to separate the [redacted] and [redacted] by at least four hours. A review of the Consultant Pharmacist's	F 756	same stated deficient practice. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1) On 11/23/2022 the consultant pharmacist was re-educated by her supervising pharmacist on the Drug Regimen review process, including the need to review all drugs for possible drug-to-drug interactions. 2) An in-service for nurses was initiated by pharmacist on 11/28/2022 on how to identify and check for possible drug-to-drug interactions when carrying out physician orders. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1) Starting on 12/19/2022 the DON or designee will conduct an audit twice a week for 4 weeks and every week for an additional 8 weeks. The audit will consist of the following: The "Order listing report" in the facility eMar software system will be ran for "New Orders" for all residents for a 24-hour lookback period and all new orders for all residents noted on the report will be audited to ensure no drug-to-drug interactions are present. 2) The consultant Pharmacist's monthly drug regimen review will be audited by the supervising consultant pharmacist for 3 months beginning in December 2022. The audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 756	Continued From page 8 Recommendations report from NJ EX Order: 264b1 through NJ EX Order: 264b1 did not reflect a recommendation to separate the administration of NJ EX Order: 264b1 and NJ EX Order: 264b1 by at least four hours apart as indicated on the manufacturer's specifications. On 11/18/22 at 10:42 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated she was not the regular CP for the facility and that all recommendations made by the CP were documented. The CP continued she was unsure if the recommendation to administer levothyroxine and ferrous sulfate at least four hours apart was made. The CP added that if Resident #26's laboratory values were stable, and the resident had been taking the medications at the same time for some time, then the physician may not have agreed to separate both medications. The CP stated she would look into what occurred and inform the surveyor if a recommendation was made. On 11/23/22 at 9:05 AM, during an interview via telephone, the surveyor asked the resident's Physician/Medical Director if NJ EX Order: 264b1 and NJ EX Order: 264b1 could be administered at the same time. The Physician/Medical Director responded that he relied on the pharmacy for drug interaction recommendations and usually followed them. The Physician/Medical Director could not speak to Resident #26's NJ EX Order: 264b1 being administered at the same time as the NJ EX Order: 264b1. On 11/23/22 at 10:28 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Clinical Operations Nurse, Regional Director of Operations, and the survey team confirmed a	F 756	will consist of the following: The supervising consultant pharmacist will sample 3 residents who are on medications common to have drug-to-drug interactions to ensure that the consultant pharmacist is identifying and reporting any interactions. 3) Results of audits will be submitted to, and reviewed by the Quality Assurance Performance Improvement Committee monthly and the committee will make recommendations to the Administrator for any further actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 756	Continued From page 9 recommendation was not made by the CP to separate NJ EX Order 264b1 and NJ EX Order 264b1. Review of the facility's undated "Medication Regimen Reviews" policy included...Policy Interpretation and Implementation: 4. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. 5. The MRR [medication regimen review] involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors and other irregularities...9. An "irregularity" refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services... NJAC 8:39-29.3(a)(1)(6)	F 756		
F 917 SS=D	Resident Room Bed/Furniture/Closet CFR(s): 483.10(i)(4), 483.90(e)(2)(3) §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv) §483.90(e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and	F 917		12/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 917	Continued From page 10 shelves accessible to the resident. §483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide a.) a chair and b.) a clean comfortable mattress to a resident. This deficient practice was identified for 1 of 2 residents reviewed for [redacted] and end of life care (Resident #1) and was evidenced by the following: On 11/14/22 at 11:05 AM, during the initial tour, the surveyor observed Resident #1 sitting on their bed. Resident #1 informed the surveyor that the bed was not comfortable and that they had previously discussed his/her discomfort with the Licensed Practical Nurse (LPN) and the previous Unit Manager (UM #1). Resident #1 also stated that he/she wanted to sit somewhere else other than their bed but was unable to since he/she has not had a chair for about three weeks. At that time, the surveyor did not observe a chair in the resident's side of the room or the hallway. The surveyor reviewed the medical record for Resident #1.	F 917	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ A [redacted] was ordered and provided for resident #1 on [redacted] A brand-new mattress was purchased and installed on [redacted] on bedframe by maintenance department in accordance with manufacturer's specifications for correct placement and fitting. Resident #1 was satisfied with the mattress and chair provided. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ Regarding "a.) Failed to provide a chair", All residents have the potential to be affected by the above stated deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 917	Continued From page 11 A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ EX Order. 264b1 with diagnoses which included NJ EX Order. 264b1 [redacted] A review of the most recent significant change Minimum Data Set (MDS; an assessment tool) dated [redacted] reflected a Brief Interview for Mental Status (BIMS) score of NJ EX Order. 264b1, which indicated a [redacted] NJ EX Order. 264b1 A review of the Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated [redacted] reflected the resident was discharged from [redacted] on [redacted] 1. On 11/15/22 at 11:05 AM, the surveyor observed Resident #1 was transferred from the bed to a chair. On 11/15/22 at 11:14 AM, the surveyor asked Resident #1 where the chair they were in came from, and the Certified Nursing Assistant (CNA) who was present at the time, stated the chair that the resident was in came from the Physical Therapy (PT)/Occupational Therapy (OT) department that day. On 11/15/22 at 11:18 AM, during an interview with the surveyor, the LPN stated the resident was discontinued from [redacted] and that [redacted] had taken [redacted] chair and the facility had to relinquish	F 917	practice. Regarding "b.) Failed to provide a clean comfortable mattress to a resident", All residents have the potential to be affected by the above stated deficient practice. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ Regarding "a.) Failed to provide a chair", An in-service for nurses, Nurse aides, therapy staff and Nursing administration staff was initiated on 11/16/2022 on the process for obtaining a chair for a resident whether for temporary or permanent use. In addition, an in-service for nurses, Nurse aides, and Nursing administration staff was initiated on 11/16/2022 to report directly to the Administrator if there is a delay in the procurement of a previously requested and needed equipment. Regarding "b.) Failed to provide a clean comfortable mattress to a resident", An in-service for nurses, Nurse aides, and Nursing administration staff was initiated on 11/16/2022 on how to report any damaged or broken equipment using the electronic work order system to alert the Maintenance department, and to report any delay in work order completion to the Administrator. 4. How the corrective actions will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 917	Continued From page 12 NJ EX Order 264 provided items once their services ended. On 11/15/22 at 11:37 AM, during an interview with the surveyor, the LPN/UM #2 confirmed that the chair was given by the PT/OT department on that day. On 11/15/22 at 11:40 AM, during an interview with the surveyor, the Director of Nursing (DON) could not recall the date when the chair was ordered. On 11/15/22 at 12:05 PM, during an interview with the surveyor, the CNA stated she transferred the resident out of bed every other day and Resident #1 has not had a chair for about two and a half weeks, since NJ EX Order 264 took their NJ EX Order 264 back. The CNA continued that she had reported to the previous UM #1 and the DON. The CNA informed the surveyor that when therapy provided a chair, she (CNA) was then able to get the resident out of bed. She also stated that she had to "hunt" for a chair to get Resident #1 out of bed. On 11/22/22 at 12:57 PM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, Regional Director of Operations (RDO), Regional Clinical Nurse, and survey team, stated that Resident #1 was being trialed for a chair by the PT/OT department. The LNHA acknowledged Resident #1 should have had an alternate chair while being trialed by the PT/OT department. The LNHA confirmed that there was breakdown in the communication process and stated this was not their normal practice or process. 2. On 11/15/22 at 11:14 AM, the surveyor in the presence of another surveyor observed Resident #1's mattress had a NJ EX Order 264(1), a NJ EX Order 264(2) area	F 917	monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ Regarding "a.) Failed to provide a chair", 1) Starting on 12/19/2022 the DOR or designee will audit weekly for 4 weeks and every other week for an additional 8 weeks, by rounding on each resident to visually confirm that all residents have an assigned chair. 2) Results of audits will be submitted to, and reviewed by the Quality Assurance Performance Improvement Committee monthly and the committee will make recommendations to the Administrator for any further actions. Regarding "b.) Failed to provide a clean comfortable mattress to a resident", 1) Starting on 12/19/2022 the Maintenance Director or designee will audit weekly for 4 weeks and every other week for an additional 8 weeks, by rounding on all residents in the building to visually confirm and assess that they all have a clean comfortable mattress to their satisfaction. 2) Results of audits will be submitted to, and reviewed by the Quality Assurance Performance Improvement Committee monthly and the committee will make recommendations to the Administrator for any further actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 917	Continued From page 13	F 917		

