

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

PRINTED: 06/17/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/23/2025
NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00179526, NJ00180804, NJ00170513, NJ00182497, NJ00185031 Survey Date: 4/14/2025-4/23/2025 Census: 99 Sample: 20+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000			
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584			5/12/25

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

TITLE

(X6) DATE

Electronically Signed

05/16/2025

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

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Repeat Deficiency Based on observation and interview it was determined that the facility failed to maintain the facility in a clean and sanitary environment. This deficient practice was identified for 2 of 2 units, (NJ Exec Order 26.4b1) and was evidenced by the following: 1. On 04/14/25 at 10:27 AM, during initial tour of the [NJ Exec Order] unit, the surveyor noted dark "scuff" marks in the hallway outside room [NJ Exec Order]. Inside room [NJ Exec Order], the surveyor observed the heater unit with a dark brown/reddish substance noted on the "fins" of the heater and brownish/blackish marks on the body of the heater unit. At 10:40 AM, the surveyor noted multiple cracked floor tiles in room [NJ Exec Order]. At 10:49 AM, the surveyor observed the heater in room [NJ Exec Order] with brown/black substances	F 584	Scuff in hallway outside room [NJ Exec Order] was immediately removed. Heater in room [NJ Exec Order] was immediately cleaned and painted cracked floor tiles in room [NJ Exec Order] were replaced. Heater in room [NJ Exec Order] was cleaned and painted. Closet door in room [NJ Exec Order] and broken bottom drawer of dresser were repaired. Missing section of floor tiles and cracks in the tile under the bed were replaced. Contractor was hired for Leak from the ceiling tile in the hallway that leads to main dining room on first floor. Guard rails in elevator and large circle are was repaired and painted. Missing tiles under the sink and brown ceiling tiles in room [NJ Exec Order] were		

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F 584	Continued From page 2 in "fins" of unit and on body of heater unit. The closet doors were noted to be off the track and bottom dresser drawer front was broken and askew. Also, in this room the surveyor noted a missing section of floor tile and cracks in the tile were noted under the bed. On 4/16/25 at 10:34 AM, the surveyor reviewed the work order report dated 4/15/25. Heaters in rooms [REDACTED] and [REDACTED] cracked tiles in room [REDACTED] and cracked/missing tile in room [REDACTED] were not found on list. On 4/16/25 at 12:41 PM, the surveyor interviewed the [REDACTED] U.S. FOIA (b)(6)). When asked about the floors on the [REDACTED] unit, specifically the scuff marks by room [REDACTED], the [REDACTED] U.S. FOIA (b)(6) stated the floors are mopped daily and the scuff marks don't come up with mopping. He stated those marks were from bed swaps. When the surveyor asked about the heaters in rooms [REDACTED] and [REDACTED] the [REDACTED] U.S. FOIA (b)(6) stated they (heater units) all need to be painted. The [REDACTED] U.S. FOIA (b)(6) further stated regarding the heater units, "This is certainly not ok, they're on the list." When the surveyor asked about the closet doors and drawer front in room [REDACTED], he stated they are currently addressing the closet doors. The [REDACTED] U.S. FOIA (b)(6) further explained that the closet doors are about forty years old and have exceeded their life expectancy. He went on to explain that the closet doors aren't an easy thing to fix, it's an involved process. When the surveyor asked about the missing tile on floor in room [REDACTED] and cracked tiles in room [REDACTED], he stated it's on the list. The surveyor mentioned that these items were not on the list he provided to the team, he stated he has other lists, in addition to the one provided to surveyors the day before. He	F 584	replaced and vent was cleaned. Corner end of hand rail between the noble nurses station and the pantry was repaired. Portion of the column at nurses station was replaced. All residents who live/use these areas have the potential to be affected. Director of maintenance/designee will conduct weekly maintenance rounds for through the whole facility, including all listed items above to ensure a clean and sanitary environment is maintained. The results of the audits will be reported at the monthly QAPI meetings for 3 months and as needed thereafter. Director of maintenance/designee will conduct weekly maintenance audits to ensure a clean and sanitary environment is maintained for one month and then monthly for two months. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee. The director of maintenance will take action as needed.		

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F 584	Continued From page 3 then showed the surveyor his phone with a long list between himself and his assistant. The [U.S. FOIA (b)(6)] further explained that he stars the priorities and can move the items around as needed. He further explained that he just discovered a cache of tiles that matched the ones on the floors and that the work just needs to be scheduled to be done. On 4/17/25 at 11:25 AM, the surveyor observed the drawer front and closet doors were repaired. The scuff marks in [NJ Exec Order] hallway outside room [NJ Exec Order] are no longer present and area of lighter colored floor noted in that area. 2. On 4/14/25 at 11:50 AM, the surveyor observed fluid leaking from the ceiling tiles in the hallway that leads to the main dining room on the first floor, in the presence of the [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] acknowledged the leak and stated the [NJ Exec Order] unit was above this area and he thought there were leaking sinks on the unit. He further stated the [U.S. FOIA (b)(6)] was aware. On 4/15/25 at 10:00 AM, the surveyor observed the back wall inside the elevator. To the right of a frame there was a large circle-like area that had multiple layers of peeled paint. In addition, the interior wooden guard rails around the perimeter of the elevator were scratched and gouged. On 4/17/25 at 12:22 PM, the [U.S. FOIA (b)(6)] acknowledge the new pictures in the elevator were covering the peeled paint and stated, "I have to do what I have to do." 3. On 4/14/25 at 11:52 AM, during the initial tour of the [NJ Exec Order 25.45] unit, the surveyor noted room [NJ Exec Order] had missing floor tile under the sink and brown	F 584			

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F 584	Continued From page 4 discolored ceiling tiles with a vent, that had a buildup of black debris, at the nurse's station. On 4/15/25 at 11:58 AM, the surveyor observe the corner end of the hand rail, between the [REDACTED] Nurse's station and the pantry, was missing and the corner piece of the lower portion of the column at the nurse's station was pulled away from the column and there was exposed white spackle and debris. On 4/15/25 at 12:00 PM, the surveyor interviewed the [REDACTED] who stated he did environment tours daily. He explained he does a visual inspection of each unit every day. He stated he looks up and down the walls of the units and stands in the doorway of every room looking for "something out of place." He stated staff can enter maintenance requests directly into the maintenance computer system. At that time, the [REDACTED] toured the [REDACTED] unit with the surveyor. He observed the missing floor tiles in room [REDACTED] and stated "the tiles are 40 years old and I can't find matching tiles." He acknowledged the brown discolored ceiling tiles and the black debris on the vent at the nurse's station. He stated, "there was a terrible leak here about 2 weeks ago and I did not replace tiles." He stated, "the vent was not clean but they should be done quarterly when we do the filters." On 4/15/25 at 12:22 PM, the [REDACTED] toured the [REDACTED] unit with the surveyor. He acknowledged the missing end cap of the hand rail at the nurse's station and stated "they are 40 year old railings and it's difficult to find replacement pieces." He acknowledged the corner of the column at the nurse's station and stated, "it's on my list."	F 584			

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F 584	Continued From page 5 On 4/17/25 at 12:22 PM, the surveyor interviewed the Certified Nursing Aid (CNA #1), who stated he would try to fix things himself and if he couldn't fix it, he would call maintenance. On 4/17/25 at 12:28 PM, the surveyor interviewed CNA #2, who stated if she identified something was in disrepair, she would report it to the nurse or the supervisor. On 4/17/25 at 12:32 PM, the surveyor interviewed the Licensed Practical Nurse (LNP #1), who stated if something needed to be repaired she would enter it directly into the maintenance computer system and if maintenance didn't respond within 30 minutes, she would call them because "they usually fixed things right away." 4. On 4/15/25 at 8:00 AM, during the morning medication administration observation, the surveyor observed a brown stain on two (2) of the ceiling tiles that were to the right of the door when entering inside Room [REDACTED]. The brown stains covered a majority of the tiles. On 4/15/25 at 8:06 AM, during the morning medication administration observation, the surveyor observed, a brown stain on one (1) ceiling tile above the doorway inside Room [REDACTED]. The brown stain covered the majority of the tile. On 4/16/25 at 12:25 PM, the surveyor observed again, the same brown stained ceiling tiles, as described above, in Room [REDACTED] and [REDACTED]. On 4/17/25 at 12:22 PM, the [REDACTED] acknowledged the brown stained ceiling tiles in room [REDACTED] and [REDACTED] and stated, "I will add them to	F 584			

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F 584	Continued From page 6 my list." On 4/22/25 at 4:26 PM the U.S. FOIA (b)(6) [REDACTED] were notified of the above concerns. The U.S. FOIA (b)(6) [REDACTED] stated the facility had a system of non-clinical rounds by the department heads and the U.S. FOIA (b)(6) [REDACTED] does his own rounds as well. The U.S. FOIA (b)(6) [REDACTED] stated they (the management company) buys buildings that need to be spruced up and then manage or buy them and fix them up, but it takes time, not everything can be done at once.	F 584			
F 732 SS=D	N.J.A.C. 8:39-31.4 (a) (c) (f) Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732			4/23/25

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F 732	Continued From page 7 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to post the nurse staffing report daily. This deficient practice was evidenced by the following: On 4/14/25 at 9:31 AM, the surveyor did not observe the nursing staffing report posted at the front reception desk, the time clock, the elevator, or at either nursing unit. The receptionist was present at the front desk. On 4/15/25 at 9:31 AM, the surveyor did not observe the nursing staffing report posted at the front reception desk, the time clock, the elevator, or on the Red Cross Orders nursing unit. The receptionist was present at the front desk. On 04/16/25 at 9:44 AM, the surveyor observed the nursing staffing report posted at the front desk dated 4/15/25 for the 7-3 shift.	F 732	On 4/15/25 Staffing schedule was immediately posted at front desk All resident that are not aware of staffing scheduled have potential to be effected. Staffing coordinator was re-educated on the importance of posting the daily staffing schedule New process implemented for posting daily schedule when the staffing coordinator is off. Staffing coordinator or designee will conduct 3 audits a week for 4 weeks then weekly for 2 months to ensure staffing schedule is being posted. The results of the audits will be reported at the monthly Quality Assurance Performance		

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F 732	Continued From page 8 On 4/16/25 at 11:16 AM, the surveyor observed the nursing staffing report posted at the front desk dated 4/16/25 for the 7-3 shift. On 04/17/25 at 9:24 AM, the surveyor observed the nursing staffing report posted at the front desk dated 4/17/25 for the 7-3 shift. On 4/22/25 at 9:32 AM, the surveyor observed the nursing staffing report posted at the front desk dated 4/22/25 for the 7-3 shift. On 4/15/25 at 11:00 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated staffing was usually posted at the front desk. She further stated "I am responsible, I have been gone for 2 weeks. I just got back yesterday. Nobody posted the staffing while I was gone. The staffing was not posted yesterday or today, until I got it here. I just now printed it. I usually wait until after morning meeting to post it so it's accurate. I give it to the lady at the front desk but doesn't look like she did it." On 4/22/25 at 4:26 PM, the survey team met with the U.S. FOIA (b)(6) who stated she was not sure who was responsible to post the nursing staffing report when the U.S. FOIA (b)(6) was away. She further stated maybe the receptionist was responsible. On 4/23/25 at 11:10 AM, the survey team met with the U.S. FOIA (b)(6), who stated the staffing report was not posted on Monday (4/14/24). A review of undated facility provided policy "Staffing Policy Statement" included: Our facility provides adequate staffing to meet	F 732	Improvement Committee and staff coordinator will take action as needed		

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F 732	Continued From page 9 needed care and services for our resident population. Policy 5. Staffing will be posted in a visible location.	F 732			
F 755 SS=E	NJAC 8:39-41.2 (a) Pharmacy Svcs/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(f). 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 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	F 755			5/12/25

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2HP811 Facility ID: NJ61805 If continuation sheet Page 11 of 57

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F 755	Continued From page 11 the [REDACTED] unit. At that time, the surveyor with LPN #1 observed a [REDACTED] labeled for Resident #201. The bottle had no date when opened and had approximately [REDACTED] remaining. On 4/17/25 at 10:47 AM, LPN #1 could not speak to the [REDACTED] for Resident #201 and referred to the U.S. FOIA (b)(6) [REDACTED] stated that Resident #201 no longer resided in the facility and that the [REDACTED] bottle should have been dated when opened and discarded 90 days after opening or when Resident #201 was discharged. At that time [REDACTED] was unable to provide the Individual Patient [REDACTED] Administration Record [REDACTED] for Resident #201 that corresponded with the [REDACTED]. The [REDACTED] acknowledged that without an [REDACTED] the [REDACTED] was not being counted during the shift-to-shift count of [REDACTED]. On 4/17/25 at 11:05 AM, during further inspection of the medication room on the [REDACTED] unit, the surveyor, with [REDACTED], observed in an unlocked cabinet, a clear plastic bag that contained the following [REDACTED] labeled for Resident #204: three (3) unopened boxes of [REDACTED] [REDACTED] [REDACTED] a bottle of [REDACTED] [REDACTED] a bottle of [REDACTED] [REDACTED] a bottle of two (2)	F 755			

