STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

(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 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). Complaint #'s: NJ157602, NJ159021, NJ159131, NJ159472, NJ160729, NJ161981, NJ167419, NJ172055, NJ173797, NJ174205, NJ174945, NJ175542. Survey Dates: 09/23/24 through 09/26/24 Survey Census: 148 Sample Size: 40 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		10/4/24

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

Electronically Signed | 10/18/2024

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facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for

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F 585	Continued From page 2	F 585		

example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

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F 585	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide information on how to file an anonymous grievance for six of six residents (Residents (R) 18, R88, R94, R97, R95, and R128) reviewed for the grievance process of 40 sample residents. The failure had the potential to affect residents' ability to safely report concerns without fear of retaliation. Findings include: A resident group interview was conducted on 09/25/24 at 3:00 PM with six residents whom the facility identified as reliable historians. During the meeting, six of the six residents (R18, R88, R94, R97, R95, and R128) expressed that they did not know how to file an anonymous grievance. They stated that "Nobody told us how to file one" and "We can go to the social worker to file a grievance, but not anonymous." Review of the Resident Council meeting minutes, dated [redacted] through 09/12/24, revealed no mention of making an anonymous grievance. During an interview on 09/25/2024 at 4:00 PM, [redacted]) stated that the residents could come to her to make a grievance. [redacted] stated that she went around to most residents in the morning to see how things were going or if they had any grievances. However, she stated she never explained to the residents about filing a grievance anonymously. During an interview on 09/25/2024 at 4:10 PM, the [redacted] stated that the residents could	F 585	1. Immediately baskets were hung on each resident unit with grievance forms and envelopes to provide them with an anonymous way to express their concerns. Locked drop boxes were ordered and installed on each unit. 2. A resident council was held to let the residents know about these boxes, their purpose and where they are located. Those residents who do not attend resident council were spoken to individually. This process will also be reviewed with the staff. 3. The box will be checked daily by Social Worker or designee and followed up immediately. Grievance procedure will be followed and logged. 4.This procedure will be reviewed monthly at resident council and grievances will be tracked and trended and reviewed at the quarterly QAPI meeting x 3 quarters.	

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F 585	Continued From page 4 file a grievance. However, she stated she never explained to the residents about filing a grievance anonymously. She also stated there was no way to file an anonymous grievance in the facility. Review of the facility's undated policy titled, "Grievance Policy and Procedure", revealed "All residents, responsible parties, interested family members, and staff of [Facility Name] have the right to voice grievances that are free from interference, coercion, discrimination, or reprisal concerning: The care, treatment, and services that are or fail to be, furnished; the policies, procedures, physical condition of the facility; the behavior of other residents, responsible parties, interested family members, and staff." NJAC 8:39- 4.1(a)35 NJAC 8:39-13.2(c)	F 585		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 625		10/11/24

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F 625	Continued From page 5 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and policy review, the facility failed to provide written notice of their bed hold policy and the cost of a bed hold when residents were transferred to [NJ Ex Order 26.4(b)(1)] for five of five residents (Resident (R) 119, R87, R83, R29, and R67) reviewed for [NJ Ex Order 26.4(b)(1)] of 40 sample residents. This failure had the potential to cause [NJ Exec Order 26.4b] or [NJ Exec Order 26] regarding the cost to hold a room and whether or not a resident would be able to return to the facility after [NJ Ex Order 26.4(b)(1)] Findings include: 1. Review of R119's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Ex Order 26.4(b] and located in the "MDS" tab of the electronic medical record (EMR), revealed the resident was unable to complete a Brief Interview for Mental Status (BIMS) and the staff assessment for cognition indicated [NJ Ex Order 26.4(b)(1)] [redacted] Review of R119's "Prog Note" tab of the EMR	F 625	1. All residents identified were already readmitted to facility at the time of the survey. 2. All residents have the potential of being affected by this deficient practice. Residents currently in the hospital have been reviewed and any needed bed hold/ notice of transfers have been issued and scanned into EMR. 3. Re-education was completed with Receptionists, [U.S. FOIA] and Nursing on facility Bed Hold and notice of transfers Policy & Procedure. 4. Administrator will monitor compliance with issuing Bed hold/Notice of Transfer, when residents are transferred ensuring all necessary information is included and that written notification is scanned into EMR. Audit will be completed by Administrator/Designee weekly for 3 quarters with results being reviewed with	

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F 625	Continued From page 6 revealed a note, dated NJ Ex Order 26.4(b at 2:26 PM, which documented R119 was sent to NJ Ex Order 26.4(b)(1) for a NJ Ex Order 26.4(b)(1) An entry dated NJ Ex Order 26.4(b)(, revealed R119 had returned from NJ Ex Order 26.4(b)(1). Review of R119's "Prog Note" tab of the EMR further revealed a note, dated NJ Ex Order 26.4(b at 10:28 PM, which documented R119 was admitted to NJ Ex for NJ Ex Order 26.4(b)(1) Review of R119's "Census" tab of the EMR revealed that R119's payor source at the facility was private pay when NJ Ex was discharged to the hospital on NJ Ex Order 26.4(b and Medicare when she was discharged to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b. Review of R119's EMR and hard chart revealed no evidence that a bed hold policy or bed hold letter was provided to the resident representative for the hospitalizations. Review of a facility provided binder of bed hold letters revealed an undated letter to R119's representative, which revealed R119 had discharged to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b(for NJ Ex Order 26 . It stated the facility would hold NJ Ex bed for ten days but did not state the cost after the ten days or whether R119 would be able to return to the facility. The binder did not include a letter for when R119 was NJ Ex Order 26.4(b to the NJ Ex Order 26.4 on NJ Ex Order 26.4(b)(Review of the facility provided copy of the undated bed hold letter for NJ Ex Order 26.4(b revealed R119 was discharged to the hospital for lethargy. It revealed the facility would hold NJ Ex bed for ten days but did not state the cost after the ten days or whether R119 would be able to return to the	F 625	QAPI committee at quarterly QAPI meetings for any further recommendations and/or resolution.	

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facility.

During an interview on 09/26/24 at 4:53 PM, the U.S. FOIA (b) (6) [redacted]) stated that R119's two discharges had no cost associated with them because [redacted] was Medicaid pending.

2. Review of R87's undated "Face Sheet" located under the "Profile" tab of the EMR, revealed R87 was admitted to the facility on [redacted] and readmitted on [redacted].

Review of "Incident Reporting Application" (initial reporting), dated [redacted] and located under the "Progress Notes" tab of the EMR, revealed "Received report [R87] noted with [redacted] towards resident ...[R87] was later sent to the hospital for further evaluation and treatment."

Review of R87's EMR revealed no documented evidence that the facility provided written information regarding the facility's bed hold policy to the resident and the resident's responsible party at the time of transfer.