above the [redacted] and was [redacted] in the middle.

On 11/15/22 at 11:18 AM, the surveyor interviewed the LPN who indicated that the mattress belonged to [redacted] but was not relinquished because they had nowhere to move the resident to and at that time Resident #1 did not have a chair.

At that time, the LPN assessed the mattress and described the mattress as [redacted], and [redacted] The LPN informed the surveyor that the Maintenance department was aware of the resident's bed. She stated that the process for requesting a new mattress would be the nurse opened an electronic work order in the [name redacted] system for the Maintenance department to check the mattress.

On 11/15/22 at 11:55 AM, the surveyor met with the Regional Director of Plant Operations (RDPO) regarding the resident's mattress. The RDPO stated there was not a previous work order in the electronic system for the resident's mattress prior to surveyor inquiry.

On 11/15/22 at 11:57 AM, during a follow up interview with the surveyor, the LPN acknowledged the mattress should not have been soiled and was aware of the conversation Resident #1 had with the previous UM #1 and CNA about the uncomfortable bed. The LPN also stated that she reminded the previous UM #1 about the need for a new mattress.

On 11/15/22 at 12:09 PM, the surveyor interviewed the CNA who confirmed the resident was complaining about their bed hurting their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 917	Continued From page 14	F 917		

"behind" and she (CNA) reported to the previous UM #1. The CNA informed the surveyor that during morning care the cream went onto the bed and that the resident had [NJ EX Order 2640] in his/her [NJ EX Order] from [NJ EX Order 2640]. The CNA called Housekeeping who cleaned the mattress, but the [NJ EX Order 2640] could not be removed.

On 11/15/22 at 12:39 PM, the surveyor interviewed the DON who confirmed the bed should not have been [NJ EX Order 2640]. She informed the surveyor that it was their policy for the CNAs to report items in disrepair and the staff should have reported to the UM.

On 11/22/22 at 2:12 PM, the Regional Clinical Nurse informed the survey team the resident's mattress was discarded.

On 11/23/22 at 10:19 AM, the LNHA in the presence of the RDO, Clinical Nurse, and survey team confirmed that the facility was aware of the resident's concerns regarding their mattress as of [NJ EX Order 2640] The LNHA confirmed the resident's mattress had been discarded in the trash.

A review of a "Staff Statement" from the CNA dated [NJ EX Order 2640], provided by the LNHA, indicated that the CNA was made aware on [NJ EX Order 2640] during morning care, Resident #1 complained to them about their mattress, and she informed the Supervisor.

A review of the facility provided undated "Work Orders, Maintenance" policy included policy statement: maintenance work orders shall be completed to establish priority of maintenance service. Policy Interpretation and Implementation 1. In order to establish a priority of maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

(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 917	Continued From page 15 service, work orders must be filled out and forwarded to the maintenance director. This may be achieved electronically via the use of [name redacted electronic work order program]. A review of the undated facility provided "Assistive Device and Equipment" policy included policy statement: our facility maintains and supervises the use of assistive devices and equipment for residents...Policy Interpretation and Implementation...6...c. Device condition - devices and equipment are maintained on schedule and according to manufacturer's instructions. Defective or worn devices are discarded or repaired. NJAC 8:39-31.8(c)(1)(10); 31.8(f)(3)	F 917		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061625	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE	261 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Part A: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 12 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	Part A "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," 1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be	12/19/22