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F 755	Continued From page 12 NJ Exec Order 26.4b1 [REDACTED] remaining and NJ Exec Order 26.4b1 [REDACTED] In addition, in the clear plastic bag, labeled for Resident #203: a NJ Exec Order 26.4b1 [REDACTED] At that time, the U.S. FOIA (b)(6) stated that she had been the U.S. FOIA (b)(6) for approximately three (3) weeks and was unaware of the clear plastic bag with controlled drugs kept in the unlocked cabinet in the medication room. The U.S. FOIA (b)(6) stated that all the controlled drugs should have been returned to the provider pharmacy or destroyed and that it was "ridiculous." On 4/17/25 at 11:35 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated she was U.S. FOIA (b)(6) for the past month and had not had any reports of discrepancies regarding NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6) also stated all the above NJ Ex Order 26.4(b)(1) in the bag should have been destroyed by the previous U.S. FOIA (b)(6) with another nurse. The U.S. FOIA (b)(6) acknowledged NJ Ex Order 26.4(b)(1) were not to be stored in the medication room in an unlocked cabinet and required double locked storage. The U.S. FOIA (b)(6) was unable to provide an NJ Ex Order 26.4(b)(1) for Resident #203 and #204 corresponding to each NJ Ex Order 26.4(b)(1) in the bag and stated she would have to check. The U.S. FOIA (b)(6) acknowledged the NJ Ex Order 26.4(b)(1) in the bag were not being accounted for during the shift-to-shift count of NJ Ex Order 26.4(b)(1) medications. The U.S. FOIA (b)(6) stated she was unaware of the NJ Ex Order 26.4(b)(1) in the cabinet and would have to begin an investigation.	F 755			

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F 755	Continued From page 13 On 4/17/25 at 1:25 PM, the surveyor interviewed LPN #2 who had completed the admission records for Resident #204. LPN #2 looked at the NJ Ex Order 26.4(b)(1) labeled for Resident #204 in the bag and stated that she could not remember the resident coming to the facility with the medications in the bag. On 4/17/25 at 1:45 PM, the surveyor interviewed the [U.S. FOIA (b)] who provided the surveyor with an NJ Ex Order 26.4(b)(1) labeled for NJ Exec Order 26.4b1 for Resident #201. The surveyor with the [U.S. FOIA (b)] reviewed the NJ Ex Order 26.4(b)(1) which revealed that NJ Exec Order 26.4b1 was received on NJ Exec Order 26.4(b)(1) and a declining inventory was documented from NJ Exec Order 26.4b1. The remaining balance was NJ Exec Order 26.4b1 on NJ Ex Order 26.4(b)(1). Further review of the NJ Ex Order 26.4(b)(1) revealed the date of disposition was NJ Ex Order 26.4(b)(1) and signed by the former [U.S. FOIA (b)] and former [U.S. FOIA (b)]. The [U.S. FOIA (b)] verified the NJ Ex Order 26.4(b)(1) inaccurately documented the NJ Ex Order 26.4(b)(1) remaining amount NJ Exec Order 26.4b1 was destroyed on NJ Exec Order 26.4(b)(1). A review of the Admission Record (AR) for Resident #201 revealed that the resident had NJ Ex Order 26.4(b)(1) the facility on NJ Exec Order 26.4(b)(1). The [U.S. FOIA (b)] was unable to provide documentation or an NJ Ex Order 26.4(b)(1) that would indicate receipt, accountability and reconciliation of the above listed NJ Ex Order 26.4(b)(1) that were contained in the clear plastic bag. A review of the AR for Resident #204 revealed that the resident had NJ Ex Order 26.4(b)(1) the facility on NJ Ex Order 26.4(b)(1). A review of the AR for Resident #203 revealed	F 755			

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F 755	Continued From page 14 that the resident was discharged from the facility on [REDACTED] On 4/17/25 at 2:06 PM, the survey team met with the [REDACTED] U.S. FOIA (b)(6) [REDACTED]. The [REDACTED] stated the [REDACTED] U.S. FOIA (b)(6) was new to the facility and would not have knowledge of the [REDACTED] NJ Ex Order 26.4(b)(1) found in the medication room. The [REDACTED] U.S. FOIA (b)(6) acknowledged that the medication room should have been checked for proper storage. The [REDACTED] U.S. FOIA (b)(6) stated that a unit inspection was performed monthly by the [REDACTED] U.S. FOIA (b)(6) and reviewed those reports. The [REDACTED] U.S. FOIA (b)(6) acknowledged that [REDACTED] NJ Ex Order 26.4(b)(1) should not have been stored in the medication room in an unlocked cabinet and accurate records were supposed to be maintained. A review of CP "Unit Inspection" reports from [REDACTED] NJ Ex Order 26.4(b)(1) had not identified the above findings. On 4/22/25 at 8:49 AM, the surveyor interviewed the [REDACTED] U.S. FOIA (b)(6) via telephone. The [REDACTED] U.S. FOIA (b)(6) stated that she was not the [REDACTED] U.S. FOIA (b)(6) who had completed the unit inspection reports but was able to speak to any questions. The [REDACTED] U.S. FOIA (b)(6) explained that medication room cabinets and medication refrigerators were checked as part of the unit inspection and any concerns identified would be listed on the reports. In addition, the [REDACTED] U.S. FOIA (b)(6) stated controlled drug accountability and reconciliation was spot checked once a month, meaning on the day of the inspection at that moment the controlled drugs were reviewed. The [REDACTED] U.S. FOIA (b)(6) added that she may not have the knowledge of residents who had been discharged but if the medication was expired would bring that to the attention of	F 755			

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F 755	Continued From page 15 nursing right away. The [U.S. FOIA (b)(6)] could not speak to what happens after bringing expired medications or medications that needed to be disposed of to nursing. The [U.S. FOIA (b)(6)] also added that the current [U.S. FOIA (b)(6)] was more receptive to the reports than the previous [U.S. FOIA (b)(6)]. On 4/22/25 at 9:56 AM, the survey team met with [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] stated the [NJ Ex Order 26.4(b)(1)] for Resident #204 that were in the bag were brought in the facility by the family and there was a nursing progress note indicating that the family was called to pick up the [NJ Ex Order 26.4(b)(1)] after Resident #204 expired. The [U.S. FOIA (b)(6)] also stated that usually medications from home would not be accepted and was unable to verify when the [NJ Ex Order 26.4(b)(1)] were accepted in [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)(6)] acknowledged there was no system of receipt, accountability and reconciliation that had been done. The [U.S. FOIA (b)(6)] could not speak to why the [NJ Exec Order 26.4b1] bottle for Resident #201 was not removed from active inventory when there was no corresponding [NJ Ex Order 26.4(b)(1)] on the unit and the opened bottle had no open date and was expired. The [U.S. FOIA (b)(6)] also could not speak to why there were no records for the bottle of [NJ Exec Order 26.4b1] for Resident #203. [NJ Exec Order 26.4b1] added that the nurses were inserviced by the [U.S. FOIA (b)(6)] and the [NJ Ex Order 26.4(b)(1)] that needed to be destroyed were documented. A review of the facility undated policy titled "Storage of Medications" provided by the [U.S. FOIA (b)(6)] reflected "Controlled Substances will be stored in a separate container under double lock." A review of the facility policy titled "Controlled Substances" updated 8/22/24 provided by CCO	F 755			

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F 755	Continued From page 16 reflected the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled substances. In addition, "Controlled substances will be counted upon delivery. The nurse receiving the order, along with the person delivering the medication order, will count the controlled substances together. Both individuals will sign the designated narcotic record for the pharmacy records." Also, "Accurate accountability of the inventory of all controlled substances is maintained." "Nursing staff will count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty will complete the count together. They must document and report any discrepancies to the Director of Nursing Services." Further review reflected, "When a resident or patient is transferred or discharged, controlled substances may not be given to the resident to take with them and may not be returned to the pharmacy, but must be destroyed in accordance with established policies." A review of the manufacturer specifications for U.S. FOIA (b)(6) reflected that the NJ Exec Order 26.4(b)(1) solution be stored in the refrigerator and "Discard opened bottle after 90 days." 2. On 4/17/25 at 11:33 AM, the surveyor with LPN #1 inspected the NJ Ex Order 26.4(b)(1) on the medication cart for Resident #202, which revealed an NJ Ex Order 26.4(b)(1) labeled for Resident #202 for NJ Exec Order 26.4b1, two (2) solutions and indicated that the remaining balance was one (1). LPN #1 was unable to show the surveyor the remaining U.S. FOIA (b)(6). LPN #1 thought there was only one (1) sent by the	F 755			

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F 755	Continued From page 17 provider pharmacy. LPN #1 verified that her signature was on the [REDACTED] as receiving the drug but had not signed the date received or amount received but the provider pharmacy label indicated two (2) solutions, the number two (2) was circled and there was a "Nurse Administering" signature for the number (2) indicating removal of one (1) and remaining balance of one (1). LPN #1 stated that she had not reported any discrepancies regarding controlled drugs for the medication cart. LPN #1 verified that she had signed the Resident [REDACTED] NJ Ex Order 26.4(b)(1) Accountability Log for the "Incoming Nurse" for 4/17/25 for the 7 AM to 3 PM shift with another nurse who signed the "Outgoing Nurse" and neither had a discrepancy. Further review of [REDACTED] NJ Ex Order 26.4(b)(1) for Resident #202 revealed two (2) [REDACTED] NJ Ex Order 26.4(b)(1) for [REDACTED] NJ Exec Order 26.4b1 as indicated: [REDACTED] NJ Ex Order 26.4(b)(1) #1 with a prescription (RX) number ending in [REDACTED] NJ Exec D dated as received [REDACTED] NJ Ex Order 26.4(b)(1) with an amount received of two (2) indicated that the remaining balance was one (1). The surveyor with LPN #1 observed [REDACTED] NJ Exec Order 26.4b1 [REDACTED] for Resident #202 with corresponding RX number ending in [REDACTED] NJ Exec D - [REDACTED] NJ Ex Order 26.4(b)(1) #2 with RX number ending in [REDACTED] NJ Exec D dated as received [REDACTED] NJ Ex Order 26.4(b)(1) with an amount received of two (2) indicated that the remaining balance was (2). The surveyor with LPN #1 observed one (1) [REDACTED] NJ Exec Order 26.4b1 [REDACTED] Resident #202 with corresponding RX number ending in [REDACTED] NJ Exec D. In addition, there was a partially torn paper wrapped around the dispenser titled "Return (discontinued crossed out) Medication Form" dated [REDACTED] NJ Ex Order 26.4(b)(1) LPN #1 stated she was not sure why the form	F 755			

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F 755	Continued From page 18 was there but thought the medication was to be returned to the provider pharmacy. At that time, LPN #1 verified [NJ Ex Order 26.4(b)] #1 and [NJ Ex Order 26.4(b)] #2 were not accurately corresponding to the remaining balances. LPN #1 also verified that the nurses should be corresponding the RX numbers of the [NJ Ex Order 26.4(b)(1)] to the [NJ Ex Order 26.4(b)(1)] On 4/17/25 at 11:35 AM, the surveyor interviewed the [U.S. FOIA (b)] who stated she was the [U.S. FOIA (b)] for the past month and had not had any reports of discrepancies regarding [NJ Ex Order 26.4(b)(1)]. On 4/17/25 at 11:42 AM, the surveyor interviewed the [U.S. FOIA (b)] and [U.S. FOIA (b)] regarding the [NJ Ex Order 26.4(b)] labeled for Resident #202 for [U.S. FOIA (b)(6)] with a remaining balance of one (1). The [U.S. FOIA (b)] stated Resident #202 was admitted to the hospital last night and would have to look for the spray if two sprays were received. [U.S. FOIA (b)] acknowledged that the [NJ Exec Order 26.4b1] [NJ Ex Order 26.4(b)] #1 and [NJ Ex Order 26.4(b)] #2 were inaccurate and that the nurses were to check the corresponding RX numbers. The [U.S. FOIA (b)] was unable to speak to the paper titled "Return Medication Form." The [U.S. FOIA (b)] added that controlled drugs were not returned to the pharmacy. On 4/17/25 at 2:06 PM, survey team met with [U.S. FOIA (b)(6)] [U.S. FOIA (b)] acknowledged that the IPCSAR for [NJ Exec Order 26.4b1] should be completed for received date and amount received. The [NJ Exec Order 26.4b1] stated that they were reviewing the shift to shift "Resident Controlled Substance Accountability Log" that the nurses signed when counting controlled drugs and had identified that the form was not being completed properly and needed to be changed.	F 755			