Review of a facility provided binder of bed hold letters revealed an undated letter that did not contain the cost associated with the bed hold.

3. Review of R83's undated "Face Sheet" located under the "Profile" tab of the EMR, revealed R83 was admitted to the facility on [redacted].

Review of R83s "Progress Notes," dated [redacted] and located in the "Progress Notes" tab of the EMR, revealed R83 was discharged to [redacted] on [redacted]

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Review of R83's EMR revealed no documented evidence that the facility provided written information regarding the facility's bed hold policy to the resident and the resident's responsible party at the time of transfer.

Review of a facility provided binder of bed hold letters revealed an undated letter that did not contain the cost associated with the bed hold.

4. Review of R29's undated "Face Sheet" located under the "Profile" tab of the EMR, revealed R29 was admitted to the facility on [redacted].

Review of R29s "Progress Notes," dated [redacted] and located in the "Progress Notes" tab of the EMR, revealed R29 was sent to [redacted] on [redacted].

Review of R29's EMR revealed no documented evidence that the facility provided written information regarding the facility's bed hold policy to the resident and the resident's responsible party at the time of transfer.

Review of a facility provided binder of bed hold letters revealed an undated letter that did not contain the cost associated with the bed hold.

During an interview on 09/25/24 at 8:48 AM [redacted]) stated, "I have nothing to do with the bed hold notice transfer. The [redacted] sends out the notice the next day." [redacted] reviewed the facility bed hold notice upon transfer and stated was familiar with the policy, but did not realize the written notice did not include the bed hold payment portion.

During an interview on 09/25/24 at 8:55 AM the

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U.S. FOIA (b) (6)) stated, "When I come in the morning, I will run the resident census to see what residents have been transferred to NJ Ex Order 26.4(b)(1) and then I will send out the facility bed hold policy to the family or responsible party." The U.S. FOIA (b) (6) further stated that she was not familiar with the official policy; she just sent it out.

5. Review of R67's "Admission Record" located in the EMR under the "Profile" tab, revealed an admission date of NJ Ex Order 26.4(b and readmission on NJ Ex Order 26.4(b with medical diagnoses that included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) .

Review of R67's EMR documented R67 was emergently hospitalized on NJ Ex Order 26.4 , NJ Ex Order 26.4(b) , NJ Ex Order 26.4(b , and NJ Ex Order 26.4(b . Review of the EMR and paper chart lacked documentation the resident representative was notified in writing the cost-if any to hold the bed.

During an interview on 09/26/24 3:57 PM, the U.S. FOIA (b) (6) explained the process of notification to the family about a resident discharge. She stated each morning the Receptionist checked the census for discharges and clarified each with the U.S. FOIA (b) (6)). She stated they checked the census tab in the EMR to confirm payment status and informed the U.S. FOIA (b) (6) to clarify if payment for bed hold was required. She stated a copy of the facility bed hold policy was not included in the mailing to the resident representative address. The U.S. FOIA (b) (6) stated she was unaware if the documentation about the bed hold notice being placed into the resident's medical record.

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F 625	Continued From page 10 During an interview on 09/26/24 at 4:12 PM, the U.S. FOIA (b) (6) explained the U.S. FOIA (b) (6) checked with the U.S. FOIA (b) (6) to verify amount of payment for Medicare and private pay residents. The U.S. FOIA (b) (6) stated they provided the amount and followed up with a call to the resident representative to confirm the bed hold. The U.S. FOIA (b) (6) was unsure if the documentation about the bed hold and cost to hold the bed was placed in the resident's medical record. Review of the facility's policy titled, "Bed Hold Notice Upon Discharge," updated 01/15/24, revealed "Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: The duration of the state bed-hold policy, if any, during which the resident is permitted io return and resume residence in the nursing facility. The reserve bed payment policy in the slate plan policy, if any ...The facility policies regarding bed-hold periods to include following a resident to return to the next available bed ...Conditions upon which the resident would return to the facility: In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies." NJAC 8:39-4.1(a)32	F 625		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		10/11/24

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F 689	Continued From page 11 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and facility policy review, the facility failed to ensure a resident's safety during transport to an outside appointment when the resident was dropped off at NJ Ex Order 26.4(b)(1) instead of a safe facility return for one of three residents (Resident (R) 298) and the facility failed to ensure safe resident transfers with use of a NJ Ex Order 26.4 for two of three residents (R119 and R121) reviewed for accident hazards of 40 sample residents. This had the potential to place all residents who are dependent on the facility at risk. Findings include: 1. Review of R298's "Face Sheet," located in the "Profile" tab of the electronic medical record (EMR), revealed R38 was admitted to the facility on NJ Ex Order 26.4(b with diagnosis of NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). Review of R298's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Ex Order 26.4(b) located under the "MDS" tab of the EMR revealed a Brief Interview for Mental Status (BIMS) of NJ Ex Orde out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1) . Further review revealed the resident used a wheelchair for NJ Exec Order 2 and was NJ Ex Order 26.4(b)(1) of one staff with NJ Ex Order 26.4(b)(Review of R298's "Care Plan" located under the "Care Plan" tab of the EMR and dated NJ Ex Order 26.4(b)(1 revealed the resident had NJ Ex Order 26.4(b)(1)	F 689	1a. Resident identified R298 is NJ Ex Order 26.4(b)(facility. 1b. Resident 119 was reevaluated by NJ Exec Order 26.4b1 and NJ Exec Order 26 status was changed to NJ Exec Order 26.4b1 1c. Resident 121 was in NJ Ex Order 26.4(b)(1) wheelchair at the time of transfer. Therapy reevaluated NJ Ex Order 26.4 status and continue to with NJ Exec Order 26.4b1. 2a. All residents identified as maximum/dependent transfer status were reevaluated by Rehabilitation for appropriate Safe-Handling of resident and plan of care was updated. 2b. Patient Appointment Form was updated to include Return Address. All scheduled appointments were audited to ensure the updated Patient Appointment Form has been completed. 3a. All residents identified as having a decline in functional status during care and/or during the Quarterly MDS assessment will notify the therapy department to evaluate appropriate transfer status. If there is a change in the current Plan of Care, education will be provided to Staff with an updated Care Plan for resident. 3b. Unit Clerk will initiate, and complete	