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

Electronically Signed | 12/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061625	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE	261 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 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 2/1/2021: 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. During entrance conference on 11/14/22 at 10:29 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to complete the "Nurse Staffing Report" for the past two weeks at the facility. At this time, the LNHA informed the surveyor that the facility did not use Agency staff and the facility was good with staffing. A review of the requested "Nurse Staffing Report" completed by the facility for the weeks of 10/30/22 to 11/5/22 and 11/6/22 to 11/12/22, revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift and minimum requirement for total staff on the overnight shift as documented below: 10/30/22 had 10 CNAs for 107 residents on the	S 560	taken. ~~ All residents have the potential to be affected. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ A)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. Trends identified from these meeting will be presented during monthly QAPI meeting. B)The facility has implemented a multifaceted approach for recruitment and retention of employees, which includes Job fairs, Flexible scheduling, Increased utilization of PRN/Per diem staff (Staff hired without any set hours, usually staff who have another job and pickup extra shifts when the need arises), Implementation of advanced staffing management software system, 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, Text message campaigns. C)The facility continues to hire Temporary Nurse Aides who worked before Jan 11th 2022 for 80 hours under a licensed nurse with a letter of competency from their DON at the time, and the facility assists these staff to prepare for the CNA exam	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061625	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE	261 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 day shift, required 13 CNAs. 11/2/22 had 12 CNAs for 106 residents on the day shift, required 13 CNAs. 11/4/22 had 12 CNAs for 106 residents on the day shift, required 13 CNAs. 11/5/22 had 10 CNAs for 106 residents on the day shift, required 13 CNAs. 11/5/22 had 7 total staff for 106 residents on the overnight shift, required 8 total staff. 11/6/22 had 10 CNAs for 106 residents on the day shift, required 13 CNAs. 11/6/22 had 7 total staff for 106 residents on the overnight shift, required 8 total staff. 11/7/22 had 8 CNAs for 106 residents on the day shift, required 13 CNAs. 11/9/22 had 7 total staff for 106 residents on the overnight shift, required 8 total staff. 11/10/22 had 12 CNAs for 106 residents on the day shift, required 13 CNAs. 11/11/22 had 10 CNAs for 105 residents on the day shift, required 13 CNAs. 11/12/22 had 11 CNAs for 105 residents on the day shift, required 13 CNAs. NJAC 8:39-5.1(a) Part B: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to implement their staff COVID-19 vaccination policy by ensuring staff were up to date with all COVID-19 vaccinations as eligible in accordance with State and Federal requirements. This deficient practice was identified for 4 of 7 staff members reviewed for COVID-19 vaccination status (Staff #1, #2, #3,	S 560	prior to April 2023. D)The facility has hired and continues to hire unlicensed staff under the position of "Caring Partner" with duties to provide assistance to aides with tasks that do not require certification. The facility then pays for these staff to go to CNA school and become certified nurse aides. E)The facility has developed a Culture Committee focused on recruitment and retention of staff by enhancing the employee experience, some of the committee's activities include a weekly event for staff where food is provided, as well as bi-monthly large fun event with food and prizes with 2 employees of the Month chosen. The facility also has seasonal holiday parties, gives all employees presents during each holiday season and celebrates all employee's birthday's once a month. F)The facility has implemented the Care Champion Program to mentor new employees where the champions/mentors (senior CNA staff) receive a bonus if the new employee stays for a certain period of time. G)The facility participates in a weekly interdisciplinary Quality Care Resource call with consultants to review open positions, recruitment tactics, and changes to improve outcomes. H)The facility has implemented processes to increase communication with employees through monthly Townhall meetings and a Digital Suggestion Box. I)The facility conducts an exit meeting with any employee who resigns to better improve the employee experience and help with retention.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061625	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE	261 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 and #4) and was evidenced by the following: Reference: New Jersey Executive Directive 290, dated 3/2/22: 2. b. All covered workers must provide adequate proof that they are up to date with their COVID-19 vaccination by May 11, 2022; provided however, that as to having received a booster dose, covered workers must provide adequate proof that they are up to date with their COVID-19 vaccinations by May 11, 2022, or within 3 weeks of becoming eligible for a booster dose, whichever is later. During entrance conference on 11/14/22 at 10:29 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to complete the "COVID-19 Staff Vaccination Status for Providers" matrix for all their staff including contracted staff. At this time, the LNHA informed the surveyor that the Infection Preventionist/Registered Nurse (IP/RN) was currently out of the facility, but she was in charge of the COVID-19 vaccination program. On 11/15/22 at 12:08 PM, the LNHA provided the surveyor with the completed "COVID-19 Staff Vaccination Status for Providers" for all facility staff that included 146 staff members. The LNHA stated he would provide a separate matrix that included contracted staff. On 11/17/22 at 12:15 PM, the LNHA provided the surveyor with the "COVID-19 Staff Vaccination Status for Providers" for contracted staff which included 56 staff members. On 11/17/22 at 12:10 PM, the surveyor selected seven staff members from