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F 755	Continued From page 19 On 4/22/25 at 8:49 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] via telephone. [U.S. FOIA (b)(6)] stated that she was not the [U.S. FOIA (b)(6)] who had completed the unit inspection reports but was able to speak to any questions. The [U.S. FOIA (b)(6)] explained that medication room cabinets and medication refrigerators were checked as part of the unit inspection and any concerns identified would be listed on the reports. In addition, the [U.S. FOIA (b)(6)] stated [NJ Ex Order 26.4(b)(1)] accountability, and reconciliation was spot checked once a month, meaning on the day of the inspection at that moment the controlled drugs were reviewed. The [U.S. FOIA (b)(6)] added that she may not have the knowledge of residents who had been discharged but if the medication was expired would bring that to the attention of nursing right away. The [U.S. FOIA (b)(6)] could not speak to what happens after bringing expired medications or medications that needed to be disposed of to nursing. The [U.S. FOIA (b)(6)] also added that the current [U.S. FOIA (b)(6)] was more receptive to the reports than the previous [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] also stated that the RX number for the IPSCAR must match the controlled drug count for accuracy. A review of CP Unit Inspections from May 2024 to March 2025 had not identified the above findings. On 4/22/25 at 9:56 AM, the survey team met with [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)] stated that [NJ Exec Order 26.4b1] for Resident #202 was not found because the night nurse had discarded the [NJ Exec Order 26.4b1] without documentation and was unsure what had happened. [U.S. FOIA (b)(6)] added that the nurse was written up. [U.S. FOIA (b)(6)] acknowledged that destruction of controlled drugs was to be documented on the IPSCAR. [U.S. FOIA (b)(6)] stated [U.S. FOIA (b)(6)] should not have had a form for	F 755			

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F 755	Continued From page 20 return because controlled drugs were not returned to the pharmacy. [U.S. FOIA (b)] added that the nurses were inserviced by the [U.S. FOIA (b)] and the [NJ Ex Order 26.4(b)(1)] that needed to be destroyed were documented. A review of the physician's orders for Resident #202 revealed that [NJ Exec Order 26.4b1] was discontinued on [NJ Exec Order 26.4b1]. On 4/22/25 at 11:52 AM, the surveyor interviewed a [U.S. FOIA (b)(6)] from the provider pharmacy via telephone. The [U.S. FOIA (b)(6)] stated that [NJ Exec Order 26.4b1] was dispensed for Resident #202 on [NJ Exec Order 26.4b1] a box containing two (2) sprays. The [U.S. FOIA (b)(6)] was unable to identify an expiration date on the [NJ Exec Order 26.4b1] dispensed at that time. On 4/22/25 at 1:19 PM, the surveyor interviewed LPN #3 who stated that she had worked last week 11 PM to 7 AM and on the morning of 4/15/25 she was cleaning out the medication cart for any expired medications. LPN #3 added that when she counted the [NJ Ex Order 26.4(b)(1)] inventory with LPN #1 she had noticed that the [NJ Exec Order 26.4b1] was expired and remembered removing the spray and carrying other expired medications with her to go to the computer to reorder the [NJ Exec Order 26.4b1] where she realized there was no current physician's order. LPN #3 then stated that she thinks she accidentally discarded the [NJ Exec Order 26.4b1] with the other medications that she had removed from the medication cart. "I made a stupid mistake." On 4/22/25 at 4:27 PM, the survey team met with [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] stated Resident #202 was in the hospital currently and	F 755			

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F 755	Continued From page 21 the [NJ Exec Order 26.4b1] were destroyed and documented. The [U.S. FOIA (b)] added that she would check regarding the physician's order dating for the [NJ Exec Order 26.4b1]. A review of the physician's orders for Resident #202 revealed [NJ Exec Order 26.4b1] was discontinued [U.S. FOIA (b)(6)]. A review of the IPCSAR #1 and IPCSAR #2 labeled for Resident #202 for the [NJ Exec Order 26.4b1] provided by the [U.S. FOIA (b)] indicated that the [U.S. FOIA (b)] and [U.S. FOIA (b)(6)] had destroyed the [NJ Exec Order 26.4b1] dispensers or [NJ Exec Order 26.4b1]. On 4/23/25 at 11:14 AM, the survey team met with [U.S. FOIA (b)(6)] stated with [U.S. FOIA (b)(6)] in place now, if a resident was discharged all medications would be removed. The [U.S. FOIA (b)] added that it was the responsibility of the nurses to remove from active inventory any medications for discharged residents or for any discontinued physician's orders. A review of the facility policy titled "Controlled Substances" updated 8/22/24 provided by CCO reflected the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled substances. In addition, "Controlled substances will be counted upon delivery. The nurse receiving the order, along with the person delivering the medication order, will count the controlled substances together. Both individuals will sign the designated narcotic record for the pharmacy records." Also, "Accurate accountability of the inventory of all controlled substances is maintained." "Nursing staff will count controlled drugs at the end of each shift. The nurse coming	F 755			

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F 755	Continued From page 22 on duty and the nurse going off duty will complete the count together. They must document and report any discrepancies to the Director of Nursing Services." Further review reflected, "When a resident or patient is transferred or discharged , controlled substances may not be given to the resident to take with them and may not be returned to the pharmacy, but must be destroyed in accordance with established policies." 3. On 4/17/25 at 11:24 AM, the surveyor with LPN #2 inspected the NJ Ex Order 26.4(b)(1) in the medication cart for Resident #34 which revealed a NJ Ex Order 26.4(b)(1) Administration Record for NJ Ex Order 26.4(b)(1) labeled for NJ Ex Order 26.4b1 dated as received NJ Ex Order 26.4b1 with the amount received as NJ Ex Order 26.4b1. Further review, revealed that at 10:41 AM on NJ Ex Order 26.4b1 LPN #2 signed on line three (3) indicating the NJ Ex Order 26.4b1 was removed from inventory and applied. In addition, on the same date and time the NJ Ex Order 26.4b1 the LPN #2 signed for was removed and wasted. LPN #2 stated she had first removed an NJ Ex Order 26.4b1 from last week and put the NJ Ex Order 26.4b1 on Resident #34. LPN #2 added she had just started the new NJ Ex Order 26.4b1 and showed the surveyor the remaining balance of (2) NJ Ex Order 26.4b1 in the medication cart. The surveyor, with LPN #2, reviewed the current physician's order which indicated a start date of NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1. NJ Ex Order 26.4b1 LPN #3 acknowledged the NJ Ex Order 26.4b1 she had applied today NJ Ex Order 26.4b1, would be removed and wasted next Thursday. LPN #2 acknowledged that the documentation on NJ Ex Order 26.4b1 indicated the NJ Ex Order 26.4b1 she applied had been	F 755			

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F 755	Continued From page 23 removed and discarded today. LPN #2 stated she would have to review with [U.S. FOIA (b) (6)]. In addition, LPN #2 stated she had wasted the [NJ Exec Order 26.4b1] that she removed from the resident and showed LPN #1, but that LPN #1 had not signed the CSARP yet. LPN #2 acknowledged that when the [NJ Exec Order 26.4b1] was wasted both signatures were needed. On 4/17/25 at 11:42 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] regarding the CSARP labeled for Resident #34 for [NJ Exec Order 26.4b1]. The [U.S. FOIA (b) (6)] stated there should be two nurses' signature for the wastage of the controlled drug. [U.S. FOIA (b) (6)] acknowledged that the CSARP had not reflected the application and removal properly and would have to look into it. On 4/17/25 at 2:06 PM, the survey team met with [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] stated that she would have to review and /or change the process of the [NJ Exec Order 26.4b1] wastage signatures. On 4/22/25 at 9:56 AM, the survey team met with [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] stated LPN #2 had signed for the removal of the [NJ Exec Order 26.4b1] but had not wasted the [NJ Exec Order 26.4b1] and was holding the [NJ Exec Order 26.4b1] in a cup in the medication cart until LPN #1 was available to destroy the [NJ Exec Order 26.4b1]. The [U.S. FOIA (b) (6)] added the regulation, and our policy requires signing at the time of destruction. The [U.S. FOIA (b) (6)] was unable to speak to the interview with the surveyor and LPN #2 at the medication cart. The [U.S. FOIA (b) (6)] stated LPN #2 was on vacation now. The [U.S. FOIA (b) (6)] also stated the corresponding [NJ Ex Order 26.4(b)] for the [U.S. FOIA (b) (6)] that was removed by LPN #2 was not in the [NJ Ex Order 26.4(b)(1)] binder at the time LPN #2 removed the [NJ Exec Order 26.4b1] to waste. The [U.S. FOIA (b) (6)] added that the nurses were inserviced by the [U.S. FOIA (b) (6)].	F 755			

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F 755	Continued From page 24 On 4/22/25 at 10:41 AM, the US FOIA stated that the policy for documenting the destruction of a NJ Ex Order 26.4(b)(1) was reflected in the policy titled "Controlled Substances" updated 8/22/24 "7. When a resident refuses a non-unit dose medication or it is not given, or receives partial tablets or single dose ampules, or it is not given, the medication shall be destroyed with two witnesses and may not be returned to the container."	F 755			
F 803 SS=F	NJAC 8:39- 29.4(g), 29.4(i), 29.4(k), 29.7(c) Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803			5/12/25

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F 803	Continued From page 25 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) the facility's U.S. FOIA (b)(6) reviewed and approved the four week cycle menus for nutritional adequacy in accordance with nationally accredited standards and the facility provided Diet Manual, b.) residents consistently received the standard serving of the main entrée/protein (16 out of 56 lunch and dinner meals were inadequate) or an alternate item (2 out of 9 were inadequate) for high biological value protein (proteins of high biological value, also known as complete proteins, are those that contain all the essential amino acids in the appropriate proportions that the body needs to carry out its functions optimally), c.) alternate menu items were available as posted, and d.) that a resident (Resident #54) consistently received NJ Ex Order 26.4(b)(1) daily as requested as well as receive a nutritionally equivalent protein food as a menu substitute from the facility Always Available List (a list of foods available for lunch and dinner besides the menu choice for that day). This deficient practice was also identified by 7 out of 7 residents that attended the Resident Council Meeting on 4/15/25. The deficient practice was evidenced by the following: On 4/14/25 at 10:05 AM, the surveyor conducted an initial kitchen tour with the U.S. FOIA (b)(6)	F 803	No residents has any ill effects. Resident 54 had no ill effects All residents that received a lower nutritive meal have the potential to be effected. U.S. FOIA and all kitchen staff were in serviced on production of recipes/portions to ensure adequate nutrition provided. U.S. FOIA (b)(6) and all dietary staff were education on ensuring the meal ticket matches what is being served. Registered dietician reviewed and signed the menus immediately U.S. FOIA educated on the process to ensure all alternate menus items remain in stock Registered Dietician will audit 3 residents meals weekly for 4 weeks then monthly for 2 months to ensure adequate portions sizes, ticket matches what is being served, and sufficient nutrients. . The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee. The Registered Dietitian will take action as needed. Registered dietician will be reviewing the menus for 3 months to ensure adequate nutrients are		

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F 803	Continued From page 26 U.S. FOIA (b)(6)). The surveyor observed an empty metal rack to the right of the kitchen entrance which the U.S. FOIA (b)(6) identified as a bread rack. The surveyor observed a few cardboard boxes with bread. The U.S. FOIA (b)(6) stated it was delivered that morning and that they received bread deliveries every three days. He further stated, "we have to stay in budget." Towards the end of this tour, the U.S. FOIA (b)(6) stated that they followed a four-week cycle menu, and they were currently on cycle 4. He provided the surveyor with a copy of these menus on 4/14/25 at 11:36 AM. There was one meal option offered for lunch and dinner. At that same time, the U.S. FOIA (b)(6) provided an "Always Available Items (only for lunch and dinner)" list which included Chicken, Hamburger, Hot Dog, Tuna Sandwich, Ham and Cheese Sandwich, Turkey and Cheese Sandwich, Peanut Butter and Jelly Sandwich, Egg Salad Sandwich, Fruit Cup, Fresh Fruit (Apple, Orange, Banana), Garden Salad, Tuna Platter, and Grilled Cheese. On 4/14/25 at 10:20 AM, the surveyor conducted an entrance conference with the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6). They stated the facility census was 99 residents. On 4/14/25 at 11:39 AM, the surveyor interviewed Resident #54. The resident stated that they were unable to choose their meals and if they called for something else, the kitchen staff would tell them that one hot dog was available. On 4/15/25 at 10:17 AM, the surveyor conducted a group meeting with seven residents. 7 out of 7 residents had the following concerns; there were	F 803	provided. Result of the audits will be reported by the monthly quality assurance performance improvement committee meeting.		