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F 689	Continued From page 12 NJ Ex Order 26.4(b) Review of R298's "Patient Appointment," (hardcopy) dated NJ Ex Order 26.4(b) and provided by the facility, revealed appointment time was 1:30 PM. The pickup time was at 12:10 PM and the return time was 6:00 PM. It was noted under transport ... R298 was dropped off at NJ Ex Order 26.4(b) and the address of the resident's NJ Ex Order was listed. During an interview on 09/25/24 at 4:32 PM, RN2 said R298 had a NJ Ex Order 26.4(b)(1) appointment on NJ Ex Order 26.4(b) but the transportation company took the resident to NJ Ex Order 26.4(b)(1). She was unsure who notified the facility but thought someone called the transportation company and they said the NJ Ex Order 26.4(b)(1) was the one on file as the drop-off location. She thought the facility requested that the transportation company to go back and pick up the resident and bring NJ Ex O to the facility, but she could not remember anything specifically. During an interview on 09/26/24 at 10:24 AM, Medical Records (MR) stated she spoke with the transport company, and they stated back on NJ Ex Order 26.4(b) the facility contacted the transportation company at 6:50 PM after the R298 did not return from his appointment. She stated the facility was informed the resident was dropped off at NJ Ex O [redacted] MR stated the previous staff who was the unit clerk/medical records at that time accidentally provided the transportation company with R298's NJ Ex Order 26.4(b)(1) listed on the face sheet instead of the facility address as the drop off location. She said it was the previous unit clerk's error. During an interview on 09/26/24 at 2:25 PM, the	F 689	documents needed for appointments when appointment is made. Night Shift Supervisor will review document packets for appointments scheduled for the day of appointment. 4a. Unit Managers will review at Quarterly/QAPI Meeting times 3 quarters, any residents who have had a decline or change in transfer status of maximum/dependent to ensure Safe Handling of Residents to ensure proper plan of care is being followed and care plan is updated. 4b. Unit Managers will review and update IDCT at QAPI/Quarterly Meeting times 3 quarters that all residents sent out for appointments returned safely to/from designated location and that they had Patient Appointment Form completed accurately.	

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U.S. FOIA (b) (6) stated it was a previous U.S. FOIA (b) (6) and U.S. FOIA at the time the incident occurred, and she was unaware of what happened.

2. Review of R119's "Admission Record" located in the "Profile" tab of the EMR revealed she was admitted to the facility on NJ Ex Order 26.4(b) with a diagnosis of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) following NJ Ex Order 26.4(b)(1) .

Review of R119's quarterly "MDS" with an ARD of NJ Ex Order 26.4(b) and located in the "MDS" tab of the EMR, revealed the resident was unable to complete a BIMS and the staff assessment for cognition indicated NJ Ex Order 26.4(b)(1) . R119 required NJ Ex Order 26.4(b)(1)) when NJ Ex Order 26.4 from NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b) and during NJ Ex Order 26.4(b)(1).

Review of R119's "Care Plan," last reviewed NJ Ex Order 26.4(b) and located in the "Care Plan" tab of the EMR, revealed no information on how R119 transferred. It directed staff to: " use caution during NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) to prevent NJ Ex Order 26.4(b)(1) , NJ Ex Ord and NJ Ex Order 2 against any NJ Ex Order ," date initiated NJ Ex Order 26.4(b)(1)

During an observation on 09/25/24 from 10:45 AM to 10:57 AM, Certified Nurse Aide (CNA) 3 and CNA8 transferred R119 from her wheelchair to bed. CNA3 stood on R119's left and CNA8 on the right. Each CNA put an arm under R119's arms and grabbed NJ Ex Order 26.4(b)(1) R119's NJ Ex Order 26.4 with the other hand. Pulling on R119's NJ Ex Order and using their arms NJ Ex Order 26.4(b) R119, the CNAs NJ Ex Order R119 and NJ Ex Order 26.4(b)(1)

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F 689		F 689		

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NJ Ex Order 26.4(b)(1) before they NJ Ex Order 26.4(b)(1) to NJ Ex for NJ Ex Order 26.4(b)(1) cares. Following cares, CNA3 and CNA8 then NJ Ex Order 26.4(b)(1) R119 NJ Ex Order 26.4 the wheelchair using the same technique and NJ Ex

During an interview on 09/26/24 at 9:36 AM, CNA2 stated R119 required two staff to NJ Ex Order

During an interview on 09/26/24 at 9:51 AM, CNA7 reported R119 needed two staff to NJ Ex Order 26.4(b CNA7 stated the floor had no NJ Ex Order 26.4(b)(but she thought one floor still used them. CNA7 stated if any changes occurred in how residents transferred, the therapy department showed the staff how to do NJ Ex Order 26.4(b)(1).

3. Review of R121's "Admission Record" located in the "Profile" tab of the EMR revealed NJ Ex O was admitted to the facility on NJ Ex Order 26.4(b)(1).

Review of R121's quarterly "MDS" with an ARD of NJ Ex Order 26.4(b and located in the "MDS" tab of the EMR, revealed a BIMS score of NJ Ex Ord out of 15 which indicated the resident had NJ Ex Order 26.4(b . R121 required NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(

Review of R121's "Care Plan," last reviewed NJ Exec Order 26.4b and located in the "Care Plan" tab of the EMR, revealed an intervention, dated NJ Ex Order 26.4(b)(1), that R121 required the NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(

During an observation on 09/26/24 at 9:29 AM, CNA2 transferred R121 from wheelchair to bed.

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F 689	Continued From page 15 Without locking the wheelchair's brakes, CNA2 faced R121, placed NJ Ex Order 26.4(b)(1) the resident's NJ Ex Order counted to three, and NJ Ex Order 26 R121 from the wheelchair NJ Ex Order 26.4(b)(1) CNA2 did not use NJ Ex Order 26.4(b)(1) During an interview on 09/26/24 at 9:36 AM, CNA2 stated R121 required NJ Ex Order 26.4(b)(1) . She reported she had NJ Ex Order 26.4(b)(1) and was unsure if there were any NJ Ex Order 26.4(b) on the floor she worked. During an interview on 09/26/24 at 10:12 AM, Licensed Practical Nurse (LPN) 3 stated they did not use NJ Ex Order 26.4(b) . LPN3 stated they let the residents know what they were doing and asked them to help. During an interview on 09/26/24 at 10:31 AM, LPN5 stated the facility did not NJ Ex Order 26.4(b)(1) . She stated therapy used them for training. LPN5 was unsure why the facility did not use NJ Ex Order 26.4(b)("It's not common practice at any facility I've been at." During an interview on 09/26/24 at 11:15 AM, the U.S. FOIA (b) (6)) reported the facility did not typically use NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b) unless therapy approved them. She thought therapy had not approved one person for NJ Ex Order 26.4 use. During an interview on 09/26/24 at 11:56 AM, the U.S. FOIA (b) (6) stated that when NJ Ex Order 26.4 had recommendations for NJ Ex Order 26.4(b)(1) a resident, they verbally told the U.S. FOIA (b) (6) to update the care plan and NJ Exec Order 26 The U.S. FOIA (b) (6) stated when a resident had a change in how they transferred, therapy provided an in-service to the CNAs. The U.S. FOIA (b) (6) stated unless a resident NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) and	F 689		

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F 689	Continued From page 16 responded well to verbal cues (or used a NJ Ex Order 26.4(b)(1)), she expected staff to use a NJ Ex O [redacted]. Review of the facility's undated policy titled, "Safe Resident Handling" revealed: "The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status ...Resident lifting and transferring will be performed according to the resident's individual plan of care." NJAC 8:39-33.1(d)	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		10/11/24

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F 700	Continued From page 17 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure residents received alternative measures and informed consent with explained risks and benefits was obtained prior to installation for one of one resident (Resident (R) 30) reviewed for [NJ Ex Order 26.4(b)] of 40 sampled residents. The lack of NJ Ex Order 26.4(b)(1) measures and proper assessment/consent could lead to potential [NJ Ex Order 26.4(] or NJ Ex Order 26.4(b)(1). Findings include: Review of R30's undated "Face Sheet" located under the "Profile" tab of the electronic medical record (EMR) revealed the resident was admitted on [NJ Ex Order 26.4(b] . Diagnoses included [NJ Ex Order 26.4(b] , [NJ Ex Order 26.4(b)(1)] , NJ Ex Order 26.4(b)(1) , [NJ Ex Order 26.] , and [NJ Ex Order 26.4] Review of R30's significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Ex Order 26.4(b] revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of [NJ E] out of 15 which indicated the resident had NJ Ex Order 26.4(b)(1). Review of R30's "Care Plan," initiated [NJ Ex Order 26.4(b)(] located under the "Care Plan" tab of the EMR, revealed R30 had NJ Ex Order 26.4(b)(1) for [NJ Ex Order 26] and NJ Ex Order 26.4(b)(1) Review of R30's "Order Summary Report" located under the "Orders" tab of the EMR, revealed an order, dated [NJ Ex Order 26.4(b] , NJ Ex Order 26.4(b)(1) as an [NJ Ex Order 26.4] for [NJ Ex Order 26] and NJ Ex Order 26.4(b)(1) in bed.	F 700	1. Resident identified as R30 had a new [NJ Ex Order 26.4(b] Assessment completed and were educated on the Risks versus Benefits along with alternatives to [NJ Exec Order 26.4b] . New consent was completed and signed. 2. All residents with Bed Rails had a new assessment completed which included Risks versus Benefits along with alternatives to Bed Rails and in addition will be completed Quarterly or as needed. 3. All nursing staff will be educated on Assessment, Consent and Alternatives to Bed Rails which need to be completed on admission and quarterly. 4. Audits will be carried out by Unit Managers weekly on all new admissions and Quarterly Assessments to ensure Bed Rails and alternatives are up to date and in compliance and will be reviewed at Quarterly/QAPI Meeting x 3 quarters.	

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Review of R30's "NJ Ex Order 26.4(b) Assessment Screening" located under the "Assessments" tab of the EMR, dated NJ Ex Order 26.4(b)(, revealed no documented evidence of any alternative measures prior to installation, and no documented evidence of obtained consent for NJ Ex Order 26.4 usage.

During an interview on 09/26/24 at 10:59 AM, Licensed Practical Nurse (LPN) 4 stated they did not try alternatives prior to NJ Ex Order 26.4 use for R30. She stated staff did obtain informed consent and reviewed risks vs benefits and that it would be documented in the resident's hard chart. She reviewed the hard chart and found two forms titled "informed consent for use of NJ Ex Order 26.4(b)(but neither were filled out or signed.

During an interview on 09/26/24 at 1:42 PM, LPN2 stated when staff were assessing residents for NJ Ex Order 26.4 use, they asked basic questions and asked about gaps between the NJ Ex Order 26.4 and mattress. LPN2 stated he was unsure what alternates would have been used and stated they did not look at alternates. He stated it's either a yes, they use NJ Ex Order 26.4(b) or a no, they did not use them.

During an interview on 09/26/24 at 2:16 PM, the U.S. FOIA (b) (6)) stated prior to a resident using NJ Ex Order 26.4(b) staff should obtain a consent form that was completed on admission. She stated staff explained the risks versus the benefits of using NJ Ex Order 26.4(b) and had them or their responsible party sign it. She stated they had a Quality Assurance and Performance Improvement (QAPI) that was implemented on NJ Ex Order 26.4(b for NJ Ex Order 26.4 use. The U.S. FOIA stated they

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F 700	Continued From page 19 had identified they were not getting informed consents, and they were not being care planned. She stated they only obtained signed consents for the residents on the 100 halls but have not obtained signed consents from residents on the 200 and 300 halls. When she was asked why that was not completed in the last month and a half since the QAPI on [redacted] was implemented, she was unsure. She confirmed the QAPI did not address the facilities lack of exploring alternates prior to [redacted] use.	F 700		
F 761 SS=D	NJAC 8:39-27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		10/11/24

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F 761	Continued From page 20 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure medication containers were labeled specific to the resident for two of six medication carts reviewed for correct labeling of medications. As a result of this deficient practice the residents had the potential for residents to receive the wrong medication. Findings include: During an observation on 09/26/24 at 5:13 PM, medication cart one on second floor revealed a box of NJ Ex Order 26.4(b)(1)) were stored in-between medication punch cards for the resident in NJ Ex O with only the room number (NJ Ex Ord on the box and a box of NJ Ex Order 26.4(b)(1) were stored in-between medication punch cards for the resident in NJ Ex O with only the room number NJ Ex Ord on the box. Both rooms NJ Ex O and NJ Ex O had residents in bed NJ and NJ E. The box only had the room number without the NJ or NJ designation. During an interview on 09/26/24 at 5:13 PM, Registered Nurse (RN) 4 explained the NJ Ex Order 26.4(were NJ Ex Order 26.4(b)(1) in the regular floor stock were not NJ Ex Order 26.4(b)(1) so a separate box was placed in with the medication punch cards for the residents in NJ Ex O and NJ Ex O so the residents would get the correct dose of NJ Ex O during medication pass. RN4 confirmed the resident name was not on the box, only the room	F 761	1. All current over the counter medications on LTC which were identified as not labeled with patient□s name were immediately discarded and new OTC medications were provided with proper labeling with name for both box and medication. 2. All residents have the potential to be affected by this deficient practice. An audit will be conducted by the unit managers of all residents with OTC Medications that are for individual use to ensure compliance with labeling of name on a weekly basis. 3. All nursing staff will be educated on labeling process. 4. All medication carts will be checked weekly by Nurse Management and monthly by Pharmacy Consultant for Compliance times 3 quarters and will be reviewed at quarterly QAPI Meetings.	

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number and should have had the resident name on the box, not just the room number.

During an observation on 09/26/24 at 5:13 PM, medication cart two on second floor revealed a bottle of NJ Ex Order 26.4(b)(1)), located in the drawer with the NJ Ex Order 26 medications, with room NJ Ex Orde written on the box with no resident name.

During an interview on 09/26/24 at 5:13 PM, Licensed Practical Nurse (LPN) 6 confirmed the NJ Ex Order 26.4(b)(1 had only the resident room number and no name. LPN6 was not sure if the NJ Ex Order 26.4(b)(1 needed a name because they were an over the counter (OTC) medication.

During an interview on 09/26/24 at 5:58 PM, the LPN4 confirmed medications with only a room number were not in compliance, including house stock OTC medications. She stated when an OTC was specific for a resident, a resident sticker (located in the front of the paper chart), should be put on the medication/or box to clearly identify the medication was for a specific resident to avoid giving a medication to the wrong resident.

During an interview on 09/26/24 at 6:04 PM, the U.S. FOIA (b) (6)) confirmed all medications, including OTC, for a specific resident, should have been labeled with the specific resident name, not just the room number.

Review of the facility policy titled "Labeling of Medication Containers," updated 01/2024, revealed, "Labels for over-the-counter drugs shall include all necessary information, such as: a. The original label, b. The resident's name, and the expiration date when applicable ..."

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	315134	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

(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 761	Continued From page 22 NJAC 8:39-29.2 NJAC 8:39-29.4 NJAC 8:39-44.2	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure food prepared by the facility was served at a palatable temperature for five of six residents (Resident (R) 97, R18, R88, R94, and R128) reviewed for palatability of 40 sample residents. As a result of this deficient practice the residents had the potential for poor nutrition and weight loss. Findings include: 1. Review of R97's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Ex Order 26.4(b), revealed a "Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1). During an interview on 09/23/24 at 2:12 PM, R97 stated the food was always cold.	F 804	1.The FSD immediately reviewed the service line checklists to ensure that food temperatures are properly recorded prior to service and that all temperature controlled, and cooking equipment is in proper working order. FSD had checked the succeeding trays of all residents to ensure they were in acceptable temperature range and checked for plate appearance. 2. All residents have the potential to be affected by this deficient practice. Test Tray and Accuracy Evaluations which monitor food temps, taste, aroma, and plate appearance will be conducted weekly with 3 trays per meal x 3 months by FSD or designee. Constant communication with residents during food	10/11/24

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F 804	Continued From page 23 2. Review of R18's quarterly MDS assessment with an ARD of NJ Ex Order 26.4(b, revealed a BIMS score of NJ Ex out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1). 3. Review of R88's quarterly MDS assessment with an ARD of NJ Ex Order 26.4(b)(revealed a BIMS score of NJ Ex out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1). 4. Review of R94's quarterly MDS assessment with an ARD of NJ Ex Order 26.4(b, revealed a BIMS score of NJ Ex out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1). 5. Review of R128's quarterly MDS assessment with an ARD of NJ Ex Order 26.4(b, revealed a BIMS score of NJ Ex out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1). During a resident group meeting on 09/25/24 at 3:20 PM, five residents (R18, R88, R94, R97, and R128) of the six residents expressed concerns that the food was cold and tasteless for most meals. They stated they had complained at the monthly council meetings as the issues had been going on for quite a while, but they saw no changes. During an observation on 09/25/24 at 11:22 AM, Dietary Staff (Dietary) 1 checked the temperatures of the food on the steam table. The readings of the main meal included: chicken 153.2 degrees Fahrenheit (F), boiled potatoes 183 degrees F, and broccoli 184 degrees F. Dietary1 then began to plate the food. Dietary staff did not check food temperatures throughout the meal service.	F 804	committee meetings and resident council to get their feedback. 3. The dietary dept has instituted the Implementation of temperature logs and Test Tray Accuracy logs. Also, we will be purchasing new heating pellets. Dietary will work closely with nursing to ensure food is passed in a timely manner by completing a daily audit on tray delivery times once on unit. Education has been provided to the dietary department and nursing department. Additionally, FSD and/ or designee will conduct daily audits at meal service times to ensure steam table, plate warmer, transport carts and refrigeration units are operating at acceptable temperatures to maintain food temp x 3 months. 4. FSD or designee will interview four residents randomly on a daily basis asking about food temperatures during various meals x 3 months. These results and the results of all test trays and resident feedback will be reviewed during quarterly QAPI meetings with the committee x 3 quarters.	

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F 804	Continued From page 24 During an observation on 09/25/24 at 1:06 PM, Dietary1 finished plating the last resident tray and then plated a test tray of the main meal and provided a facility thermometer to check the temperatures of the food on the test tray. During an observation on 09/25/24 at 1:12 PM, dietary staff brought the wheeled, enclosed cart to the second floor, which included the test tray, and left the cart to return to the kitchen in the basement. During an observation on 09/25/24 at 1:22 PM, as staff passed the last two trays to residents, the temperatures of the food on the test tray were: chicken 130.3 degrees F, potatoes 113.3 degrees F, and broccoli 112.8 degrees F. Human Resources (HR) verified the temperature readings and tasted the food for palatability, spitting out the chicken. During an interview on 09/25/24 at 1:23 PM, HR described the food on the test tray as "room temperature" and stated it could definitely be warmer. During an interview on 09/25/24 at 1:36 PM, the U.S. FOIA (b) (6)) stated the facility needed to do audits to determine why the food temperatures dropped. During an interview on 09/25/24 at 1:41 PM, the U.S. FOIA (b) (6) reported the temperature drops were significant. The U.S. FO expected the temperatures to be equivalent to the temperatures displayed on an undated, untitled paper which listed desired temperatures of food by category, hot entrees, starches, and	F 804		

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F 804	Continued From page 25 vegetables had a desired temperature range of 140-165 degrees F. The [redacted] stated the facility used heated pellets, which held temperatures for up to 20 minutes. Review of the facility's policy titled, "Food Temperature Policy," revised 08/23, revealed "All hot food items must be ... held and served at a temperature of at least 135 [degrees] F. Take temperatures often to monitor for safe food holding temperature ranges ... at or above 135 [degrees] F for hot foods ...Temperatures should be taken periodically to assure hot foods stay above 135 [degrees] F ... during the portioning, transporting and delivery process until received by the individual recipient ...Foods sent to the units for distribution (such as meals, ...) will be transported and delivered to maintain temperatures ... at or above 135 [degrees] F for hot foods." NJAC 8:39-17.4(a)	F 804		

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	061806	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

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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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1. Inadequate number of CNA□s 2. The facility recognizes that all residents have the potential to be affected by this practice. 3. The Administrator will review Staffing Coordinator in reference to the state guideline S560.The Director of Human Resources will continue to post the vacancies on all 3 shifts.The Director of Human Resources will schedule the Open House.The Administrator will boost the rate when there is emergency staffing coverage.The facility is contracted with multiple staffing agencies for temporary	10/19/24