both the staff and	S 560	4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ A)Starting on 12/19/2022 the Administrator/designee will review the minutes from monthly resident council meetings for 3 months to determine whether there are any concerns regarding care and services. B)Starting on 12/19/2022 the Administrator/designee will review the minutes from the daily staffing meeting to determine whether all efforts are resulting in meeting staffing requirements. C)Starting on 12/19/2022 the Administrator/designee will interview five residents weekly for 4 weeks and then monthly for an additional 3 months to determine if needs are being met. D)Results of audits and reviews noted above, will be submitted to, and reviewed by the Quality Assurance Performance Improvement Committee monthly and the committee will make recommendations to the Administrator for any further actions and will recommend tapering and dissolution of audits and reviews once consistent compliance has been achieved. Part B: "All covered workers must provide	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061625	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE	261 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 contracted staff matrixes provided and requested from facility administration to provide a copy of their COVID-19 vaccination card or their exemption (religious or medical) if applicable. On 11/18/22 at 9:30 AM, the Regional Director of Operations (RDO) provided the surveyor with the requested COVID-19 vaccination documentation which revealed the following: Staff #1, a Certified Nursing Aide (CNA), received their completed primary series dose on 9/23/21 with no booster received. Staff #2, a CNA, received their completed primary series dose on 2/21/22 with no booster received. Staff #3, a Hospice Aide, received their completed primary series dose on 12/24/21 with no booster received. Staff #4, an X-ray Technician, received their completed primary series dose on 7/30/21 with no booster received. On 11/18/22 at 10:45 AM, the surveyor interviewed Staff #1 (CNA) who confirmed she had only received her COVID-19 vaccination primary series and not the booster. Staff #1 stated that she was educated and offered the booster, but she declined to receive it. Staff #1 stated the booster was not required for her; it was optional to receive. A review of the National Healthcare Safety Network (NHSN) data's "Recent Facility Resident and Staff Vaccination Rates and Other Data, as reported for the week ending 10/30/22" revealed 53.4% of staff were up to date with vaccines. A review of the facility provided "New Jersey COVID-19 Vaccination Mandate" policy dated updated 3/2/22, included the facility has	S 560	adequate proof that they are up to date with their COVID-19 vaccination by May 11, 2022" 1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. 1)On 11/28/2022 the Administrator issued a Memo to all staff on the requirement to get vaccinated as well as the benefits of getting vaccinated, and included relevant information regarding the safety and effectiveness of the new bivalent boosters. The Memo also included an offer for any employee to have a one-on-one audience with our Medical Director upon request to discuss their concerns. The Memo included a warning that failure to get boosted by 12/19/2022 will result in termination. 2)The Department heads, Administrator, Infection Preventionist and the Medical Director have spoken to upboosted employees to encourage them to get boosted, many have agreed, and some will require more cajoling as the deadline	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061625	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE	261 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 implemented this policy that requires covered workers to provide adequate proof that they have received recommended COVID-19 vaccinations or a valid exemption... Covered workers that have not provided adequate proof that they are up to date with required vaccinations will be subject to disciplinary action within two weeks of the deadlines outlined in this policy...Staff Vaccine Requirements...All facility staff will be up to date with their booster dose by April 11, 2022 or within three weeks of becoming eligible for booster dose, whichever is later... On 11/21/22 at 12:10 PM, the surveyor interviewed the IP/RN who confirmed she was in charge of the facility's COVID-19 vaccination effort and reported the facility's vaccination status to the NHSN. The IP/RN stated that she educated and offered staff the booster, but the facility had staff who were not up to date with their COVID-19 booster. The IP/RN stated any staff not up to date with their COVID-19 booster were tested twice a week for COVID-19. The IP/RN confirmed that all staff were required to be boosted by May 2022. At this time, the surveyor asked the IP/RN to provided them with a list of all staff who were eligible for the COVID-19 booster vaccine. On 11/22/22 at 11:50 AM, the IP/RN informed the surveyor the facility had 20 employees who were eligible for their COVID-19 booster vaccine that declined to receive the vaccine and had no documented medical or religious exemption. The IP/RN stated the facility did not use Agency staff so they could not afford to lose staff for the vaccination requirement, so they have continued to use these employees. On 11/23/22 at 10:19 AM, the survey team met	S 560	approaches. 3) The facility has begun administering boosters to upboosted employees and contractors, and will continue to do so until all staff are boosted. 4) The facility will terminate/ban any employee/contractor who refuses to receive a booster by 12/19/2022. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)The facility will not hire any staff member that is not vaccinated and boosted or does not have a valid exemption. 2)The facility will inform all contractors that any new staff they intend to send to the facility must be vaccinated and boosted, or must have a valid exemption. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1) Once compliance is met on 12/19/2022, the HR director will audit all new hires monthly for 4 months to ensure any new staff are vaccinated and boosted. 2) Once compliance is met on 12/19/2022, the ADON will audit all new contractors monthly for 4 months to ensure any new staff are vaccinated and boosted. 3) Results of audits noted above, will be submitted to, and reviewed by the Quality Assurance Performance Improvement Committee monthly for 4 months and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061625	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE	261 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6 with the facility's administration which included the LNHA, DON, RDO, and Regional Clinical Nurse. The RDO informed the survey team that all staff did not have their required COVID-19 vaccine booster was an "oversight" with staffing shortages. The administration team acknowledged that the state required all staff to have received their COVID-19 booster as of 5/11/22 or within three weeks of being eligible or had a documented exemption (religious or medical). NJAC 8:39-5.1(a); 19.4(a)	S 560	committee will make recommendations to the Administrator for any further actions.	