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F 803	Continued From page 27 limited food choices, the quality of the food was poor, always available items were not consistently available, sandwiches were available if there was bread, the kitchen "never have buns for hamburgers or hot dogs," they "can't order something if it's not on the menu," the fish patty had very little fish, the chicken patty was all breading, the burgers tasted like they had fillers and were not real meat, and when spaghetti and meatballs were served they received three meatballs which was not enough and did not taste like real beef. On 4/16/25 at 9:13 AM, the surveyor interviewed Resident #54, who stated they had spoken to the U.S. FOIA (b) (6) to request a serving of a breakfast meat each morning. The resident stated they did not always receive breakfast meats daily. On 4/16/25 at 12:14 PM, the surveyor interviewed Resident #54 who stated there was only one menu choice and even if you requested an alternate item, it was not always available. On 4/16/25 at 12:36 PM, the surveyor observed Resident #54 in their room who stated they received chili but did not want that and the nurse ordered hotdogs as a substitute. On 4/16/25 at 1:01 PM, the surveyor observed one hotdog in a bun brought up by kitchen staff on a plate for Resident #54. On 4/22/25 at 1:15 PM, the surveyor observed a food service staff member deliver two hot dogs on bread (not hotdog buns) to a resident on the unit.	F 803			

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F 803	Continued From page 28 On 4/22/25 at 10:24 AM, the surveyor interviewed the [REDACTED] who stated he did not have a diet manual, and that the [REDACTED] may have one. He stated that he thought his [REDACTED] U.S. FOIA (b)(6) and the [REDACTED] U.S. FOIA (b)(6) developed and reviewed the menus, but he "could not really speak the process." On 4/22/25 at 5:17 PM, the [REDACTED] U.S. FOIA (b)(6) stated that the menus were developed as a team and the [REDACTED] U.S. FOIA (b)(6) approved the menus for adequacy. At this same time the [REDACTED] U.S. FOIA (b)(6) entered the conference room and provided the surveyor with the last three months' worth of food purchase invoices. On 4/22/25 at 1:01 PM, the surveyor conducted an additional kitchen tour in the presence of a second surveyor. The [REDACTED] U.S. FOIA (b)(6) acknowledged that the facility did not provide residents with a selective menu. He stated the facility made macaroni and cheese from scratch, and they used 2-5 pound (lb.) bags of cheddar cheese to prepare the cheese sauce. He stated that when they served manicotti on the menu, they provided two per serving and they provided four to five ravioli per serving when on the menu. The [REDACTED] U.S. FOIA (b)(6) also acknowledged that on Tuesday mornings they may not have breakfast meats available for resident who requested it daily. He stated that they are "light on meat" at times because meat deliveries were on Tuesdays. During this kitchen tour the surveyors reviewed some items on the Always Available list as well as other menu items for nutritional adequacy. There was a box of frozen hamburgers and a box of frozen manicotti (60 per box) that did not have nutritional information nor ingredients listed on the box. There were [name redacted] hotdogs	F 803			

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F 803	Continued From page 29 and the nutritional information on the package indicated one hotdog provided 6 gms of protein. The [U.S. FOIA] stated that if a resident wanted hotdogs to replace a meal, they would have provided two. He acknowledged 6 gms of protein would not have been adequate and that a minimum of 3 ounces (oz.) of protein should be provided at the lunch and dinner meals. He further acknowledged that 3 oz. of protein was equivalent to 21 gms. The [U.S. FOIA] also acknowledged that food items that provided less than that would not be an adequate serving of protein as a main meal or alternate/substitute. There was a plastic 5 lb. sleeve of sliced cheese which had the nutritional information on the package and indicated two slices of cheese provided 4 gms of protein. The [U.S. FOIA] stated that when the kitchen prepared cheese sandwiches or grilled cheese, two slices of cheese were used. There were frozen chicken patties and the nutritional information on the box indicated that one patty provided 11 gms of protein. The [U.S. FOIA] stated that one patty was served per meal and acknowledged that was an inadequate amount of protein. A few other menu items in question regarding protein content per serving were the breaded fish, meatballs, manicotti and ravioli, which were not available for review. The surveyor requested the [U.S. FOIA] for the nutritional information. The surveyor observed that the bread rack did not have hot dog or hamburger buns. The [U.S. FOIA] acknowledged the same and stated he would give a slice of bread instead and that a delivery would arrive tomorrow. On 4/22/25 at 2:40 PM, the surveyor interviewed the [U.S. FOIA]. She stated that the menus were developed by the [U.S. FOIA (b)(6)] and that she and the [U.S. FOIA] also reviewed them and collectively they approved the menus for nutritional adequacy.	F 803			

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F 803	Continued From page 30 She stated she would provide the surveyor with the Diet Manual for review. She stated that she was aware there were no selective menus and that residents could choose from the Always Available list. The [REDACTED] stated she was unaware of concerns about always available items not being available as well as bread and buns. She could not speak to who ensured food products were nutritionally adequate. She acknowledged that 3 oz. or 21 gms of protein should be provided for lunch and dinner. She acknowledged that one hotdog which provided 6 gms of protein was not an adequate substitution. On 4/22/25 at 2:35 PM, the [REDACTED] provided the surveyor with copies of the nutritional information for the frozen manicotti, breaded fish and ravioli. On 4/22/25 at 5:30 PM, the [REDACTED] provided the surveyor with a copy of an undated [name redacted] "Dietary Manual" and a [name redacted] "Cycle Menu Recipe Book." On 4/23/25 at 10:47 PM, the surveyor interviewed the [REDACTED] in the presence of the [REDACTED]. The [REDACTED] stated that when they make pizza for the residents, they used nine-inch round pie crusts and 12-13 lbs. of mozzarella cheese. He acknowledged that if a resident ordered a substitute it was required to be nutritionally equivalent and that some prepared products that were used did not meet protein requirements. He also acknowledged that recipes provided to the surveyor, as an example "Breaded Baked Fish," was for a scratch recipe (which was not used) and only had instructions for a one serving recipe and indicated that the fish ingredient would be a four oz. portion of cod fillet (which would have provided 28 gms of protein).	F 803			

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F 803	Continued From page 31 On 4/23/25 at 1:04 PM, the U.S. FOIA (b)(6) provided the surveyor with a copy of cycle 1 and 2 of the menus signed and undated by the facility U.S. FOIA (b)(6). On 4/23/25 at 1:21 PM, the surveyor interviewed the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) in the presence of the survey team. The U.S. FOIA (b)(6) stated, she signed cycle 1 and 2 within the last week (but could not speak to date) and that her signature attested to the fact that cycle 1 and 2 were nutritionally adequate. Both stated that they were still working on cycle 3 and 4. The U.S. FOIA (b)(6) stated she could not attest to whether or not they were nutritionally adequate. They acknowledged that a 3 oz. portion of protein equaled 21 gms of protein. They acknowledged the surveyor had previously discussed examples of menu items did not meet nutritional requirements for protein. The U.S. FOIA (b)(6) stated the menus were nutritionally adequate for protein. The "Always Available" list provided hotdog and grilled cheese; already established to have inadequate protein per serving during survey which yielded 6 and 4 gms of protein, respectively. During interviews with the U.S. FOIA (b)(6), he stated that he used 10 lbs. of cheddar cheese to make macaroni and cheese for the building (99 residents/census). That would yield approximately 12 gms of protein per person. He also stated that when cheese pizza was prepared, he used 12-13 lbs. of mozzarella cheese for the building. If 13 lbs. were used, that would yield approximately 15 gms of protein per person. A review of the food purchase invoices the U.S. FOIA (b)(6)	F 803			

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F 803	Continued From page 32 provided reflected that on 3/20/25, the facility received 3 cases of frozen manicotti. There were 60 manicotti per case which yielded 180 pieces. That would provide 1.8 manicotti per person. The nutritional information provided to the surveyor indicated that 1 manicotti provided 7 gms of protein. Therefore approximately 2 manicotti provided 14 gms of protein per person. A review of a food purchase invoice dated 3/27/25, reflected the facility received 3 cases of frozen medium cheese ravioli. The invoice indicated the brand [redacted] and that there were 200 ravioli per case. The [redacted] provided the surveyor with nutritional information for a different brand [name reacted] and there were 100 ravioli per case and were "Jumbo" verse the invoice "Med (medium)." Investigation for the brand [name redacted] ravioli indicated on the invoice, would have provided 9.1 gms of protein per 1 cup portion of those ravioli, which was the portion size indicated on the cycle menus. A review of the food purchase invoice dated 4/1/25, reflected the facility received 3 cases of 1 oz meatballs from brand [name redacted]. Investigation for the brand [name redacted] meatballs revealed 12 gms of protein would have been provided if 3 meatballs were served, which was the portion size indicated on the cycle menus as well as verbalized by residents in the Resident Council Meeting. A review of the nutritional information for the Breaded Fish provided by the [redacted], indicated a 4 oz. portion (1 piece) provided 14 gms of protein. A review of the facility's "Week-At-A-Glance [name redacted] Spring/Summer 2025" four-week	F 803			

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F 803	Continued From page 33 cycle menus reflected the following items served 16 meals out of 56 provided an inadequate amount of protein: Week 1 Monday Lunch Cheese Pizza (15 gms) Dinner Breaded Baked Fish (14 gms) Tuesday Dinner Chicken Patty on a Bun (11 gms) Thursday Dinner Manicotti (14 gms) Friday Dinner 1 All Beef Hot Dog on a Bun (6 gms) Week 2 Wednesday Lunch Baked Macaroni and Cheese (12 gms) Thursday Dinner Manicotti (14 gms) Week 3 Sunday Dinner Cheese Ravioli (9.1 gms) Monday Lunch Breaded Baked Fish (14 gms) Dinner Macaroni and Cheese (12 gms) Friday Dinner Cheese Ravioli (9.1 gms) Week 4 Sunday Dinner Spaghetti with Meatballs (12 gms) Monday Lunch Breaded Baked Fish (14 gms) Dinner Cheese Pizza (15 gms) Wednesday Lunch 1 All Beef Hot Dog on a Bun (6 gms) Friday Lunch Cheese Pizza (15 gms) A review of the "Dietary Manual" [name redacted] provided by the facility, included the Regular diet portion sizes for protein at lunch and dinner should be 3 oz. In addition, the section titled "Quality of Life" reflected, "The obligation of Nutrition	F 803			

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F 803	Continued From page 34 Professionals is to ensure and enhance the quality of life for each resident in the nursing facility by providing appropriate nutrition care and by recognizing and honoring the individuality of each person." The section titled "Resident Rights and Responsibilities" included the following rights: To make choices about where, when and what to eat. To be served attractive, well-seasoned food in portions acceptable. To be offered substitutes of similar nutritive value when food served is refused.	F 803			
F 809 SS=F	NJAC 8:39-17.1 (b), 17.4 (a) (1) (3) (c) (e) Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with	F 809			5/12/25

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F 809	Continued From page 35 the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documents, it was determined that the facility failed to serve and document residents received a nourishing snack in the evening when there was more than a 14-hour span between dinner and breakfast mealtimes. This deficient practice was identified for 6 of 7 alert and oriented residents (Resident's #4, #22, #53, #58, #70, and #81) during the resident council meeting and was evidenced by the following: On 4/14/25 at 10:05 AM, the surveyor conducted a kitchen tour with the U.S. FOIA (b)(6) (REDACTED). At the end of the initial tour, the surveyor requested a copy of residents who received labeled snacks, as well as a list of snacks that were sent to the units in the evening to be distributed after dinner. The U.S. FOIA (b)(6) (REDACTED) stated, "we really don't send HS (evening) snacks," there was no list. He further stated, we send labeled snacks and if another resident wanted something before the kitchen closed, we would provide it; "and if a resident wanted something later there was a key at the front desk," and a supervisor could get a snack. On 4/15/25 at 9:00 AM, the surveyor reviewed an undated "Mealtime and Delivery Schedule," which the facility provided to the survey team. There was more than a 14-hour span between dinner and breakfast service. On 4/15/25 at 10:17 AM, the surveyor conducted a resident council meeting with 7 residents invited by the President of Resident Council. 6 of 7 residents had a Brief Interview for Mental Status	F 809	New process was implemented for delivering and documenting night snack provision. All residents that dont receive night snacks have the potential to be affected. New process was implemented for delivering and documenting night snack provision. Food service director was in serviced on the proper meal timeframe Director of nursing or designee will audit 3 residents a week for 4 weeks then monthly for 2 months to ensure they are receiving there night snacks. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee. The director of Nursing will take action as needed.		

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F 809	Continued From page 36 of NJ Ex out of 15, which indicated their cognition was NJ Exec Order 26 On 4/15/25 at 10:57 AM, 7 of 7 residents stated that labeled HS snacks were put on the nursing station or in the pantry after dinner. They stated that Certified Nurse's Aides (CNA) were supposed to give out labeled snacks, which was done inconsistently. They agreed that when the snacks were left on the nurse's station, other residents would take the snacks. They agreed that there were no extra items delivered or available to provide to residents without a labeled snack. On 4/22/25 at 9:36 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 on the NJ Exec Order 26 Unit. They both stated that there was no accountability system in place to account for the provision of HS snacks to residents in the electronic medical record (EMR) or on paper. On 4/22/25 at 9:50 AM, the surveyor interviewed RN #2, who was the U.S. FOIA (b)(6) for both the NJ Exec Order 26 4b1 Units. She stated that some residents received labeled snacks, however there was no accountability system to record the provision of HS snacks to residents. She stated residents should be provided HS snacks and if they refused, it should be documented. On 4/22/25 at 10:24 AM, the surveyor interviewed the U.S. FOIA (b)(6). He stated that there should be no more than a 10-12-hour span between dinner and breakfast service. He could not speak to further requirements if the span of time was greater. On 4/22/25 at 12:43 PM, the U.S. FOIA (b)(6)	F 809			

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F 809	Continued From page 37 U.S. FOIA (b)(6), stated in presence of survey team, that the facility would be installing kiosks (an electronic accountability system which would provide CNAs the ability to record the provision of HS snacks to residents) for CNAs. At that time, she could not speak to whether or not there was an accountability system on paper. On 4/22/25 at 2:40 PM, the surveyor interviewed the U.S. FOIA (b)(6). She stated that if there was more than a 14-hour span between dinner and breakfast service, the residents should be provided with a nutritious snack like a half of a sandwich. The [redacted] stated there should be accountability; however, she stated there was no accountability in the EMR and she did not think there was accountability on a paper system. A review of the minutes from "Resident Council Meetings" dated 1/30/25, 2/26/25 and 3/27/25, all included "[name redacted], and other residents reported CNAs do not distribute the snacks when the kitchen brings up the snacks." The facility was unable to provide policy's related to mealtimes and HS snacks.	F 809			
F 812 SS=F	NJAC 8:39-17.2 (f))(1) (i) (ii) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812			5/12/25

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F 812	Continued From page 38 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, and b.) failed to maintain the kitchen equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 4/14/25 at 10:05 AM, the surveyor toured the kitchen with the U.S. FOIA (b)(6). The following was observed: 1. Inside the ice machine there was a reddish like substance on the bottom of the white baffle (a flow-directing panel that restrained ice), as well as both sides of the interior walls of the ice machine near screws. The U.S. FOIA (b)(6) took a clean towel and wiped both areas. The discoloration was removable and the U.S. FOIA (b)(6) acknowledged that it needed to be cleaned. 2. There was a two door reach in refrigerator in	F 812	All equipment were immediately cleaned including ice machine, Door of 2 door fridge, Exhaust fan near two prep sinks, grease trap, bottom of the spice rack, can opener and the wells of the steam table. Spatula by prep sink and soiled rag were immediately discarded. All cutting boards with gouging were discarded and new ones were ordered. Plastic scoop stored in floor bin was immediately removed. FSD threw our mop head. Raw eggs were immediately removed from on top of the pasteurized eggs and the pasteurized eggs were discarded. Outside company was called to perform a thorough deep cleaning. All residents who received meals from the kitchen have the potential to be affected. U.S. FOIA (b) (6) and all kitchen staff were educated on not leaving the mop		

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F 812	Continued From page 39 which the [REDACTED] stated was for the cooks. The surveyor observed built up debris on the inside and gasket of the left door as well as the bottom of the unit. The [REDACTED] acknowledged the debris and stated, "It's Monday." 3. There was a large exhaust fan near two prep sinks, which had a heavy buildup a fuzzy grey/brown debris. The [REDACTED] acknowledged the debris and stated that maintenance needed to clean it. 4. There were two prep sinks which had a broken handle plastic spatula on the bottom of the right sink. The top of the spatula was discolored and disfigured. The [REDACTED] acknowledged it "was broken and the front was melted and should not be used." In addition, there was a soiled rag with debris draped over the divider between the two sinks. The [REDACTED] acknowledged it was soiled and should not have been there. 5. There was a metal covering to a grease trap on the floor, which had a heavy buildup of a black sticky-like substance, which the [REDACTED] acknowledged. 6. There were two green, one blue and one yellow cutting boards observed on a clean dry equipment rack which had gouging. The [REDACTED] acknowledged the same and stated they should be changed since gouging was where bacteria can collect and could cause cross contamination. 7. The bottom of the spice rack had built up debris. The [REDACTED] stated the rack was "old" and would, "take a long time to clean." 8. There was a soiled mop head on the floor near	F 812	head on the floor and the process for inputting repairs into the TELS Software system for Maintenance Repairs. [REDACTED] and kitchen staff were educated on proper food storage practices and the importance of maintaining equipment in a clean and sanitary condition. Outside company conducted comprehensive deep cleaning of the kitchen. Registered Dietician/designee will be conducting weekly audits on all these items above for 4 weeks then monthly for 2 months. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee. The Registered dietitian will take action as needed.		

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F 812	Continued From page 40 the right side of a griddle. The [U.S. FOIA] stated the griddle leaked grease and they keep the mop head there, "so we don't fall or slip." 9. There was a plastic scoop stored inside the flour bin, the handle was in direct contact with the flour. The [U.S. FOIA] stated it should not be stored inside the bin. 10. The base of the can opener had a buildup of a black sticky substance. The [U.S. FOIA] acknowledged the buildup and stated, it needed to be cleaned. 11. Three wells of a four well steam table, had a heavy buildup of brown debris on the bottom. On top of each the four wells were stainless steel folding covers which had a reddish/brown built up substance. The [U.S. FOIA] stated they were "old," and that "it would take a long time to clean." 12. In the first walk-in refrigerator, the surveyor observed a case of raw eggs stored above a case of liquid pasteurized eggs. The [U.S. FOIA] stated that the raw eggs were pasteurized yet was unable to show where that was indicated on the case. 13. In the second walk-in refrigerator, the surveyor observed 3 metal shelves that had a buildup of black debris. The [U.S. FOIA] wiped the shelving with a clean wet pink and wipe cloth towel. The debris was removable and the [U.S. FOIA] acknowledged it needed to be cleaned. 14. The towel dispenser above the hand washing sink was broken and empty. The towel ring was exposed and placed on the metal post of the spice rack for use, opposite the hand washing sink.	F 812			

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F 812	Continued From page 41 On 4/22/25 at 2:02 PM, the U.S. FOR provided the surveyor with vendor invoices from January 2025 to present. Invoices from [name redacted] indicated, "MEDIUM EGGS GRADE A" were delivered. There was no indication that they were pasteurized. A review of an undated facility policy "Ice Machines and Ice Storage Chests," reflected that ice machines will be used and maintained to ensure a safe and sanitary supply of ice. It also included that ice could become contaminated by unsanitary manipulation by employees, water-borne microorganisms, colonization by microorganisms, and improper storage or handling of ice. A review of an undated facility policy "Sanitation," reflected the food service area will be maintained in a clean and sanitary manner. It also reflected all kitchen areas should be kept clean, including shelves, counters, utensils and equipment. This included maintaining food service items in good repair so as not to affect their use and proper cleaning. Additionally, it reflected that ice that is used in connection with food and drink should be handled in a sanitary manner. A review of an undated facility policy "Food Storage," reflected that food storage areas should be maintained in a clean, safe, and sanitary manner; and that food service staff should maintain clean food storage "areas at all times." NJAC 8:39-17.2(g)	F 812			
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)	F 814			5/12/25

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F 814	Continued From page 42 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observations, interviews and review of pertinent facility documents, it was determined that the facility failed to have a system in place to ensure that facility garbage receptacles were covered, and all garbage was contained and removed timely to prevent a buildup of refuse, and that the receptacles including a trash compactor and the surrounding areas were maintained in a clean manner to prevent the accumulation of debris. The deficient practice was evidenced as follows: On 4/14/25 at 9:00 AM, the survey team arrived at the facility. From the parking lot, the surveyor was able to view the dumpster area, in the presence of the survey team. There were two oversized uncovered dumpsters overflowing with waste/debris and had black garbage bags around and between the two dumpsters, as well as debris on the ground. Up against the building loading dock there was a compactor, and an uncovered cardboard dumpster overflowing with cardboard. On 4/14/25 at 10:05 AM, the surveyor conducted a kitchen tour with the U.S. FOIA (b)(6) During this tour, the surveyor and U.S. FOIA (b)(6) went outside the building and onto the loading dock to view the receptacle area for refuse. The cardboard container was uncovered and	F 814	Dumpster Company was called and area was cleaned 4/22/25 All residents have the potential to be effected by this deficient practice Director of housekeeping/designee re-educated housekeeping staff on maintaining the cleanliness of the dumpster area. New cleaning schedule was created to ensure these areas are consistently maintained. Director of housekeeping/designee will be conducting weekly audits on dumpster area for 4 weeks and then monthly for 2 months to ensure area is maintained properly. . The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee. The director of Housekeeping will take action as needed.		

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F 814	Continued From page 43 overflowing. The [U.S. FOIA (b)(6)] stated it did not need to be covered. The compacter had a buildup of discolored liquid underneath. The [U.S. FOIA (b)(6)] stated the compacter was picked up once every week or week and a half. There were two oversized dumpsters overflowing with debris to the right of this area along a back fence. There was debris on the ground around the three dumpsters as well as the compacter. The [U.S. FOIA (b)(6)] acknowledged there was debris on the ground and could not speak to who was responsible to ensure the area was clean, maintained and free of debris on the ground. On 4/22/25 at 2:26 PM, the surveyor interviewed the [U.S. FOIA (b)(6)]. He stated he was ultimately responsible to ensure the dumpster area was clean and maintained. He stated he had porters that clean that area however, the observation was made early Monday, and he was unable to get that done. The [U.S. FOIA (b)(6)] further stated the cardboard dumpster was picked up once a week and when the compacter was picked up, staff would clean underneath. He stated, [name redacted] company was used for removal of the cardboard dumpster and compacter; however, he was unable to speak to the responsibility for the two other oversized dumpsters. On 4/22/25 at 5:29 PM, the surveyor reviewed the above concern with the [U.S. FOIA (b)(6)] team [U.S. FOIA (b)(6)], in the presence of the survey team. On 4/23/25 at 11:30 AM, the survey team met with the [U.S. FOIA (b)(6)] team for responses or additional information. Nothing further was	F 814			

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F 814	Continued From page 44 provided.			F 814			
F 850 SS=E	A review of an undated facility policy "Maintenance Service," reflected that maintenance service would be provided to all areas of the building and grounds, which included the parking lot. NJAC 8:39-31.4(b) Qualifications of Social Worker >120 Beds CFR(s): 483.70(o)(1)(2) §483.70(o) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(o)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(o)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to employ a full time NJ Exec Order 26.4b1) from 12/7/24 to 4/16/25. This deficient practice was evidenced by the following: On 4/15/25 at 10:17 AM, the surveyor met with			F 850	Facility hired full time social worker NJ Exec Order 26.4b1. No residents has any ill effects as they had access to a part time social worker All resident who required a full time social worker have the potential to be effected Full time Social worker was hired		5/12/25

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F 850	Continued From page 45 seven residents for a resident council meeting. During that meetin, 6 out of the 7 alert and oriented residents voiced concerns that the facility did not have a full-time social worker. The residents explained for the last 2 or 3 months there was a social worker that worked only Saturdays/Sundays for about 5 hours. On 4/15/25 at 1:05 PM, the surveyor interviewed the U.S. FOIA (b)(6), who stated there was a new social worker starting this week. He confirmed the current social worker (SW#2) usually comes in a few hours on Saturday's and Sundays. He verified the last SW's (SW#1) last day was NU Exec Order 25-49 A review of the facility provided time clock punches for SW #2 revealed SW #2 worked as follows: -12/7/24 to 12/29/24 a total of: 31.5 hours -1/8/25 to 1/25/25 a total of: 22.58 hours -2/1/25 to 2/15/25 a total of: 23.41 hours -3/1/25 to 3/29/25 a total of: 37.61 hours -4/5/25 to 4/12/25 a total of:10.68 hours On 4/16/25 at 1:35 PM, the surveyor interviewed SW#2 via telephone. SW #2 stated that he had a full-time position at another facility and had been helping by working on Saturdays for five (5) hours since the middle of January. SW #2 stated that his responsibilities on Saturday were to complete any needed social histories, social determinants of health, Minimum Data Set (an assessment tool used to facilitate the management of care for a resident) requirements and/or obtain signed pertinent paperwork for identified residents. SW #2 added that his responsibilities were based on a list or print out of identified residents he received. In addition, he stated that he would try	F 850	NU Exec Order 25-49 Administrator/designee will interview 2 residents weekly for 4 weeks then monthly for 2 months to ensure all there social worker needs are met. The results of the interviews will be reported at the monthly Quality Assurance Performance Improvement Committee. The Administrator will take action as needed.		

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F 850	Continued From page 46 to spend time with any resident that wished to speak with him. SW #2 also stated, "I do what I can in 5 hours." He added that when residents spoke with him and had a concern that he was unable to follow up with, he would refer the resident's concern to a full-time administrative staff that could handle what the resident needed. SW #2 explained for example that if a resident wished to be discharged or transferred then he would let the U.S. FOIA (b)(6) know because they worked Monday through Friday and would be able to handle those type of requests. On 4/22/25 at 11:46 AM, the surveyor interviewed the U.S. FOIA (b)(6), who stated her role was to bring the residents in, and the U.S. FOIA brings them out. She stated if a resident wanted to transfer to another facility the resident or family would let her know what facility and she would facilitate the transfer. The U.S. FOIA explained that the rehabilitation department would set up durable medical equipment if a resident needed to be discharged home and nursing would do the actual discharge paperwork. On 4/22/25 at 4:28 PM, during a meeting with the survey team, the U.S. FOIA (b) (6) were made aware of the above concerns. The facility was on record as being licensed for 180 beds. The CMS guidelines implemented 11/28/17, included but were not limited to a qualified U.S. FOIA full-time for a facility with over 120 beds. A review of the facility's Social Worker job description revealed "The primary purpose of	F 850			

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F 850	Continued From page 47 your job position is to assist in the planning, organization, and developing of the Social Services Department in accordance with current federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis."	F 850			
F 868 SS=D	N.J.A.C. 8:39-9.3(a); 39.2; 39.4(i) QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance	F 868		5/12/25	

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F 868	Continued From page 48 activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the U.S. FOIA (b)(6), or at least one of the individuals if there is more than one U.S. FOIA (b)(6), must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, the facility failed to ensure the required committee members, the U.S. FOIA (b)(6), was present for two out of four Quality Assurance and Performance Improvement (QAPI) meetings reviewed and was evidenced by the following: 04/23/25 11:33 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated QAPI meetings were held at least quarterly and as needed, he added we also meet monthly. He stated the required members were the U.S. FOIA (b)(6), the U.S. FOIA (b)(6), the U.S. FOIA (b)(6) and other staff were required to attend the meetings at least quarterly. The U.S. FOIA (b)(6) stated also will be including a certified nursing assistant in the meetings. At that time, the U.S. FOIA (b)(6) reviewed the facility provided QAPI sign in sheets, he removed the sign in sheets for the quarterly QAPI meetings. A review of the "Quarterly QAPI Meeting Attendance" sign in sheets revealed meeting were conducted on 4/17/2024, 7/17/2024, 10/16/24 and 1/15/2025. The surveyor asked the	F 868	Previous Infection Preventionist is no longer with us, CCO immediately in serviced the new U.S. FOIA (b)(6), U.S. FOIA (b)(6), and the U.S. FOIA (b)(6) on the importance of attending the quarterly QAPI meetings. No residents had any ill effects All residents who have infections have the potential to be infected. IP no longer with us, CCO immediately in serviced the U.S. FOIA (b)(6), U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) on the importance of attending the quarterly QAPI meetings. Administer/don or designee will be ensuring Infection preventionist attends meetings for the 3 QAPI meetings. If Infection preventionist is unable to attend, the Infection control minutes will be reviewed by Director of nursing during		

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F 868	Continued From page 49 U.S. FOIA (b)(6) to identify the U.S. F on the sign in sheets. After reviewing the sheets, he was unable to identify the U.S. F was present at the 4/17/2024, 10/16/24 and 1/15/2025 meetings. During the same interview, the U.S. FOIA (b)(6) stated he was not aware the U.S. F was required to be in attendance. At 12:32 PM, the U.S. FOIA (b)(6) provided evidence that the U.S. F was off on 1/15/2025 but was able to provide evidence that infection control was reviewed with the committee. At that time, the surveyor requested evidence of infection control review for the 4/17/204 and 10/16/24 QAPI meetings. No additional information was provided. A review of the facility's policy "Quality Assurance and Performance Improvement Plan" revealed III. Guidelines for Governance and Leadership ...b. i. The QAPI committee provides the organization structure for QAPI. This group includes administrator, DON, medical direction and/or designee, at least three other members of the facility's staff and the infection control and prevention officer ...ii. Currently QAPI committee maintains record of attendance and minutes with supporting documentation.	F 868	QAPI meetings. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee. The Administrator will take action as needed.		
F 880 SS=D	NJAC 8:39-33.1(b) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880			5/12/25

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F 880	Continued From page 50 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880			

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F 880	Continued From page 51 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Repeat Deficiency Based on observation, record review, interview, and review of pertinent facility documents, it was determined that the facility failed to prevent the potential for cross contamination by not placing a resident with NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED], for one of two residents (Resident #45) reviewed for NJ Ex Order 26.4(b)(1) [REDACTED] The deficient practice was evidenced by the following:	F 880	Resident 45 was immediately placed on NJ Exec Order 26.4b1 [REDACTED]. All residents with wounds have the potential to be affected who require enhance barrier precautions. Director of nursing /designee educated nurses on enhanced barrier precaution protocols for any residents with wounds. Director of nursing /designee will review 3 residents with wounds weekly for 4 weeks then monthly for 2 months to ensure they are on enhanced barrier precautions. .		

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F 880	Continued From page 52 On 4/16/25 at 9:33 AM, during a [redacted] treatment observation, the surveyor observed the [redacted] holding Resident #45 on their [redacted] with their [redacted] NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1. The [redacted] was wearing gloves. The surveyor then observed the [redacted] U.S. FOIA (b)(6) [redacted] cleanse the [redacted] NJ Exec Order 26.4b1 and apply the treatment and dressing. The [redacted] was wearing gloves. After performing hand hygiene, the [redacted] U.S. FOIA (b)(6) [redacted] donned (put on) gloves and the [redacted] U.S. FOIA (b)(6) [redacted] cleansed the [redacted] NJ Exec Order 26.4b1 and applied the treatment. The surveyor had not observed [redacted] NJ Exec Order 26.4b1 signage at the resident's doorway or in the room. The surveyor reviewed the electronic medical record (EMR) for Resident #45. A review of the "Order Summary Report" revealed a physician orders (PO) dated [redacted] NJ Exec Order 26.4b1 for [redacted] NJ Exec Order 26.4b1. Apply to [redacted] U.S. FOIA (b)(6) [redacted] and "U.S. FOIA (b)(6) [redacted] NJ Exec Order 26.4b1 ... A review of the Admission Record, (an admission summary), reflected diagnoses that included but not limited to [redacted] NJ Exec Order 26.4b1 [redacted] The Individual Comprehensive Care Plan (ICCP) included a focus area of potential [redacted] NJ Ex Order 26.4(b)(1) [redacted] to [redacted] NJ Ex Order 26.4(b)(1). Interventions included [redacted] NJ Exec Order 26.4b1 [redacted] On 4/16/25 at 9:48 AM, the surveyor interviewed the [redacted] U.S. FOIA (b)(6) [redacted]. The [redacted] U.S. FOIA (b)(6) [redacted] stated that Resident #45 should not be on [redacted] NJ Exec Order 26.4b1 because there was no [redacted]	F 880	The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee. The director of nursing will take action as needed.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 53 discharge from the [REDACTED] [NJ Exec Order 26.9]. She further stated that [REDACTED] [NJ Exec Order 26.9] was important if [REDACTED] [NJ Exec Order 26.9] was involved. On 4/16/2025 at 10:10 AM, the surveyor interviewed the [REDACTED] [U.S. FOIA (b)(6)]. The [REDACTED] [U.S. FOIA (b)(6)] stated that she should not have worn a gown when caring for Resident #45. She further added that she knew who was [REDACTED] [NJ Exec Order 26.4(b)(1)] from report and signage on the door. On 4/16/2025 at 12:11 PM, the surveyor interviewed the [REDACTED] [U.S. FOIA (b)(6)]. She acknowledged that Resident #45 should have been on [REDACTED] [NJ Exec Order 26.9] because they had a [REDACTED] [NJ Exec Order 26.9]. On 4/22/25 at 10:10 AM, the surveyor interviewed the [REDACTED] [U.S. FOIA (b)(6)], who stated that if a resident had a [REDACTED] [NJ Exec Order 26.9], [REDACTED] [NJ Exec Order 26.9] were needed. A review of facility policy "PPE for MDRO" Updated December 15, 2024 revealed: Enhanced Barrier Precautions Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi-drug-resistant organisms) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with	F 880			

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

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FORM APPROVED
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F 880	Continued From page 54 wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: ... Wound care: any skin opening requiring a dressing.	F 880			
F 925 SS=D	N.J.A.C. 8:39-19.4 (a) Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain an effective pest control program so that the kitchen was free of pests. The deficient practiced was evidenced by the following: On 4/14/25 at 10:05 AM, the surveyor conducted a kitchen tour with the U.S. FOIA (b)(6) [redacted]. During this tour, he stated that he used a [name redacted] electronic communication system as well as verbal communication with the U.S. FOIA (b)(6) when there was a maintenance concern in the kitchen. The surveyor observed an open drain on the floor next to a grease trap. The surveyor observed many flies in this area, coming from the drain, in	F 925	A special chemical floor cleaning was ordered to prevent flies from breeding. Outside company was called to perform a thorough deep cleaning. All residents who receive meals from the kitchen have the potential to be affected. Chemical floor cleaner will be used daily in the kitchen to prevent flies. Outside company conducted comprehensive deep cleaning of the kitchen. U.S. FOIA [redacted] and kitchen staff were educated on logging all pest concerns in the logbook.		5/12/25

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F 925	Continued From page 55 the air and on the wall. The [U.S. FOIA (b)] acknowledged this and stated they were "drain flies," and that the grease trap needed to be cleaned. In addition, the [U.S. FOIA (b)] stated the exterminator treated the area and that it did not help since there was an open drain. On 4/22/25 at 1:01 PM, the surveyor conducted a second kitchen tour with an additional surveyor and the [U.S. FOIA (b)]. The [U.S. FOIA (b)] provided a pest control logbook to the surveyor for review. The form indicated the last visit from the exterminating company was on 4/1/25; however, there was no indication of what or where treatment was performed in the kitchen. The [U.S. FOIA (b)] stated that the exterminator conducted weekly visits every Tuesday. During this tour, both surveyors observed the same type of flies on the wall just outside the dish machine room. On 4/22/25 at 2:26 PM, the surveyor interviewed the [U.S. FOIA (b)]. He stated that the pest control company came in weekly and there was a logbook for the kitchen. He stated that he was unaware there were drain flies in the kitchen. On 4/22/25 at 3:36 PM, the [U.S. FOIA (b)] provided the surveyor invoices from the exterminating company from 2/18/25 through 4/8/25 which revealed kitchen pests had not been addressed. In addition, there was an invoice dated 4/15/25, which indicated "No service was performed due to state conducting survey." On 4/22/25 at 3:51 PM, the surveyor interviewed the [U.S. FOIA (b)(6)], who was unaware of a fly issue in the kitchen. On 4/22/25 at 5:29 PM, the surveyor reviewed the	F 925	Food service director will conducted audits of the grease trap/kitchen weekly for 4 weeks and monthly for 2 months to ensure kitchen is free of pest. The results of the audits will be reported by the monthly Quality Assurance Performance Improvement Committee. The Food service director will take action as needed.		

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F 925	Continued From page 56 above concern with the administrative team U.S. FOIA (b)(6) _____), in the presence of the survey team. On 4/23/25 at 11:26 AM, the U.S. FOIA (b)(6) stated that the exterminator treated for flies in the kitchen about a month and a half ago but nothing specific to flies were recorded on paperwork. A review of the facility "Work Orders" between the kitchen and maintenance department from 3/18/24 through 3/31/25, did not address flies. A review of an undated facility policy "Pest Control," reflected the facility would maintain an effective pest control program. It also reflected the facility maintained an "on-going" pest control program to ensure the building was kept free of insects. A review of an undated policy "Sanitation," reflected kitchen areas would be kept clean and protected from flies and other insects. N.J.A.C. § 8:39-31.5	F 925			

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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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. 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 maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 12 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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	All residents are potentially affected by this practice. Rates increased Sign on with new agencies Offer agency staff bonuses Offer our staff bonuses New retention and recruitment plan Job Fair Posting new ads around town and via social media Staff Testimonial videos for recruitment Referral bonuses for our staff Referral bonuses for community Sign on bonus	5/12/25

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

TITLE

(X6) DATE

Electronically Signed

05/16/25

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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 2/01/21: 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. The survey team requested staffing for the weeks from 03/30/25 to 4/12/25. The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -03/30/25 had 5 CNAs for 101 residents on the day shift, required at least 13 CNAs. -03/31/25 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/01/25 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/02/25 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/03/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/04/25 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/05/25 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.	S 560	Utilizing temporary nursing assistants The don to have weekly meetings with staffing coordinator to determine upcoming schedules to anticipate needs. The DON/designee will report findings to the administrator. The DON/designee will aggregate findings from these rounds monthly and review the findings with the administrator quarterly on an ongoing basis the DON/designee will provide a report of his/her findings to the QA committee for action as appropriate.	

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S 560	Continued From page 2 -04/06/25 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. -04/07/25 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -04/10/25 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -04/11/25 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -04/12/25 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs On 4/15/25 at 11:00 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was aware of the staffing ratios. She also stated that she was sometimes able to meet the ratios, but lately 7-3 was becoming an issue. She further stated that when they were unable to meet the ratios, "they are usually short 1 or 2, it's not like a vast difference, so it's not too bad". A review of undated facility provided policy "Staffing Policy Statement" included: Our facility provides adequate staffing to meet needed care and services for our resident population. Policy 4. These ratios will be adjusted based on federal or state guidelines Direct care staff to resident ratio "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. 1. One certified nurse aide to every eight residents for the day shift	S 560			

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S 560	Continued From page 3 2. 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 certified nurse aides, and each direct staff member shall perform certified nurse aide duties: and 3. One direct care staff member to every 14 residents for the night shift, providing that each direct care staff member shall perform certified nurse aide duties.	S 560			
S1450	8:39-19.7(b) Mandatory Infection Control and Sanitation Storage areas for solid waste containers shall be kept clean. Waste shall be collected from all storage areas regularly to prevent nuisances such as odors, flies, or rodents. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that newly hired employees had received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment, or within thirty days if a Registered Nurse (RN) completed an assessment upon employment, for 4 out of 10 newly hired employee files reviewed. This deficient practice was evidenced by the following: On 04/22/25 at 11:26 AM, the surveyor reviewed the employee health files of ten random newly	S1450	New employee health examination forms were created with the required information that is needed. All residents that were in contact with employees number 1,2,3,4 have the potential to be affected. New employee health examination forms were created with the required information that is needed. Director of HR, DON and IP were in serviced on the importance of completing the employee health		5/12/25

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S1450	Continued From page 4 hired employees since the last Recertification survey date of 10/31/23, which revealed the following: Employee #1, with a hire date of [REDACTED] had a completed "Employee Health Examination Form" which was signed by a Registered Nurse (RN) on [REDACTED]. The physician signed the form; however, there was no date for the physician signature. Employee #2, with a hire date of [REDACTED], had a photo copy of a completed "Employee Health Examination Form" which was signed by a RN on [REDACTED]. The physician signed the form; however, there was no date for the physician signature. Employee #3, with a hire date of [REDACTED], had a photo copy of a completed "Employee Health Examination Form" which was signed by a RN on [REDACTED]. The physician signed the form; however, there was no date for the physician signature. Employee #10, with a start date of [REDACTED], had a completed "Employee Health Examination Form" which was signed by a RN on [REDACTED]. The physician signed the form; however, there was no date for the physician signature. On 4/16/25 at 1:05 PM, the surveyor met with the Human Resources Manager (HRM), who stated that when someone was hired the health portion of the new hire process was completed by nursing. When asked about the physicals without physician dates, he stated that he wasn't sure why they were not dated by the physician and stated the physician was in the facility weekly. The surveyor requested the original forms for Employee #2 and Employee #3.	S1450	examinations within the proper time frame. Director of Human Resources or designee will be auditing 3 new employee examination health forms a week for 4 weeks then monthly for 2 months to ensure all employee examinations are completed within 2 weeks prior to to employment. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee. The director of Human Resources will take action as needed		

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S1450	Continued From page 5 On 4/16/25 at 2:07 PM, the HRM brought the original health file for Employee #2. He stated they could not find the original file for Employee #3. On 4/22/25 at 4:26 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), who stated that the medical director should date the physicals and would get back to the team regarding the dates of Employee #3. On 4/23/25 at 11:10 AM during a meeting with the survey team, the LNHA stated the facility changed the employee physical forms to include a date. He also stated that the Medical Director was at the facility weekly and was very good about signing off on the physicals. Regarding Employee #3, the LNHA stated that employee was supposed to start in [REDACTED] NJ Exec Order 26.4b, but her start date was pushed back to [REDACTED] NJ Exec Order 26.4b1. He further stated that he didn't see anything wrong with the time frame the physical was completed according to the regulations. The surveyor questioned how Employee #3 was to start in [REDACTED] NJ Exec Order 26.4b1 when according to the file, the application for employment was dated [REDACTED] NJ Exec Order 26.4b. No further information was provided regarding this issue. The LNHA stated that there could be various reasons why the facility does not have the original forms, the physician could have taken it, or the employee could have asked for it. A review of undated facility provided policy "Employee Health Records" included: A condition of employment requires you to have a physical assessment, urine screen, and, if OSHA guidelines and/or state tuberculosis requirements	S1450			

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S1450	Continued From page 6 for health care workers apply to your job, Mantoux skin test for tuberculosis and/or a chest x-ray (this test may be required on an annual basis). A health record for each employee will contain at a minimum: 6. History and Physical	S1450			
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day	S1680			5/12/25

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S1680	Continued From page 7 Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 03/30/2025 to 04/12/2025, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days.	S1680	All residents are potentially affected by this practice. Rates increased		

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S1680	Continued From page 8 The required staffing hours and actual staffing hours are as follows: For the week of 03/30/25 Required Staffing Hours: 265 -03/30/25 had 224 actual staffing hours, for a difference of -41 hours. For the week of 04/06/25 Required Staffing Hours: 260 -04/06/25 had 256 actual staffing hours, for a difference of -4 hours. During an interview on 4/15/25, the Staffing Coordinator stated that they were sometimes able to meet the staffing mandates and when unable to meet them, "it wasn't too bad". A review of undated facility provided policy "Staffing Policy Statement" included: Our facility provides adequate staffing to meet needed care and services for our resident population.	S1680	Go to nursing schools to recruit Sign on with new agencies Offer agency staff bonuses Offer our staff bonuses New retention and recruitment plan Job Fair Posting new ads around town and via social media Staff Testimonial videos for recruitment Referral bonuses for our staff Referral bonuses for community Sign on bonus The don to have weekly meetings with staffing coordinator to determine upcoming schedules to anticipate needs. The Director of nursing /designee will report findings to the administrator. The DON/designee will aggregate findings from these rounds monthly and review the findings with the administrator quarterly on an ongoing basis the DON/designee will provide a report of his/her findings to the QA committee for action as appropriate.	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315141	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/6/2025
NAME OF FACILITY ABINGDON CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812	

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 F0584	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/12/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 4/23/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315141	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/6/2025
NAME OF FACILITY ABINGDON CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812	

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0732	Correction	ID Prefix F0755	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	05/12/2025	LSC	04/23/2025	LSC	05/12/2025
ID Prefix F0803	Correction	ID Prefix F0809	Correction	ID Prefix F0812	Correction
Reg. # 483.60(c)(1)-(7)	Completed	Reg. # 483.60(f)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	05/12/2025	LSC	05/12/2025	LSC	05/12/2025
ID Prefix F0814	Correction	ID Prefix F0850	Correction	ID Prefix F0868	Correction
Reg. # 483.60(i)(4)	Completed	Reg. # 483.70(o)(1)(2)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC	05/12/2025	LSC	05/12/2025	LSC	05/12/2025
ID Prefix F0880	Correction	ID Prefix F0925	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)(4)	Completed	Reg. #	Completed
LSC	05/12/2025	LSC	05/12/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 4/23/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061805	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/6/2025
NAME OF FACILITY ABINGDON CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812	

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1450	Correction	ID Prefix S1680	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.7(b)	Completed	Reg. # 8:39-25.2(b)(1)&(2)	Completed
LSC	05/12/2025	LSC	05/12/2025	LSC	05/12/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/23/2025		☐ 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

PRINTED: 06/17/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315141	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2025
NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
(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	E 000			
	Abingdon Care and Rehabilitation Center 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.				
K 000	INITIAL COMMENTS	K 000			
	A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/21/25 and 04/22/25 and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy				
	Abingdon Care and Rehabilitation Center is a 2-story building that was built in 1970's. It is composed of Type II protected construction. The facility is divided into 12- smoke zones. The generator powers approximately 50 % of the building per the Regional Plant Operations Director. The current occupied beds are 99 of 180.				
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321			5/12/25
	Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing				

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

TITLE

(X6) DATE

Electronically Signed

05/16/2025

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

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K 321	Continued From page 1 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/21/25 in the presence of the U.S. FOIA (b)(6) [REDACTED], it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7, 8.4. This deficient practice had the potential to affect all 99 residents and was evidenced by the following: An observation at 9:30 AM revealed that the tub	K 321	Self closers were purchased for all these doors and were installed immediately All resident have the potential to be effected. Maintenance director/ designee will conduct weekly audits for 4 weeks then monthly 2 months of all hazardous areas to ensure doors are self-closing. The results of the audits will be reported at the monthly Quality assurance Performance		

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K 321	Continued From page 2 room next to room 104 was being used to store combustible items and was not provided with a self-closing or automatic-closing door. An observation at 12:10 PM revealed that the combustible storage room by the dining room was over 50 Square feet. The door to the room was not self-closing or automatic-closing. An observation at 12:48 PM revealed that the Maintenance storage room was over 100 Square feet and the door was not self-closing or automatic-closing. An observation at 1:10 PM revealed that one of 2 laundry room doors was not self-closing or automatic-closing. In an interview at the time, the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] confirmed the findings. The [U.S. FOIA (b)(6)] were informed of the findings at the Life Safety Code exit conference on 04/22/25 at 3:10 PM.	K 321	improvement Committee meetings for 3 months and as needed thereafter.		
K 324 SS=F	N.J.A.C 8:39-31.2 (e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324			5/12/25

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K 324	Continued From page 3 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/21/25 in the presence of the U.S. FOIA (b)(6) [REDACTED], it was determined that the facility failed to ensure that A) the kitchen hood suppression systems was inspected monthly, B) two of 6 kitchen cooking equipment's Wet Chemical fire suppression systems nozzles were in the proper position to protect against fire, C) one of 6 spray nozzle cap was in place to protect the nozzle from grease clogs in accordance with NFPA 101:2012 edition, Section 19.3.2.5.3*(10) and NFPA 17 and 96. These deficient practices had the potential to affect all 99 residents and were evidenced by the following: Observations at 12:36 AM in the kitchen revealed the following:	K 324	APS was immediately contacted to replace the nozzle cap and to reposition the suppression spray nozzles to protect cooking equipment. U.S. FOIA (b) (6) [REDACTED] was immediately in serviced on including the inspection tag for the suppression system on our monthly fire extinguisher rounds. All residents have the potential to be affected Director of maintenance/ designee will be auditing the fire suppression system on the kitchen line weekly for 4 weeks then monthly for 2 months to ensure proper nozzle alignment and functionality. Director of maintenance will also be		

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K 324	Continued From page 4 1. One of 6 kitchen nozzle blow-off caps was not in place to protect the spray nozzle from being clogged from grease build up. 2. The monthly inspection tag to the fire suppression system lacked documentation of monthly visual inspection. 3. Two of 6 suppression spray nozzles were not positioned to protect the cooking equipment. In an interview at the time, the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] confirmed the finding. The [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] were informed of the findings at the Life Safety Code exit conference on 04/22/25 at 3:10 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 17, 96	K 324	auditing the monthly fire suppression system to ensure its being inspected monthly. . The results of the audits will be reported at the monthly quality assurance performance committee meetings for 3 months and as needed thereafter.		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/21/25 in the presence of the [U.S. FOIA (b) (6)] and [redacted]	K 345	K345- The tape on the smoke detector in Heritage day room, heritage nurses station, heritage exit stairway were		5/12/25

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K 345	Continued From page 5 the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that fire alarm system was maintained in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 99 residents and was evidenced by the following: An observation in the Heritage dayroom at 9:37 AM revealed that the smoke detector was covered with blue tape. An observation in the Heritage nurses' station at 9:41 AM revealed that the smoke detector was covered with blue tape and hanging from the ceiling. An observation in the Heritage exit stairway at 10:15 AM revealed that the smoke detector was covered with blue tape. An observation in room 118 at 10:21 AM revealed that the smoke detector was covered with a red plastic smoker detector cover. In an interview at the time, the U.S. FOIA and the U.S. FOIA confirmed the findings. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference on 04/22/25 at 3:10 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	immediately removed. Room 118 plastic cover was immediately removed from smoke detector. All resident have the potential to be effected from smoke detectors being covered Staff was in serviced on the importance of smoke heads not being covered Director of maintenance/ designee will conduct an audit 3 times a week for 4 weeks then monthly for 2 months of the construction site to ensure no tape is covering smoke detectors. . The results of the audits will be reported at the monthly Quality Assurance Performance Committee meetings for 3 months and as needed thereafter.		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353			5/12/25

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K 353	Continued From page 6 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/21/25 in the presence of the U.S. FOIA (b)(6) [REDACTED], it was determined that the facility failed to maintain the automatic fire sprinkler system and ensure the ceiling level was smoke resisting in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7, 9.7.8 and NFPA 25: 2011 Edition, Section 5.2.1.1.1(2). This deficient practice had the potential to affect all 99 residents and was evidenced by the following: Observations on 04/21/2025 revealed the following: At 9:37 AM, the heritage dayroom had four (2-foot by 4-foot) ceiling tiles not in place.	K 353	All missing ceiling tiles in heritage day room, Room 111, room 110, heritage exit stairway, room 117 were all immediately replaced. Room 111 tape on sprinkler head was immediately removed., Room 110 smoke detector was immediately put back in place. Room 117 tape on sprinkler system, was immediately removed. All residents have the potential to be effected by missing ceiling tiles and smoke detectors not in place. Director of maintenance / designee will conduct 3 audits a week for 4 weeks then monthly for 2 months of heritage of day room to ensure all ceiling tiles and sprinkler system are in place. The results of the audits will be reported at the		

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K 353	Continued From page 7 At 9:52 AM, Room 111 had two (2- foot by 4-foot) ceiling tiles not in place and the sprinkler head was covered with blue tape. At 10:10 AM in Room 110, a ceiling tile by the sprinkler head and the smoke detector was not in place. At 10:15 AM, the Heritage exit stairway had two (2-foot by 4-foot) ceiling tiles not in place. At 10:21 AM, Room 117 had sprinkler head covered with blue tape. In an interview at the time, the U.S. FOIA (b)(6) confirmed the findings. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference on 04/22/25 at 3:10 PM. N.J.A.C. 8:39-31.2(e) NFPA 13, 25	K 353	monthly Quality Assurance Performance Improvement Committee meetings for 3 months		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/21/25, in the presence of the U.S. FOIA (b)(6) _____ , it was	K 355	Place card for k- type fire extinguisher in kitchen was immediately placed above extinguisher.		5/12/25

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K 355	Continued From page 8 determined that the facility failed to provide the required instructional placards near the Class K portable fire extinguisher in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition. This deficient practice had the potential to affect all 99 residents and was evidenced by the following: An observation during the kitchen tour at 12:30 PM revealed that one K- Type fire extinguisher did not have the required instructional placard indicating the fire protection system must be activated prior to using the portable fire extinguisher. The U.S. FOIA (b)(6) confirmed the finding during the observation. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference on 04/22/25 at 3:10 PM. NJAC 8:39-31.2(e) NFPA 10, 96	K 355	All residents have the potential be affected by not having Place card for k-type fire extinguisher in place Director of maintenance/designee in serviced U.S. FOIA (b) (6) , cooks and dietary aides that fire protection system must be activated prior to using portable extinguishers. Director of maintenance/ designee will conduct weekly audit of the place card for the k-type extinguisher for 4 weeks and then monthly for 2 months to ensure sign is in proper place. . The results of the audits will be reported at the Quality Assurance performance improvement Committee meetings for 3 months and as needed thereafter.		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted	K 362			5/12/25

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K 362	Continued From page 9 by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/21/25 in the presence of the U.S. FOIA (b)(6) [REDACTED], it was determined that the facility failed to ensure that corridor walls were constructed to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6.2 and 19.3.2.7. This deficient practice had the potential to affect limited residents and was evidenced by the following: An observation at 1:25 PM revealed that the wall above the set of smoke barrier doors by room 260 had a hole in the ceiling. An observation at 2:00 PM revealed that the wall above the set of smoke barrier doors by room 264 had a hole in the ceiling. In an interview at the time, the U.S. FOIA (b)(6) confirmed the findings. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference on 04/22/25 at 3:10 PM.	K 362	All penetrations above smoke barriers door, including 260 and 264 have been sealed with red fire calk. All residents residing between both of these smoke barriers have the potential to be affected. Director of Maintenance/ designee will conduct weekly audit for 4 weeks to ensure there are no unsealed penetrations through smoke barrier walls. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee meetings for 3 months and as needed thereafter.		

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K 362	Continued From page 10	K 362			
K 374 SS=D	N.J.A.C 8:39-31.2 (e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/21/25 in the presence of th U.S. FOIA (b)(6) [REDACTED], it was determined that the facility failed to ensure that smoke barrier doors were able to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Section 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect 24 of 99 residents was evidenced by the following: Observation at 10:10 AM revealed that the set of smoke barrier doors between room 119 and 120 was not closing when tested by U.S. FOIA (b)(6) Further observation revealed that the doors were not	K 374	self closers were reinstalled on the smoke barriers door between room 119 and 120 All residents have the potential to be affected by this deficient practice All smoke barriers will be inspected by maintenance director / designee weekly for 4 weeks then monthly for 2 months to ensure self-closure is evident on all smoke barrier doors. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee meetings for 3		5/12/25

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K 374	Continued From page 11 provided with self-closing devices. The U.S. FOIA (b)(6) confirmed the finding during the observation. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference on 04/22/25 at 3:10 PM. N.J.A.C. 8:39-31.2(e) HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/21/25 in the presence of the U.S. FOIA (b)(6) _____ it was determined that the facility failed to ensure that their air conditioning units were installed in a safe manner. This deficient practice had the potential to affect all 99 residents and was evidenced by the following: An observation in the U.S. FOIA (b)(6) _____ office at 1:18 PM revealed that the portable air condition unit duct was vented to the	K 374	months and as needed thereafter.		
K 521 SS=F		K 521	exhaust port for the portable unit in the assistant director of nursing office was immediately removed from ceiling and redirected through office window. All residents have the potential to be affected by this Director of maintenance/ designee will conduct weekly audit of all portable air conditioners for 4 weeks then monthly for 2 months to ensure all portable air		5/12/25

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K 521	Continued From page 12 ceiling, discharging hot air into the ceiling. The U.S. FOIA (b)(6) confirmed the finding during the observation. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference on 04/22/25 at 3:10 PM. N.J.A.C. 8:39-31.2(e) NFPA 99 A	K 521	conditioners are vented properly. . The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee meetings for 3 months and as needed thereafter.		
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 04/22/25 in the presence of the U.S. FOIA (b)(6)	K 531	Facility obtained elevator certificates for both elevators. Facility found	5/12/25	

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K 531	Continued From page 13 U.S. FOIA (b)(6) it was determined that the facility failed to properly inspect, test and maintain 2 of 2 elevators in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A 17.1/CSA B 44, Safety Code for Elevators and Escalators and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4, 9.4.2, and 9.4.6 . This deficient practice had the potential to affect all 99 residents and was evidenced by the following: A record review at 2:25 PM revealed the following: 1. The annual elevator Certificate of Use for 2 of 2 elevators were not provided 2. No documentation was provided for 2 of 2 elevator annual Fire Service Operations Phase 1 and Phase 2 testing. In an interview at the time, the U.S. FOIA (b)(6) confirmed the finding. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference on at 3:10 PM. N.J.A.C 8:39-31.2(e) ASME A 17.1	K 531	documentation for both annual fire service operations phase open and phase 2. All resident have the potential to be effected Will Review this during our Quality Assurance Performance Improvement Committee meetings for the next 3 months		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:	K 741		5/12/25	

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K 741	Continued From page 14 (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/21/25 in the presence of the U.S. FOIA (b)(6) [REDACTED] it was determined that the facility failed to maintain the smoking area in accordance with NFPA 101: 2012 Edition, Section 19.7.4. The practice of littering the ground with cigarette butts and other combustibles, increases the risk of fire to facility occupants. This deficient practice was evidenced for 1 of 1 smoking area observed, had the potential to affect 17 residents and was evidenced by the following:	K 741	All cigarettes butts were immediately removed from smoking area. All 17 residents have the potential to be affected by this practice of littering cigarettes butts on the floor. In serviced activities aides and all who may do the supervised smoking on the importance of residents using cigarettes receptacles Director of housekeeping/ designee will		

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K 741	Continued From page 15 An observation in the smoking courtyard at 10:43 AM revealed that more than 38 cigarette butts were littering the ground in the resident smoking courtyard. The area was observed to have 2-outdoor cigarette receptacles. The smoking area was provided with an approved self-closing covered metal (black) container for the disposal of cigarette butts and ashes in the area and was observed to be empty. The U.S. FOIA (b)(6) confirmed the findings during the observations in the resident smoking courtyard. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference at 3:10 PM on 04/22/25.	K 741	conduct weekly audits for 4 weeks then monthly for 2 months of the courtyard to ensure it is clean from cigarette butts. . The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee meetings for 3 months and as needed thereafter.		
K 912 SS=F	NJAC 8:39-31.2(e) Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/21/25 in the presence of the U.S. FOIA (b)(6)	K 912	Ice machine in 2nd floor pantry #1 and Coffee machine in pantry #2	5/12/25	

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K 912	Continued From page 16 U.S. FOIA (b) (6) it was determined that the facility failed to ensure that electrical outlets located next to a water source were equipped with Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 and NFPA 99. This deficient practice had the potential to affect all 99 residents was evidenced by the following: An observation in second floor pantry #1 at 2:08 PM revealed that the coffee machine was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. An observation in second floor pantry #2 at 2:33 PM revealed that the ice machine was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. In an interview at the time, the U.S. FOIA (b)(6) confirmed the findings. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference on 04/22/25 at 3:10 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K 912	Was immediately plugged into GFCI outlets. All resident have the potential to be effected by equipment not being plugged into proper outlets Director of maintenance/ Designee in-serviced all departments on which items need to be plugged into GCFI outlets. Director of maintenance / designee will conduct weekly audit on all equipment that require GCFI outlets for 4 weeks and then monthly for 2 months to ensure there plugged into appropriate outlets. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement Committee meetings for 3 months and as needed thereafter.		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918			5/12/25

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K 918	Continued From page 17 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 04/22/2025 in the presence of the [U.S. FOIA (b)(6)] [REDACTED] [REDACTED] it was determined that the facility failed to ensure that the emergency generator was exercised for 4 continuous hours every 36-months in accordance with NFPA 99:2012	K 918	Director of maintenance immediately called company down to perform the 4 hour load bank test All residents have the potential to be effected		

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K 918	Continued From page 18 Edition. This deficient practice had the potential to affect all 99 residents and was evidenced by the following: A documentation review 11:45 AM revealed that the generator was not tested at least once every 36 months, under load for a minimum of four continuous hours. No further document was provided regarding when it was last tested under load for a minimum of four continuous hours. In an interview at the time, the U.S. FOIA (b)(6) confirmed the finding. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference at 3:10 PM. N.J.A.C 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	Facility completed the 4 hour load bank test on the emergency generator. Added it to our tells system to schedule for next due date. The Administrator/Designee in-serviced the Director of maintenance/designee on the importance of completing the of 4 hour load bank test. Director of maintenance/Designee will conduct audit weekly for 4 weeks and monthly for 2 months of load bank test to ensure it is completed. The result of the audit will be reported at the monthly quality assurance performance improvement Committee meetings.		
K 921 SS=F	Electrical Equipment - Testing and Maintenance CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as	K 921		5/12/25	

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

PRINTED: 06/17/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315141	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2025
NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 921	Continued From page 19 required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 04/21/25 and 04/22/25 in the presence of the U.S. FOIA (b)(6) U.S. FOIA (b)(6) it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all 99 residents and was evidenced by the following: Observations on 04/21/2025 and 04/22/2025 revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility. In an interview at the time, the U.S. FOIA (b)(6)	K 921	K921- facility immediately created policy for all the patient care related electrical equipment. Administrator/designee in-serviced maintenance team on policy to ensure policy is followed Director of maintenance/designee will review this policy during our Quality Assurance Performance Improvement Committee meetings to ensure policy is being followed. Director of maintenance/Designee will conduct audit of 3 electrical equipment a week for 4 weeks then monthly for 2 months.to ensure they are being used/plugged in appropriately. The result of the audit will be reported at the monthly quality assurance performance improvement Committee meetings.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315141	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2025
NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 921	Continued From page 20 confirmed the finding. A documentation review on 04/22/2025 at 3:10 PM revealed there was no policy for patient care related electrical equipment. In an interview at that time, the U.S. FOIA (b)(6) confirmed the finding and acknowledged that no policy was provided. The U.S. FOIA (b)(6) staff were informed of the findings at the Life Safety Code exit conference at 3:10 PM on 04/22/25. NJAC 8:39-31.2(e) NFPA 99	K 921			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315141	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 6/6/2025	Y3
NAME OF FACILITY ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	05/12/2025	LSC K0324	05/12/2025	LSC K0345	05/12/2025
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	05/12/2025	LSC K0355	05/12/2025	LSC K0362	05/12/2025
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	05/12/2025	LSC K0521	05/12/2025	LSC K0531	05/12/2025
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0741	05/12/2025	LSC K0912	05/12/2025	LSC K0918	05/12/2025
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0921	05/12/2025	LSC _____		LSC _____	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) _____	DATE _____	SIGNATURE OF SURVEYOR _____	DATE _____	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS) _____	DATE _____	TITLE _____	DATE _____	
FOLLOWUP TO SURVEY COMPLETED ON 4/22/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			