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

Electronically Signed | 10/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 9 weeks of Complaint staffing from 08/21/2022 to 10/22/2022, the facility was deficient in CNA staffing for residents on 63 of 63 day shifts as follows: -08/21/22 had 11 CNAs for 142 residents on the day shift, required at least 18 CNAs. -08/22/22 had 13 CNAs for 141 residents on the day shift, required at least 18 CNAs. -08/23/22 had 13 CNAs for 140 residents on the day shift, required at least 17 CNAs. -08/24/22 had 14 CNAs for 140 residents on the day shift, required at least 17 CNAs. -08/25/22 had 10 CNAs for 140 residents on the day shift, required at least 17 CNAs. -08/26/22 had 13 CNAs for 140 residents on the day shift, required at least 17 CNAs. -08/27/22 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. -08/28/22 had 15 CNAs for 146 residents on the day shift, required at least 18 CNAs. -08/29/22 had 14 CNAs for 141 residents on the	S 560	and permanent staffing assistance. Human Resources recruits from various local colleges and other schools with CNA programs by direct contact and attendance at Job Fairs. Employee Referral Bonus Program was implemented. Regular meetings are held including the Administrator, Director of Nursing and Human Resources to review direct care staffing and develop strategies for recruitment and retention of direct care staff. 4.The Staffing Coordinator will audit the staffing weekly for 4 weeks then monthly for 3 months. The Staffing Coordinator will submit the audit report to the QAPI committee at quarterly QAPI meetings x 3 quarters.	

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S 560	Continued From page 2	S 560		

day shift, required at least 18 CNAs.
-08/30/22 had 10 CNAs for 141 residents on the day shift, required at least 18 CNAs.
-08/31/22 had 12 CNAs for 141 residents on the day shift, required at least 18 CNAs.
-09/01/22 had 12 CNAs for 141 residents on the day shift, required at least 18 CNAs.
-09/02/22 had 14 CNAs for 143 residents on the day shift, required at least 18 CNAs.
-09/03/22 had 12 CNAs for 143 residents on the day shift, required at least 18 CNAs.
-09/04/22 had 11 CNAs for 143 residents on the day shift, required at least 18 CNAs.
-09/05/22 had 13 CNAs for 147 residents on the day shift, required at least 18 CNAs.
-09/06/22 had 11 CNAs for 146 residents on the day shift, required at least 18 CNAs.
-09/07/22 had 14 CNAs for 145 residents on the day shift, required at least 18 CNAs.
-09/08/22 had 12 CNAs for 145 residents on the day shift, required at least 18 CNAs.
-09/09/22 had 13 CNAs for 145 residents on the day shift, required at least 18 CNAs.
-09/10/22 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs.
-09/11/22 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-09/12/22 had 11 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-09/13/22 had 13 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-09/14/22 had 13 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-09/15/22 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-09/16/22 had 14 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-09/17/22 had 14 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-09/18/22 had 16 CNAs for 153 residents on the

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day shift, required at least 19 CNAs.
-09/19/22 had 15 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-09/20/22 had 15 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-09/21/22 had 18 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-09/22/22 had 18 CNAs for 152 residents on the day shift, required at least 19 CNAs.
-09/23/22 had 14 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-09/24/22 had 17 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-09/25/22 had 13 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-09/26/22 had 12 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-09/27/22 had 12 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-09/28/22 had 14 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-09/29/22 had 15 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-09/30/22 had 15 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-10/01/22 had 11 CNAs for 156 residents on the day shift, required at least 19 CNAs.
-10/02/22 had 11 CNAs for 156 residents on the day shift, required at least 19 CNAs.
-10/03/22 had 13 CNAs for 156 residents on the day shift, required at least 19 CNAs.
-10/04/22 had 15 CNAs for 156 residents on the day shift, required at least 19 CNAs.
-10/05/22 had 13 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-10/06/22 had 13 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-10/07/22 had 10 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-10/08/22 had 16 CNAs for 153 residents on the

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S 560	Continued From page 4	S 560		

day shift, required at least 19 CNAs.
-10/09/22 had 13 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-10/10/22 had 12 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-10/11/22 had 12 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-10/12/22 had 11 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-10/13/22 had 15 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-10/14/22 had 14 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-10/15/22 had 17 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-10/16/22 had 16 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-10/17/22 had 13 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-10/18/22 had14 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-10/19/22 had 11 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-10/20/22 had 13 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-10/21/22 had 14 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-10/22/22 had 18 CNAs for 154 residents on the day shift, required at least 19 CNAs.

2. For the week of Complaint staffing from 11/06/2022 to 11/12/2022, the facility was deficient in CNJA staffing for residents on 7 of 7 day shifts as follows:

-11/06/22 had 11 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-11/07/22 had 12 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-11/08/22 had 12 CNAs for 153 residents on the

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day shift, required at least 19 CNAs.
-11/09/22 had 11 CNAs for 152 residents on the day shift, required at least 19 CNAs.
-11/10/22 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs.
-11/11/22 had 14 CNAs for 152 residents on the day shift, required at least 19 CNAs.
-11/12/22 had 10 CNAs for 152 residents on the day shift, required at least 19 CNAs.

3. For the week of Complaint staffing from 01/01/2023 to 01/07/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-01/01/23 had 14 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-01/02/23 had 13 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-01/03/23 had 13 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-01/04/23 had 10 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-01/05/23 had 15 CNAs for 158 residents on the day shift, required at least 20 CNAs.
-01/06/23 had 16 CNAs for 158 residents on the day shift, required at least 20 CNAs.
-01/07/23 had 19 CNAs for 158 residents on the day shift, required at least 20 CNAs.

4. For the week of Complaint staffing from 02/19/23 to 02/25/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-02/19/23 had 15 CNAs for 165 residents on the day shift, required at least 21 CNAs.
-02/20/23 had 15 CNAs for 165 residents on the day shift, required at least 21 CNAs.
-02/21/23 had 13 CNAs for 165 residents on the

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day shift, required at least 21 CNAs.
-02/22/23 had 17 CNAs for 165 residents on the day shift, required at least 21 CNAs.
-02/23/23 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs.
-02/24/23 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs.
-02/25/23 had 17 CNAs for 163 residents on the day shift, required at least 21 CNAs.

5. For the week of Complaint staffing from 09/03/2023 to 09/09/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-09/03/23 had 13 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-09/04/23 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-09/05/23 had 14 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-09/06/23 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/07/23 had 15 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/08/23 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/09/23 had 15 CNAs for 148 residents on the day shift, required at least 18 CNAs.

6. For the 2 weeks of Complaint staffing from 03/03/2024 to 03/16/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-03/03/24 had 13 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-03/04/24 had 14 CNAs for 152 residents on the day shift, required at least 19 CNAs.
-03/05/24 had 17 CNAs for 152 residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061806	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 7	S 560		

day shift, required at least 19 CNAs.
-03/06/24 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs.
-03/07/24 had 17 CNAs for 152 residents on the day shift, required at least 19 CNAs.
-03/08/24 had 16 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-03/09/24 had 17 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-03/10/24 had 14 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-03/11/24 had 16 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-03/12/24 had 18 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-03/13/24 had 18 CNAs for 154 residents on the day shift, required at least 19 CNAs.
-03/14/24 had 15 CNAs for 153 residents on the day shift, required at least 19 CNAs.
-03/15/24 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs.
-03/16/24 had 14 CNAs for 151 residents on the day shift, required at least 19 CNAs.

7. For the week of Complaint staffing from 05/05/2024 to 05/11/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-05/05/24 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-05/06/24 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-05/07/24 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-05/08/24 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-05/09/24 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs.
-05/10/24 had 16 CNAs for 143 residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061806	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 8	S 560		

day shift, required at least 18 CNAs.
-05/11/24 had 14 CNAs for 143 residents on the day shift, required at least 18 CNAs.

8. For the week of Complaint staffing from 06/16/2024 to 06/22/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-06/16/24 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-06/17/24 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-06/18/24 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-06/19/24 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs.
-06/20/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs.
-06/21/24 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs.
-06/22/24 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs.

9. For the week of Complaint staffing from07/07/2024 to 07/13/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-07/07/24 had 12 CNAs for 140 residents on the day shift, required at least 17 CNAs.
-07/08/24 had 12 CNAs for 138 residents on the day shift, required at least 17 CNAs.
-07/09/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs.
-07/10/24 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs.
-07/11/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs.
-07/12/24 had 16 CNAs for 138 residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061806	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 9 day shift, required at least 17 CNAs. -07/13/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. 10. For the 2 weeks of staffing prior to survey from 09/08/2024 to 09/26/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -09/08/24 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. -09/09/24 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs. -09/10/24 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs. -09/11/24 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. -09/12/24 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. -09/13/24 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. -09/14/24 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -09/15/24 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. -09/16/24 had 15 CNAs for 143 residents on the day shift, required at least 18 CNAs. -09/17/24 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/18/24 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/19/24 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/20/24 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/21/24 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315134 Y1	A. Building B. Wing Y2	11/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

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 F0585	Correction	ID Prefix F0625	Correction	ID Prefix F0689	Correction
Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.15(d)(1)(2)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	10/04/2024	LSC	10/11/2024	LSC	10/11/2024
ID Prefix F0700	Correction	ID Prefix F0761	Correction	ID Prefix F0804	Correction
Reg. # 483.25(n)(1)-(4)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	10/11/2024	LSC	10/11/2024	LSC	10/11/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/26/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061806	A. Building B. Wing	11/19/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/19/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON 9/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 09/24/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 09/24/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Green Knoll is a three-story building with basement built in 1967. It is composed of Type II protected construction. The facility is divided into nine - smoke zones. The generator does approximately 45% of the building per the Maintenance Director. The current occupied beds are 148 of 176.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		10/4/24

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

Electronically Signed | 10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

(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 211	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure janitor carts were not stored in the exit stairways in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.1.3.2.3. This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include: An observation on 09/24/24 at 1:12 PM revealed a janitor's cart was stored in the Back Stairway on the first floor. An observation on 09/24/24 at 1:18 PM revealed a janitor's cart was stored in the South Wing Stairway on the first floor. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the janitor's carts were stored in the Back Stairway and the South Wing Stairway. During an interview on 09/24/24 at 4:50 PM, the U.S. FOIA (b) (6) stated the housekeeping department just had an in-service on not storing the janitor carts in the stairways. NJAC 8:39-31.1(c). 31.2(e)	K 211	1.The janitorial carts were immediately removed from the stairwell. 2.All residents have the potential to be affected. All other stairwells were checked to ensure they were in compliance. 3.Inservices were provided to all housekeeping staff regarding keeping all stairways clear and free of obstruction. Random audits will be completed weekly by the housekeeping director to ensure they are clear. 4.The housekeeping director or designee will report back findings from the audits at the quarterly QAPI meetings x 3 quarters.	
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release	K 223		10/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

(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 223	Continued From page 2 device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the mechanical room door closed and latched in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.2.3. This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include: An observation on 09/24/24 at 11:36 AM revealed the mechanical room door in the basement did not fully close when released, leaving a gap for the passage of smoke. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the door would not close.	K 223	1.The hardware on the affected mechanical door was changed immediately. 2. All residents have the potential to be affected. All doors were checked for proper function and closure. 3. Random audits will be completed by the maintenance director on all doors will be completed weekly for proper function. 4. The corrective action will be monitored at the QAPI meeting x 3 quarters. The maintenance director or designee will report findings at the quarterly QAPI meeting.	
K 227 SS=F	NJAC 8:39-31.2(e) Ramps and Other Exits CFR(s): NFPA 101 Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through	K 227		12/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

(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 227	Continued From page 3 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure doors protecting the exit passageway were fire rated in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.6.3. This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include: Observations on 09/24/24 at 1:23 PM revealed the corridor smoke barrier doors and the door to room 101 were not at least 90 minutes "B" labeled fire doors which was what the connected exit passageway stairways were rated. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the smoke barrier doors and the door to room 101 were not fire rated. NJAC 8:39-31.2(e)	K 227	1. Grove lock came to facility, measured and ordered all doors that were not properly fire rated. Doors scheduled to arrive and installed by December 13, 2024. 2. All residents have the potential to be affected. All doors were checked for proper fire rating. 3. Audits on the doors will be completed monthly by the Maintenance director to ensure they are properly fire rated. 4. The corrective action will be monitored by the QAPI meeting x 3 quarters. The maintenance director or designee will report findings at the quarterly QAPI meeting.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced	K 291		10/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

(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 291	Continued From page 4 by: Based on observation and interview, the facility failed to ensure emergency lighting was operational at the emergency generator, occupational therapy, and activities room in accordance with NFPA 110, Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. and NFPA 101 Life Safety Code (2012 Edition) Section 7.9.2. This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include: An observation on 09/24/24 at 11:05 AM revealed emergency lighting was not operational at the emergency generator located in the back mechanical room. An observation on 09/24/24 at 12:03 PM revealed emergency lighting was not operable in Occupational therapy. An observation on 09/24/24 at 12:14 PM revealed emergency lighting was not operable in the activities room. During an interview at the time of each observation, the U.S. FOIA (b) (6) confirmed the emergency lighting was not operable. NJAC 8:39-31.1(c), 31.2(e)	K 291	1. New LED emergency lights were installed in the affected areas, emergency generator room in back, 2 lights were replaced in occupational therapy and activities room. 2. ALl resident shave the potential to be affected. All other emergency lights were checked to ensure compliance. 3. Audits will be completed to ensure all emergency lights remain in compliance. Emergency lights will be audited on a weekly basis. 4. The maintenance director will conduct weekly audits for 3 quarters and will be reviewed with the QAPI committee at the Quarterly QAPI meeting.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation	K 311		10/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

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K 311	Continued From page 5 shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure stairway doors were fire rated and latched when closed in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.1.1 and 19.3.1.7. This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include: Observations on 09/24/24 at 11:11 AM revealed the Back Stairway Door in the basement would not close and latch when closed. Continued observation revealed the latching mechanism had been removed from the door. Observations on 09/24/24 at 12:22 PM revealed two out of nine stairway doors did not have the required fire ratings. The North Stairway basement door going to physical therapy did not have a rating on the door and the door would not latch when closed. Also, the South Stairway third floor door did not have a rating. The U.S. FOIA (b) (6) [redacted] retrieved a ladder so the top of the doors could be inspected for a fire rating label. During an interview at the time of the observations, the U.S. FOIA (b) (6)	K 311	1. All affected doors were fixed immediately. Additionally, those doors also were scraped to expose the fire rating labels. 2. All residents have the potential to be affected. All doors were checked to ensure that they closed properly and that the fire rating label was visible. 3. The Maintenance Director or designee will audit doors weekly x 4 times 2 quarters to make sure that they latch properly, and all fire rating labels are visible. 4. All audit findings will be reviewed during quarterly QAPI meeting times 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

(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 311	Continued From page 6 confirmed the doors did not latch and the doors did not have a fire rating. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 311		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire alarm pull station was not obstructed at the main entrance in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 9.6.2.7. This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include:	K 341	1. Opsec Alarm company was immediately called to move the pull station from behind the glass door and relocated 5 feet from the exit door. 2. All residents have the potential to be affected. All other pull stations were checked to ensure that they were not obstructed.	10/4/24

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K 341	Continued From page 7 An observation on 09/24/24 at 10:55 AM revealed the fire alarm pull station at the main entrance near the receptionist desk was block buy a glass door when the door was opened. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the fire alarm pull station was blocked. NJAC 8:39-31.1(c). 31.2(e) NFPA 72	K 341	3. All pull stations will be checked weekly by the maintenance director to ensure they are not obstructed. 4. Maintenance/designee will report the findings from all weekly checks to the QAPI committee quarterly at QAPI meeting x 4 times 3 quarters.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the sprinklers were the same throughout a compartment in accordance with	K 351	1. NJ Ex Order 26.4(b)(1) was immediately contacted to evaluate the sprinkler heads in the lobby will be	10/23/24

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	315134	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 351	Continued From page 8 NFPA 13 Standard for the Installation of Sprinkler Systems (2012 Edition) Section 8.3.32. This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include: Observations on 09/24/24 at 11:05 AM revealed quick response sprinkler and standard sprinklers in the same compartment in the lobby. The lobby was open to the first floor which indicated the area was considered one compartment. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the quick response sprinklers, and the standard sprinklers were installed in the same compartment. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	replaced by NJ Ex Order 26.4(b). 2. All residents have the potential to be affected. NJ Ex Order 26.4(b)(1) checked the sprinkler heads throughout the center to ensure that all other sprinkler heads are in compliance. 3. Sprinkler heads will be replaced in the lobby by 10/23/24. Sprinkler heads will be checked monthly by maintenance director to ensure compliance. 4. Completed work will be reviewed in quarterly QAPI times 3.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by:	K 511		10/4/24

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	315134	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

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K 511	Continued From page 9 Based on observation and interview, the facility failed to ensure Nonmetallic Sheathed Cable was concealed within walls, floors, or ceilings that provided a thermal barrier of material which had at least a 15-minute finish rating as identified in listings of fire-rated assemblies and that the electrical panels had updated panel schedules in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 334.10 (3) (5) and Article 408.4 (A). This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include: An observation on 09/24/24 at 11:17 AM revealed Nonmetallic Sheathed Cable was exposed in the laundry room, on the soiled side from panel to disconnect. An observation on 09/24/24 at 11:44 AM revealed in the panel schedules (directories) were missing from the emergency panel and normal electrical panel in the kitchen next to the entrance doors. During an interview at the time of the observations, the U.S. FOIA (b) (6) verified the Nonmetallic Sheathed Cable was not protected by a 15-minute fire rating and that the panel schedules were missing from the panels. NJAC 8:39-31.2(e) NFPA 70	K 511	1. Electrical Panels were immediately labeled. They are inside the panels and also in a binder in Maintenance Directors office. 2. All residents have the potential to be affected. Exposed nonmetallic wiring in the laundry area was sleeved in non metallic UL liquid tight conduit. All electrical panels were checked to ensure that they were properly labeled. 3. All electrical panels will be checked weekly by the maintenance director to ensure that they are properly labeled, and all wires are protected x 4 weeks times 3 quarters. 4. All findings will be reported to the QAPI committee at the quarterly QAPI meeting times 3 quarters.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes	K 541		11/18/24

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COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

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K 541	Continued From page 10 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the linen chute doors were at least one-hour fire rated assembly in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.5.4.1. This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include: Observations on 09/24/24 at 12:50 PM revealed that all three linen chutes which opened directly in the corridor did not have a rating on the chute doors. Additionally, the chute doors were modified with new locking mechanisms that were not fire	K 541	1. Laundry Chute door was measured and replacement ordered. 2. All residents have the potential to be affected. All laundry doors were evaluated to ensure compliance. replacement is being worked on. 3. Due to irregular size of laundry chute, it needed to be special ordered and will be installed by November 18, 2024. All chutes will be checked weekly by the maintenance director to make sure they are functioning properly and in compliance.	

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K 541	Continued From page 11 rated. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the chute doors were not rated, and the locks were not fire rated. NJAC 8:39-31.2(e)	K 541	4. QAPI committee will be informed when all work is completed, and all audits will be reviewed in quarterly meeting times 3 quarters.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure fire doors were inspected by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 148 residents who resided at the facility. Findings include:	K 761	1. Fire door audits were immediately completed. 2. All residents have the potential to be affected. All fire rating labels on doors were inspected and paint removed to make visible. 3. Audits of all fire doors will be completed weekly by the maintenance director times	10/15/24

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K 761	Continued From page 12 A review of the facility's untitled fire safety binder provided by the facility revealed no documented evidence the facility's fire doors were inspected. Observations on 09/24/24 from 10:50 AM to 1:25 PM of the facility's fire doors revealed the doors fire rating tags were painted over, and the fire ratings were not legible. During an interview at the time of each observation, the U.S. FOIA (b) (6) confirmed the fire doors were not inspected. NJAC 8:39-31.2(e) NFPA 80	K 761	3 quarters to ensure compliance. 4. All findings will be reported to the QAPI committee at quarterly meetings times 3 quarters by maintenance director or designee.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315134 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/13/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

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 K0211	10/04/2024	LSC K0223	10/04/2024	LSC K0227	12/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	10/04/2024	LSC K0311	10/04/2024	LSC K0341	10/04/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	10/23/2024	LSC K0511	10/04/2024	LSC K0541	11/18/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0761	10/15/2024	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		
9/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	☐ YES ☐ NO