S2315	8:39-31.6(i)(1-2) Mandatory Physical Environment (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan; or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents.	S2315		1/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061625	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE	261 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2315	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to meet with municipal and county emergency management officials annually to review and update the emergency evacuation plan. This deficient practice was evidenced by the following: On 11/22/22 at 10:00 AM, the surveyor began reviewing the facility provided Emergency Preparedness Plan (EPP) binder marked "FO". The surveyor was unable to locate current documentation that the municipal and county emergency management officials reviewed the emergency evacuation plan annually. On 11/22/22 at 12:29 PM, the surveyor interviewed the Maintenance Director who was identified as responsible for the facility's EPP. The Maintenance Director stated there were five EPP binders and he would have to locate his copy. On 11/22/22 at 2:16 PM, the Licensed Nursing Home Administrator (LNHA) informed the survey team with the facility's remodeling, the EPP binders were misplaced, and he could only find two binders. The LNHA stated the EPP binder marked "FO" was the main binder. On 11/23/22 at 10:05 AM, the LNHA in the presence of the Regional Director of Operations (RDO) provided the surveyor with four EPP binders. The LNHA stated that he removed the outdated information and made additional copies to replace the missing binders. At this time, the	S2315	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. Emergency Preparedness Book was sent on 12/16/2022 to municipal and county emergency management officials to review and update the emergency evacuation plan. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ a) Administrator was educated by Regional Director of Operations on 12/07/2022 of requirement for Emergency Preparedness Book to be sent annually to municipal and county emergency management officials to review and update the emergency evacuation plan as necessary. b) On 12/16/2022 the facility added an annual task to the facility's maintenance and safety software system,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061625	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE	261 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2315	Continued From page 8 surveyor requested a copy of documentation that the municipal and county emergency management officials reviewed their emergency evacuation plan for 2022. On 11/23/22 at 11:10 AM, the LNHA informed the surveyor that he did not send the emergency evacuation plan to the municipal and county emergency management; he was unaware he had to send it. The LNHA stated he seen the facility's previous owners kept copies of the mail receipts to the local emergency management from years past in the EPP binder, but he discarded them because he was unaware what the mail receipts were for. During Life Safety Code exit conference on 11/23/22 at 11:51 AM, the Regional Director of Plant Operations (RDPO) in the presence of the LNHA and RDO informed the surveyor that he reached out to their local emergency management for documentation that they reviewed their emergency evacuation plan for that year. The LNHA and RDO stated they would email the surveyor the documentation. A review of a post survey email dated 11/28/22 at 2:12 PM, the LNHA informed the surveyor they were unable to obtain the requested document and would send their emergency evacuation plan to the fire marshal, municipal emergency management, and municipal police department. NJAC 8:39-31.2(e); 31.6(i)	S2315	for the Maintenance Director or Administrator to send the Emergency Preparedness Book to municipal and county emergency management officials to review and update the emergency evacuation plan as necessary. All open/due task reports will automatically be sent weekly to the Regional Director of Operations as well as the Regional Director of Plant Operations to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1) The Reginal Director of Operations will audit on January 2nd of 2023 to ensure that the Emergency Preparedness Book and the included emergency evacuation plan was reviewed by municipal and county emergency management officials. The Regional Director of Operations will follow up as necessary. 2) An audit report of all open tasks will be ran from the facility's maintenance software system prior to each quarterly QAPI meeting for the next 4 Quarterly QAPI meetings and will be reviewed by the Quality Assurance Performance Improvement Committee and the committee will make recommendations to the Administrator for any further actions.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061625		2/9/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/19/2022	ID Prefix S2315 Reg. # 8:39-31.6(i)(1-2) LSC	Correction Completed 01/02/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 11/23/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315234	A. Building B. Wing	2/9/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

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 F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 12/19/2022	ID Prefix F0756 Reg. # 483.45(c)(1)(2)(4)(5) LSC	Correction Completed 12/19/2022	ID Prefix F0917 Reg. # 483.10(i)(4), 483.90(e)(2)(3) LSC	Correction Completed 12/19/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
11/23/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO