STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Standard Survey: 7/17/2023 Census: 112 Sample Size: 23 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 3 of 5 residents (Resident # 268, #36, and #116) reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following:	F 641	F641 Accuracy of Assessments Element One – Corrective Actions • MDS coding for Resident #s 268, 36 and 116 was immediately corrected/changed to the appropriate coding to match the physician's order (PO), progress note, and/or Physician Discharge Summary as may be	7/18/23

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

Electronically Signed | 08/04/2023

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

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F 641	Continued From page 1 1. On 6/30/23 at 12:02 PM, the surveyor observed Resident #268 in the dayroom on the A2 unit, sitting in a wheelchair with a seatbelt and shoulder harness that was connected to the back of the wheelchair. Visually, the surveyor noted that Resident #268 could not reach the buckle to release the seatbelt as well as the Velcro straps to release the shoulder harness both connected behind the resident's wheelchair. A review of Resident #268's Face Sheet (a one-page summary of important information about the patient) reflected that the resident was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses which included but were not limited to Ex.Order 26.4(b)(1) A review of the July 2023 Physician's order (PO) form for Resident #268 showed an order listed under Ex.Order 26.4(b)(1) for positioning dated 4/15/2022 and an additional PO for Ex.Order 26.4(b)(1) for positioning dated 4/15/2022. A review of the resident's Minimum Data Set (MDS), tool for implementing standardized assessment and for facilitating care management in nursing homes dated 4/20/23 reflected under Section P (used to assess physical restraints and alarms used during a seven-day look-back period), the assessment showed that Resident #268 did not use the Ex.Order 26.4(b)(1). On 7/5/23 at 12:00 PM, the surveyor interviewed the Licensed Nurse Practitioner (LPN #1) who explained, "Resident # 268 has a Ex.Order 26.4(b)(1) for when they are in their	F 641	applicable. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change • All MDS coordinators were re-educated on accurately coding the MDS to match the physician's order (PO), progress note, and/or Physician Discharge Summary as may be applicable, and to facilitate the management of care. Element Four – Quality Assurance • MDS coordinator(s) will monitor once a week for one month that all MDS of residents will be checked within seven days of completion to ensure that the MDS coding matches the most current PO (ordering restraints), progress note, and/or Physician Discharge Summary as may be applicable. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: July 18, 2023	

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wheelchair. Both are used for Ex.Order 26.4(b)(1) and Ex.Order 26.4(b) but are categorized as Ex.Order 26.4(b)(1)."

2. On 7/3/23 at 11:01 AM, the surveyor observed Resident #36 in their room seated in a wheelchair with a seatbelt and lap tray in place. Both were connected and buckled to the back of the wheelchair. Visually, the surveyor noted that Resident #110 could not reach the buckle to release the lap tray or the seat belt.

A review of Resident #36's FS reflected that the resident was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses which included but were not limited to Ex.Order 26.4(b)(1)

A review of the EX Order 26.4B1 PO sheet revealed an order listed under Ex.Order 26.4(b)(1) when pt out of bed in Wheelchair w/ Ex.Order 26.4(b)(1) for optimal Ex.Order 26.4(b)(1) dated 4/16/16.

A review of the resident's MDS dated EX Order 26.4B1 reflected under Section P the assessment showed that Resident #268 did not use Ex.Order 26.4(b)(1)

On 7/6/23 at 9:50 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a copy of the facilities policy titled, Restraints with a revision date of January 25, 2023. Under the Procedure section subsection IV Ongoing Review of the policy it states, "A. Restrained residents will be reviewed regularly (at a minimum of quarterly) by the IDT to determine the continued need for restraints."
On 7/7/23 at 12:04 PM, the surveyor team met with the LHNA and Director of Nursing (DON) to review concerns. The surveyor reviewed the PO, restraint policy and documentation associated

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with the resident's MDS. The DON clarified that the MDS should match the most current PO ordering Ex.Order 26.4(b)(1)

The surveyor reviewed the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual updated October 2019. The manual included, "A physical restraint is any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The manual instructed for section P to identify all physical restraints that were used at any time (day or night) during the 7-day look-back period and code the frequency of use; Code 0, not used; Code 1, used less than daily; and Code 2, used daily. The steps for assessment and determining physical restraint use included to review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look back period. It further included that any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition."

On 7/14/23 at 1:16 PM, the survey team met with the LNHA, DON and MDS coordinator. The MDS coordinator acknowledged that as per the RAI definitions of Ex.Order 26.4(b)(1), Resident #268 and #36 MDS's had been coded incorrectly. The LNHA, DON and MDS coordinator had no further comments or information submitted.

3. On 7/12/23 at 12:30 PM, the surveyor reviewed the closed medical record for Resident #116,

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which revealed the following:

The closed medical record FS revealed that Resident #116 was admitted to the facility on Ex.Order 26.4(b) with diagnosis that included but were not limited to Ex.Order 26.4(b)(1) unspecified.

A progress note, dated 6/1/23, documented that the resident was discharged to Ex.Order 26.4(b)(1).

The surveyor reviewed the Pos for Resident #116, which revealed an order, dated Ex.Order 26.4(that read "May Ex.Order 26.4(b)(1)".

The surveyor reviewed the Physician Discharge Summary, which documented that the resident was Ex.Order 26.4(b)(1)

A review of the discharge MDS, dated Ex.Order 26.4, revealed under Section A2100, the "Discharge Status" was coded "Ex.Or" which indicated that the resident was Ex.Order 26.4(b)(1).

On 7/14/23 at 1:17 PM, the surveyor informed the MDS Coordinator, LNHA, and DON about the above concerns. The surveyor reviewed Resident #116's discharge MDS assessment coding for discharge status with the MDS Coordinator. The MDS Coordinator, LNHA, and DON confirmed Resident #116 was discharged Ex.Order 26.4(b)(1) No further information was provided by the facility.

A review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, updated

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F 641	Continued From page 5 October 2019, indicated in Chapter 3 MDS Items [A] section A2100: OBRA Discharge Status under Coding Instructions: "Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home". NJAC 8:39-11.1, 11.2(e)(1)	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		7/19/23

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F 657	Continued From page 6 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies it was determined that the facility failed to review and revise care plans to reflect changes of resident's care for 3 of 6 residents (Resident # 20, #55, and #36) reviewed. The deficient practice was evidenced by the following: 1. On 6/30/23 at 11:23 AM, the surveyor observed Resident #20 in their room sitting on their bed. The resident informed the surveyor that they had lost Ex.Order 26.4(b)(1) over the past year and were currently taking a Ex.Order 26.4(b)(1) twice a day. On 7/6/23 at 9:32 AM, the surveyor reviewed the Face Sheet (FS), (a one-page summary of important information about the patient) belonging to Resident #20 that reflected admission to the facility on Ex.Order 26.4(b)(1) with diagnoses that included but not limited to Ex.Order 26.4(b)(1) [redacted] A review of the July 2023 Physician's order (PO) form showed an order for Ex.Order 26.4(b)(1) by mouth twice daily at 10AM and 2PM with a start date of 1/11/2023. Further review of Resident #20's electronic medical record showed that the resident's weight was as follows: 7/4/2023 11:30 Ex.Order 26.4(b)(1) Lbs. 6/7/2023 08:52 Ex.Order 26.4(b)(1) Lbs.	F 657	F657 Care Plan Timing and Revision Element One – Corrective Actions • A Ex.Order 26.4(b)(1) care plan matching the current physician's orders and addressing significant Ex.Order 26.4(b)(1) on Resident #s 55, 36, and 20 was immediately done by the dietician. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change • The dietician was re-educated on Ex.Order 26.4(b)(1) care plan timing and revision: Create/review and update care plans to match the most current physician's orders as well as address significant Ex.Order 26.4(b)(1) [redacted] for the resident. Element Four – Quality Assurance • Dietician will monitor once a week for two months that all Ex.Order 26.4(b)(1) care plans are created/reviewed and updated to match the most current physician's orders and address significant Ex.Order 26.4(b)(1), if any.	

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F 657	Continued From page 7 5/2/2023 08:38 Ex.Order 26.4 Lbs. 4/1/2023 09:25 Ex.Order 26.4 Lbs. 3/1/2023 07:27 Ex.Order 26.4 Lbs. 2/1/2023 13:56 Ex.Order 26.4 Lbs. 1/4/2023 10:06 Ex.Order 26.4 Lbs. 12/5/2022 16:48 Ex.Order 26.4 Lbs. 11/2/2022 10:43 Ex.Order 26.4 Lbs. A review of the resident's Ex.Order 26.4(b)(progress notes revealed a Ex.Order 26.4(b)(assessment written by the Registered Dietitian (RD) dated 5/25/2023 which stated, Ex.Order 26.4(b)(1) concern - assessment. Resident on Ex.Order 26.4(b)(1) (twice per day). Current body weight (cbw) 5/2/23 Ex.Order 26.4 lb., weight history: 30days - Ex.Order 26.4 lb. 90 days- Ex.Order 26.4 lb. cbw -4.5% 180 days- Ex.Order 26.4. cbw -10.3% significant Ex.Order over 180 days. Weight continues to Ex.Order 26.4(b)(1) ." A review of the most current Ex.Order 26.4(b)(care plans dated 5/29/23-6/12/23 had no documentation indicating Resident #20 has had any significant Ex.Order 26.4(b)(1) as well as the addition of Ex.Order 26.4 (started on 1/11/23). 2. On 7/3/23 at 10:26 AM, the surveyor observed Resident #55 in their room. Resident #55 informed the surveyor that they believed they had Ex.Order 26.4(b)(1) since being admitted to the facility but was not sure of the exact amount. On 7/3/23 at 11:15 AM, the surveyor reviewed the FS belonging to Resident #55 which revealed that the resident was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses that included but were not limited to Ex.Order 26.4(b)(1)	F 657	• Data obtained will be reported at the quarterly QAPI meeting. Completion Date: July 19, 2023	

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Further review of Resident #55's electronic medical record showed the resident's weight as the following:

6/7/2023 08:50 [redacted] Lbs.
5/2/2023 16:00 [redacted] Lbs.
4/1/2023 10:07 [redacted] Lbs.
3/27/2023 15:11 [redacted] Lbs.
3/1/2023 15:44 [redacted] Lbs.
2/20/2023 17:07 [redacted] Lbs.
2/1/2023 15:48 [redacted] Lbs.
1/4/2023 15:45 [redacted] Lbs.
12/21/2022 13:07 [redacted] Lbs.
12/6/2022 10:52 [redacted] Lbs.

A review of the resident's [redacted] progress notes revealed a [redacted] assessment written by the Registered Dietitian (RD) on 6/6/2023, which stated, [redacted] concern - assessment resident on [redacted] reports [redacted] is feeling well, more active. Estimated intake 1500 calories, 54-gram protein, and 480 ml water. Body mass index [redacted] Current Body Weight as of 5/2/23 [redacted] lb., weight history 30 days: [redacted] lb., 90 days [redacted] lb., and 180-day [redacted] lb. 17.3% significant [redacted] over 180 days. appears multi factorial. fluid and intake related. weight [redacted] over 30/90 days. Current intake 87% of estimated needs. Resident educated on nutrient dense foods. Slow [redacted] would be favorable. No changes in care recommended. Care goals: weight [redacted] lbs. +/-5%, intake 75-100%, continue risk monitor."

A review of the most current [redacted] care plans dated 5/18/23-6/11/23 had no documentation indicating that Resident #55 has had any significant [redacted] or that there were "Care goals: weight [redacted] lbs. +/-5%, intake 75-100%," in place to maintain a specific weight.

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3. On 7/3/23 at 11:01 AM, the surveyor observed Resident #36 in their room sitting in their wheelchair. Resident #36 was noted with an Ex.Order 26.4(b)(1) machine (Ex.Order 26.4(b)(1) patients who cannot obtain such by Ex.Order 26.4(b)(1)) in the room, that was not currently running.

On 7/3/23 at 11:47 AM, the surveyor reviewed the FS for Resident #36 which revealed that the resident was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses which included but were not limited to Ex.Order 26.4(b)(1)

A review of the July 2023 PO form documented an order for Ex.Order 26.4(b)(1) dated 12/20/2022, Ex.Order 26.4(b)(1) s(ml)/hour (hr.) administered via Ex.Order 26.4(b)(1)) (a Ex.Order 26.4(b)(1) for 20 hours up at 1 PM start / ending at 9 AM, with a total volume (TV) 700ml or until total volume reached.

A review of the most current Ex.Order 26.4(b)(1 care plan, the intervention section dated 5/31/23-6/14/23 documented, "The resident is Ex.Order 26.4(b)(1) Ex.Order 26.4(b)(1) source 40 ml/hr. x 20 hr., TV 800 ml."

On 7/5/23 at 11:34 AM, the Licensed Nursing Home Administrator (LHNA) provided the surveyor with a facility policy titled, Interdisciplinary Care Plan Guidelines for Development and Maintenance, with a revision date of 8/2022. The policy indicated, "Problem: The problem should be stated as specifically as

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F 657	Continued From page 10 possible using actual resident data and objective descriptions. Interventions: Interventions should also be specific and individualized." On 7/7/23 at 12:04 PM, the surveyor team met with the LHNA, and the Director of Nursing (DON). The surveyor reviewed concerns related to the Care Plan discrepancies and omissions. The DON stated that the care plans should match what is the most current orders as well as address significant weight changes for the individualized resident. On 7/12/23 at 12:05 PM, the surveyor interviewed the Registered Dietitian (RD). The RD stated that she creates the nutrition care plan and that the care plans are updated quarterly or as needed. The RD further stated that she was not sure if significant weight changes, nutrition supplements and other nutrition interventions needed to be addressed in the care plan as long as it was addressed in a nutrition note. The RD acknowledged that the resident's care plans were not individualized to the resident. On 7/17/23 9:29 AM, the surveyor team met with the DON, Admin, and MDS coordinator, they had no further responses with regards to care plans. NJAC 8:39-27.1(a)	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that	F 661		7/19/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 11	F 661		

includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of the medical records and other facility documentation, it was determined that the attending physician failed to document a discharge summary which included a recapitulation (recap) of the resident's stay and a final summary of the resident's status for 2 of 3 closed records reviewed for discharge to Ex.Order 26.4(b)(1), and discharge to the Ex.Order 26.4(b)(1) (Resident #114 and Resident #115).

This deficient practice was evidenced by the following:

1. On 7/12/23 at 10:51 AM, the surveyor

F661
Discharge Summary

Element One – Corrective Actions

• Physician discharge summaries of Resident #s 114 and 115 were completed immediately by the attending physician.

Element Two - Identification of at-Risk Areas

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F 661	Continued From page 12 reviewed the closed hybrid medical record for Resident #115. The Face Sheet (a one-page summary of important information about the patient) reflected that the resident was admitted to the facility on Ex.Order 26.4(b) and was discharged Ex.Order 26.4(b)(1) Further review of the hybrid medical record revealed that the Physician Discharge Summary was blank. 2. On 7/12/23 at 11:30 AM, the surveyor reviewed the closed hybrid medical record for Resident #114. The closed record revealed that the resident was admitted to the facility on Ex.Order 26.4(b) and had Ex.Order 26.4(b)(1) Further review of the medical record revealed that the Physician Discharge Summary was blank. On 7/12/23 at 1:27 PM, the surveyor conducted an interview with the Director of Nursing (DON), who stated that she did not remember and was unsure when a Physician Discharge Summary should be completed. On 7/12/23 at 1:30 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated physicians have 30 days to complete a discharge summary. The LNHA explained that all residents who were discharged from the facility to home, hospital, or had expired in the facility, should have a Physician Discharge Summary completed within 30 days of discharge. On 7/12/23 at 1:41 PM, the surveyor interviewed medical record staff member, who stated it was expected for the physician to complete a Discharge Summary within 30 days. A review of the facility's policy titled, "Establishing and Closing the Records" with a revised date of	F 661	• All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change • The physicians as well as the medical records staff member were re-educated that the Physician Discharge must be completed within 30 days from date of resident's discharge. Element Four – Quality Assurance • 7-3 Nursing Supervisor will monitor once a week for one month that all resident physician discharge summaries are completed within 30 days from date of resident discharge. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: July 19, 2023	

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F 661	Continued From page 13 10/22, under procedure subsection discharge letter J read: "Notify attending physician to complete the discharge summary or other forms for signature within 30 days from date of resident's discharge." No further information was submitted by the facility. N.J.A.C. 8:39-35.2(d)(16)	F 661		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		7/20/23

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F 755	Continued From page 14 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure a) a routine medication was timely ordered, b) received, c) a physician's order was obtained prior to administration, and d) administration of medication was documented for Resident #18, identified during the medication administration observation for one of three nurses. This deficient practice was evidenced by the following: On 7/7/23 at 9:11 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare medication for Resident #18. At that time, the LPN stated that Resident #18 had a routine order for 5 milligrams (mg) of Ex.Order 26.4(b)(1) medication used to treat Ex.Order 26.4(b)(1) which was not available. The LPN stated she would have to get it from the electronic back-up medication machine (eBMM). On 7/7/23 at 9:31 AM, the LPN requested Ex.Order 26.4(mg tablet from the Registered Nurse (RN)/In-service Coordinator (IC) who was at the nurses' station.	F 755	F755 Pharmacy Services/Procedures/Pharmacist/Records Element One – Corrective Actions • Resident #18's Ex.Order 26.4(b)(1) tablet was delivered immediately. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change • Nurse staff re-education was initiated and is ongoing to ensure the following: o That routine medication is timely ordered; o That the medication is received; o That if the medication is not received, Nurse must follow up with the provider Pharmacy as well as notify the Director of Nursing and the Administrator of the delay(s) in receiving medication from the provider Pharmacy;	

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F 755	Continued From page 15 On 7/7/23 at 9:32 AM, the surveyor and the RN/IC observed that the monitor of the eBMM listed the stock medication Ex.Order 26.4(b)(1) with zero quantity on-hand. The eBMM did not have the Ex.Order 26.4(b)(1) listed as an available stocked item. The surveyor reviewed the hybrid medical record for Resident #18. A review of the July 2023 Physician's Order Form (POF) reflected that the resident was admitted to the facility with diagnoses that included the following Ex.Order 26.4(b)(1) [redacted] On 7/7/23 at 9:47 AM, the surveyor and the RN/IC reviewed the July 2023 POF signed by the physician on 6/26/2023 for Resident #18. The RN/IC confirmed the order handwritten on the Physician's Order Form was for Ex.Order 26.4(b)(1) at 9 AM with a diagnosis of Ex.Order 26.4(b)(1) and an original order date of 7/17/21. At that time the surveyor and RN/IC reviewed the pharmacy Re-Order Medication Forms (RMF) dated 6/16/23, and 7/2/23 that reflected requests faxed by the LPN to the provider pharmacy for Ex.Order 26.4(b)(1) tabs. There was no proof that the Ex.Order 26.4(b)(1) requested had been sent by the provider pharmacy.	F 755	o That a physician's order is obtained prior to administration; o That administration of medication is documented; and o That there is a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. Element Four – Quality Assurance • 11-7 Nursing Supervisor shall monitor weekly for two months each unit that all medications are ordered and received in a timely manner, and that if the medication is not received, Nurse must follow up with the provider Pharmacy as well as notify the Director of Nursing and the Administrator of the delay(s) in receiving medication from the provider Pharmacy. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: July 20, 2023	

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A review of the RMF dated 5/17/23, had a corresponding packing slip (signed received on 5/19/23) documenting 30 tablets received by the facility.

A review of the paper medication administration record (MAR) for May 2023, June 2023, and July 2023 (up until July 7th), reflected signed administrations for Ex.Order 26.4(b)(1) tablets daily except for July 7th.

On 7/10/23 at 10:26 AM, the surveyor performed a phone interview of the provider pharmacy pharmacist. The pharmacist stated based on his records the medication was only dispensed on 5/5/23 for [redacted] tablets, and 5/17/23 for [redacted] tablets prior to the 7/7/23.

The surveyor reviewed the POF for July 2023 which did not reflect an order for Ex.Order 26.4(b)(1).

The surveyor reviewed the MAR for July 2023, which did not reflect an administration of [redacted] on July 3, 2023.

The surveyor inspected the eBMM which documented ten tablets of Ex.Order 26.4(b)(1) was issued once on 7/3/23 at 7:16 AM for the resident.

A review of the re-stock report provided by the PPR reflected that the eBMM was not restocked of Ex.Order 26.4(b)(1) between 7/1/23 to 7/11/23.
A review of the Inventory on hand report reflected the maximum amount contained within the eBMM machine was ten tablets of Ex.Order 26.4(b)(1)

On 7/10/23 at 10:49 AM, during a follow-up

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interview, the LPN stated that she worked on 7/6/23, 7/5/23 and 7/3/23. LPN #2 worked on 7/4/23 and LPN #3 worked on 7/1/23.

At that time, the surveyor asked the LPN what she administered on her shifts on 7/3/23 and 7/5/23. The LPN stated that she removed [redacted] tablets of Ex.Order 26.4(b)(1) from the eBMM and administered it to Resident #18. The LPN revealed that she signed the MAR documenting that she administered a Ex.Order 26.4(b)(1) tablet. The LPN did not administer any [redacted] to Resident #18 on 7/5/23, as the eBMM was void of any [redacted] available.

On 7/10/23 at 1:40 PM, the surveyor team met with the Registered Nurse/Inservice Coordinator (RN/IC), the Provider Pharmacy Representative, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) and the LPN. The LPN stated she was the regular nurse caring for Resident #18 in the morning. The LPN confirmed there was no order for the Ex.Order 26.4(b)(1) mg removed from the eBMM that she administered to Resident #18 on 7/3/23.

On 7/10/23 at 1:46 PM, in the presence of the survey team, RN/IC, Provider Pharmacy Representative (PPR), and the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) stated that medications ordered by a physician should be available for the residents. The DON stated that there should have been a follow up and an accurate accounting of medications ordered, received, and administered to ensure the residents received their medication.

The DON added that the nurses should have notified her and the administrator of any delays

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receiving medication from the provider pharmacy. The LNHA stated that no notifications were received from the nurses or the supervisor that Ex.Order 26.4(b)(1) was not received from the pharmacy. When asked to explain where the nursing staff acquired the Ex.Order 26.4(b)(1) documented as administered to Resident #18, the LNHA replied "we do not have an answer for you".

On 7/10/23 at 2:25 PM, during a follow-up interview with the surveyor, the RN/IC stated the nurses should have followed-up when the medications were not received on 6/16/23 and 7/2/23. The RN/IC confirmed there were no documentations on the medical record that she could provide that the nurses communicated the with the provider pharmacy when the medications were not received.

A review of the facility policy provided; Medication Administration, revised on 6/2023 included the following:
Purpose: The facility will provide safe and accurate medication administration to the residents, at all times mindful of resident's rights.
Policy: It is the policy of (name redacted), to follow guidelines set by the facility pharmacy for medication administration and to assure that the safety and rights of each resident receiving their medication will be respected.
c. Compare pharmacy label to the MAR. If they do not match, verify correct orders in the resident's chart. If there is a discrepancy, report it to your supervisor. MAKE SURE, the labels match before administering medication ...
f. Right Documentation
Document administration of the medication immediately after is given ...
l. Sign MAR after administration of medication

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F 755	Continued From page 19 m. If the medication is not available at the designated time, notify your Nursing Supervisor who will check the back-up box (if available), place a follow-up call to the pharmacy, report missing medication to your supervisor and document according to facility policy ... A review of the undated facility policy provided; Back-up Box/Stat/Emergency Kit Supply of Medications included the following: Procedure, section C. A valid physician's order is required to justify the use of any medication from an [a] Back-up Box/ Stat/Emergency Kit NJAC 8:39-11.2(b), 29.2(a)(d), 27.1(a)	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757		7/20/23

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F 757	Continued From page 20 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure an Ex.Order 26.4(b)(1) was administered to effectively treat a resident with diagnosis of Ex.Order 26.4(b)(1) This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #1) and was evidenced by the following: On 7/3/23 at 12:25 PM, the surveyor observed Resident #1 sitting in the dining room. The surveyor also observed that the resident had an Ex.Order 26.4(b)(1) A review of the Resident #1's face sheet (an admission summary) indicated that Resident #1 was admitted to the facility on Ex.Order 26.4(b)(1) with diagnosis that included but were not limited to Ex.Order 26.4(b)(1) A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care dated 5/31/23 reflected the resident's cognitive decision-making capacity was Ex.Order 26.4(b)(1). Further review of the Q/MDS under Section H indicated that Resident #1 used Ex.Order 26.4(b)(1) A review of the Physician's Order form (PO) dated 4/17/23 revealed a telephone order (TO) for Ex.Order 26.4(b)(1) (given orally) daily x 10 days Diagnosis: Ex.Order". Further review of the PO dated 4/17/23 for Ex.Order 26.4(b)(1) daily indicated that there was a TO dated 4/20/23 from	F 757	F757 Drug Regimen Element One – Corrective Actions • Resident #1 Ex.Order 26.4(b)(1) has been changed to the appropriate Ex.Order 26.4(b)(1) Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change • New policy is being implemented on tracking cultures and communicating a positive culture obtained from the lab to the ordering physician. Nurse staff education on this new policy was initiated and is ongoing. • Nurse staff re-education was initiated and is ongoing to ensure that Ex.Order 26.4(b)(1) are administered appropriately per facility policy Ex.Order 26.4(b)(1) Stewardship Program. Element Four – Quality Assurance • Infection Control Nurse will monitor all	

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F 757	Continued From page 21 the physician discontinuing the Ex.Order 26.4(b)(1) [redacted] A review of the April 2023 Medication Administration Record revealed that Resident #1 was able to receive the dose for 3 days from April 18 through April 20, 2023. A review of the laboratory results for th Ex.Order 26.4(b)(1) [redacted] The sensitivity test will identify the best medicine to treat the infection) with a collection date of 4/12/23, and a print date of 4/17/23 documenting that Resident #1's Ex.Order 26.4(b)(1) [redacted] The surveyor discussed the above concerns with the facility's Director of Nursing (DON) who agreed that the UA/CS result for Resident #1 showed that the Ex.Order 26.4(b)(1) [redacted]. A review of the facility's policy and procedure titled, "Antibiotic Stewardship Program" reviewed on 12/7/22 indicated, "Policy: The antibiotic stewardship program (ASP) is designed to promote use of antibiotics while optimizing the treatment of infections, simultaneously reducing the possible adverse events associated with antibiotic use." Review of the facility's policy and procedure titled, "Policy for Communication of Positive Cultures" which indicated, "Policy: It shall be the policy of	F 757	residents' culture and sensitivity results once a week for four weeks that said results are reviewed and communicated by Nurse staff to the ordering physician so that the appropriate Ex.Order 26.4(D)(1) [redacted] are ordered and administered to effectively treat a resident with diagnosis o Ex.Order 26.4(b)(1) [redacted] other cultures as indicated. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: July 20, 2023	

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the facility to effectively communicate a positive culture obtained from the lab to the ordering doctor." Under the "Procedure" section of the policy, "When the nurse receives notification by the lab of positive culture results the ordering physician will immediately be notified." The procedure continues, "If the sensitivity is available this will be reviewed with the ordering doctor during the first contact."

On 7/17/23 9:29 AM, the surveyor team met with the DON, and Licensed Nurse Administrator who acknowledged that the Ex.Order 26.4(b)(1) should not have been ordered by the Physician. The DON explained that the Physician as well as nursing should have reviewed the UA/CS and ordered an Ex.Order 26.4(b)(1) that was documented on the lab report as Ex.Order 26.4(b)(1)) to the organism causing Resident #1's Ex.Order 26 There were no further response or documentation received in reference to the concern.

NJAC 8:39-29.2 (d)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENT	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and 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. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.	S 560	S560 Mandatory Access to Care – Minimum Direct Care Staff-to-Resident Ratios Element One – Corrective Actions • The certified nurse aides (CNA) staffing issue has been and is being addressed by placing ads online – indeed.com and apploi.com. • For the past six months, the facility has hired eight (8) CNAs, the most recent hire date being May 15, 2023. • This summer, some CNAs went on	8/1/23

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

Electronically Signed | 08/04/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061902	A. BUILDING: _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENT	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of	S 560	vacation – the most recent date of CNA return from vacation being August 1, 2023. • Currently, however, four (4) CNAs are on vacation and four (4) on (medical or family) leave of absence. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change • Staff re-education was initiated and is ongoing to ensure that the staffing reports are provided daily to the Administrator and Director of Nursing (DON), specifying the number of CNAs and professional nurses on each shift. Staffing will be according to the acuities of residents in-house, and facility will continue to staff according to State mandatory regulations. • Facility continues to offer overtime, sign-on bonuses, and referral bonuses to attract new employees and to maintain at least minimum staffing levels. Element Four – Quality Assurance • Staffing levels will be monitored once a week for three months through the staffing reports that are given to the Administrator and DON. These reports will specify the number of CNAs and professional nurses	

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	061902	A. BUILDING: _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENT	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 6/11/23 and 6/18/23 revealed that the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -06/17/23 had 9 CNAs for 112 residents on the day shift, required 14 CNAs. -06/18/23 had 8 CNAs for 112 residents on the day shift, required 14 CNAs. -06/24/23 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. On 7/14/23 at 1:17 PM, the surveyor informed the facility's Licensed Nursing Home Administrator and Director of Nursing of the above staffing ratio concerns.	S 560	on each shift. Staffing will be according to the acuities of residents in house. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: August 1, 2023	

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
315044 Y1	A. Building B. Wing Y2	8/10/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	1 O'BRIEN LANE LAFAYETTE, NJ 07848

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 F0641	Correction	ID Prefix F0657	Correction	ID Prefix F0661	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed
LSC	07/18/2023	LSC	07/19/2023	LSC	07/19/2023
ID Prefix F0755	Correction	ID Prefix F0757	Correction	ID Prefix	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(d)(1)-(6)	Completed	Reg. #	Completed
LSC	07/20/2023	LSC	07/20/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061902 Y1	A. Building B. Wing Y2	8/10/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	1 O'BRIEN LANE LAFAYETTE, NJ 07848

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/01/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
7/17/2023	☐ 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
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/05/2023, 07/06/2023 and 07/07/2023 and Limecrest Subacute and Rehabilitation Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. King Manor is a two-story, Type I Fire Resistant building that was built in January 1967. The facility is divided into 10 smoke zones. The facility has one Diesel emergency generator.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS	K 222		8/8/23

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

Electronically Signed | 08/08/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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

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	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 07/05/2023, 07/06/2023 and 07/07/2023, it was determined that the facility failed to provide 1 of 10 designated exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 07/05/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story building with ten (10) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:36 AM on 07/05/2023 and continued on 07/06/2023 in the presence of the facility MD a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor inspected ten (10) designated exit discharge doors with the following results, On 07/06/2023 at approximately at approximately	K 222	K222 Egress Doors (free of impediments to full instant use in case of fire or other emergencies) Element One – Corrective Actions • The facility has scheduled with a vendor the removal of the latch or lock from the main entrance two sets of exit discharge doors (internal set of doors and external set of doors). • An audit was completed to ensure all other facility egress doors are not equipped with a latch or a lock that requires the use of a tool or key from the egress side. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Education was initiated and is ongoing in the maintenance department on the regulations requiring that: o Egress doors must not be equipped with a latch or a lock that needs the use of a tool or key from the egress side unless using remote control of locks, keying of all locks or keys carried by staff at all times, or other reliable means are available to the staff at all times for the rapid removal of occupants if needed and	

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K 222	Continued From page 3 9:58 AM, the surveyor observed the main entrance two sets of exit discharge doors (internal set of doors and external set of doors) revealed thumb turn locks on the egress side of both sets of doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The doors had a sign that read, Push here in the event of an emergency. Thumb turn locks and fastening device on the door could restrict emergency use of the exit. The MD confirmed the findings at the times of observations. On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222	o The designated exit discharge doors as a means of egress must be readily accessible and free of all obstructions or impediments to full instant use in case of fire or other emergencies. Element Four – Quality Assurance • An audit of the egress doors will be completed by the Maintenance Director/Supervisor or designee monthly for two (2) months to ensure continued compliance. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: August 8, 2023	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations on 07/05/2023 and 07/06/2023 it was determined that the facility failed to ensure continuous illumination for 2 of 9 designated exit discharges was provided and arranged so that the failure of any single lighting unit did not result in an illumination level of lass	K 281	K281 Illumination of Means of Egress Element One – Corrective Actions • Double light bulb fixtures will be	8/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 281	Continued From page 4 than 0.2 ft-candle in any designated area in accordance with NFPA 101 Life Safety Code (2021 edition) Sections 7.8.1.1, 7.8.1.2 and 7.8.1.4 The evidence includes the following, On 07/05/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with nine (9) designated exit discharge (illuminated exit signs above doors) doors in the facility for Residents to use during an evacuation in the facility. Starting at approximately 9:36 AM on 07/05/2023 and continued on 07/06/2023 in the presence of the facility MD a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor observed the following, On 07/05/2023, 1) At approximately 9:59 AM, the surveyor observed outside the first floor stairwell designated exit discharge door next to the locker room, had a single light bulb fixture. 2) At approximately 10:05 AM, the surveyor observed outside the first floor stairwell designated exit discharge door next to Resident room [redacted] had a single light bulb fixture. The MD confirmed the findings at the time.	K 281	installed outside the first-floor stairwell designated exit discharge door next to the locker room and the first-floor stairwell designated exit discharge door next to Resident room [redacted], the identified 2 of 9 designated exit discharges, to ensure continuous illumination. • The facility signed the proposal by vendor on August 7, 2023. • An audit was completed to verify that there are double light bulb fixtures by the other 7 designated exit discharges to ensure continuous illumination. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Re-education was initiated and is ongoing in the maintenance department on the regulations regarding continuous illumination of means of egress including exit discharges for residents to use during an evacuation in the facility. Element Four – Quality Assurance • An audit of the facility's exit discharges will be completed by the Maintenance Director/Supervisor or designee monthly for two (2) months to ensure that there is continuous illumination thereat. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: August 7, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 281	Continued From page 5 On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. N.J.A.C. 8:39 -31.2 (e) NFPA 101 2012 -19.2.8	K 281		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 07/05/2023 and 07/06/2023 in the presence of facility management, it was determined that the facility failed to ensure that illuminated exit signs were in six (6) locations to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3,	K 293	K293 Exit Signage with Continuous Illumination Element One – Corrective Actions • The six (6) observed exit signs will be illuminated at all times, to clearly identify the exit access path. • The facility signed the proposal by vendor on August 7, 2023. • An audit was completed to verify that all exit signs are illuminated at all times, to clearly identify the exit access path. Any exit sign not functioning properly has been scheduled to be repaired or replaced. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice.	8/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

(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 293	Continued From page 6 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 07/05/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with ten (10) smoke compartments. Starting at approximately 9:36 AM on 07/05/2023 and continued on 07/06/2023 in the presence of the facility MD a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor observed no evidence of six (6) illuminated exit signs in the following locations to clearly identify the exit access route, On 07/05/2023: 1) At approximately 10:10 AM on the first floor, the surveyor observed no evidence of one (1) illuminated exit sign above the smoke door next to the Central bathing. 2) At approximately 10:40 AM on the first floor, the surveyor observed no evidence of one (1) illuminated exit sign above the smoke door next to the Main Kitchen. 3) At approximately 10:55 AM on the first floor, the surveyor observed no evidence of one (1) illuminated exit sign above the smoke door near the Nursing station and Central bathing.	K 293	Element Three – Systemic Change • Re-education was initiated and is ongoing in the maintenance department on the regulations requiring continuous illumination of exit signs to clearly identify the exit access path to reach an exit discharge door. Element Four – Quality Assurance • An audit of the exit signages will be completed by the Maintenance Director/Supervisor or designee monthly for two (2) months to ensure exit. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: August 7, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

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LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 293	Continued From page 7 A review of an emergency evacuation diagram posted on the 2nd. floor corridor identified you would need to pass the Nursing station as the Primary and or Secondary egress route to reach an exit. On 07/06/2023: 4) At approximately 10:07 AM on the second floor, the surveyor observed no evidence of one (1) illuminated exit sign above the smoke door next to the Central bathing. 5) At approximately 10:40 AM on the second floor, the surveyor observed no evidence of one (1) illuminated exit sign above the smoke door next to the Human Resources department. 6) At approximately 11:01 AM on the first floor, the surveyor observed no evidence of one (1) illuminated exit sign above the smoke door near the Nursing station and Central bathing. A review of an emergency evacuation diagram posted on the 2nd. floor corridor identified you would need to pass the Nursing station as the Primary and or Secondary egress route to reach an exit. The MD confirmed the finding at the time of observations. On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 324 SS=E	Cooking Facilities	K 324		8/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

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LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

(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 324	Continued From page 8 CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation on 07/05//2023, 07/06/2023 and 07/07/2023, in the presence of facility management, it was determined that the facility failed to inspect the range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. The deficient practice was evidenced by the	K 324	K324 Cooking Facilities – Cooking Equipment Protected Element One – Corrective Actions • The facility contacted the vendor on August 7, 2023 to schedule the second semi-annual range-hood fire suppression system inspection due in October 2023.	

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K 324	Continued From page 9 following: During the survey entrance on 07/05/2023 (day one of survey) at 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide all mandatory inspections from 01/01/22 to 07/04/2023 for review later. Review of the facility's range-hood fire suppression system inspections for the previous 18 months identified the system had two (2) semi-annual inspection on 09/20/2022 and 04/05/2023. The surveyor interviewed the DOM on 07/07/2023 at approximately 9:59 AM. The surveyor asked the facility to provide the previous inspection for the range-hood system. The DOM provided an inspection that was conducted on 12/10/2021. The surveyor asked if there were any inspections between 12/10/2021 and 09/20/2022. The DOM said, "No." The facility went nine (9) months between semi-annual inspections. On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e) NFPA 99	K 324	The vendor will send a notification per their scheduling system, i.e., within two weeks before the due date for the second semi-annual inspection. The vendor has informed the facility that they cannot schedule at this time as it is too early or too soon to do so as their computer system will not allow scheduling to be done prior to the two-week period preceding the due date. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Re-education was initiated and is ongoing in the maintenance department and food service (dietary) department on the regulations requiring inspection of the range-hood fire suppression system semi-annually (every six months). Element Four – Quality Assurance • An audit of the facility's documentation of mandatory fire suppression system inspections will be conducted by the Maintenance Director/Supervisor or designee monthly for three (3) months to ensure that the mandatory inspections are done per required schedule/frequency. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: August 7, 2023	

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	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

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LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 351	Continued From page 10	K 351		
K 351 SS=E	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 review of facility provided documentation on 07/05/2023 and 07/06/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, 2) Failed to provide fire sprinkler coverage to all areas of the facility as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition The deficient practice is evidenced by the following,	K 351	K351 Sprinkler System – Installation Element One – Corrective Actions • The facility has since installed the ceiling tile on the ceiling grid in the first-floor Resident central Bathing room next to room [redacted]. • A fire sprinkler coverage will be installed in the main kitchen, specifically, under the Heating, Ventilation and Air Conditioning (HVAC) duct work, particularly, over the microwave, serving counter and paper products. • Vendor is coming on August 11, 2023	8/1/23

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K 351	Continued From page 11 On 07/05/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is two (2) story building with 73 Resident sleeping rooms and various common areas in the facility.. Starting at approximately 9:36 AM on 07/05/2023 and continued on 07/06/2023 in the presence of the facility MD a tour of the building was conducted. Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: 1) On 07/05/2023 at approximately 10:00 AM, the surveyor observed inside the first floor Resident Central Bathing room next to room [redacted] ceiling grid was missing one (1) 2' by 3' ceiling tile. With the missing ceiling tile, in the event of a fire this would allow the heat to by-pass the fire sprinkler and take longer to activate. 2) On 07/05/2023 at approximately 10:38 AM, the surveyor observed in the main kitchen had no evidence of a fire sprinkler coverage under the Heating, Ventilation and Air Conditioning (HVAC) duct work. The surveyor observed under the duct work a microwave, serving counter and paper products. At this time the surveyor measured and recorded the area was 7 feet 2 inch wide by 7 feet 3 inch deep area.	K 351	to do an ocular inspection, take measurements and specifications, procure and install the fire sprinkler for the area. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Re-education was initiated and is ongoing in the maintenance department that a missing ceiling tile in the ceiling grid posed a fire hazard as it would allow the heat to bypass the fire sprinkler and take longer to activate. • Re-education was initiated and is ongoing in the maintenance department and food service (dietary) department on the regulatory requirement on properly installing fire sprinkler coverage to all areas needed. Element Four – Quality Assurance • An audit of the ceiling grids in the entire building will be conducted by the Maintenance Director/Supervisor or designee monthly for two (2) months to ensure that there is no missing ceiling tile in any area of the building. Data obtained will be reported at the quarterly QAPI meeting. • An audit of various areas of the facility will be done monthly for two (2) months by the Maintenance Director/Supervisor or designee to ensure that various areas have the necessary fire sprinkler coverage. Data obtained will be reported	

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K 351	Continued From page 12 The facility failed to provide fire sprinkler coverage to all areas in the facility. The MD confirmed the finding at the time of observations. On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	at the monthly QAPI meeting. Completion Date: August 1, 2023	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 07/05/2023, 07/06/2023 and	K 353	K353 Sprinkler System – Maintenance and	8/7/23

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K 353	Continued From page 13 07/07/2023 in the presence of facility management, it was determined that the facility failed to comply with the inspection and testing requirements NFPA 25 as evidenced by the following: During the survey entrance on 07/05/2023 (day one of survey) at 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide all mandatory inspections from 01/01/22 to 07/04/2023 for review later. On 07/06/2023 during the documentation review of the mandatory inspections of the facility's quarterly (every 3 months) fire sprinkler system system inspections for the previous 18 months identified the system had two (2) Quarterly inspections on 08/31/2022 and 05/16/2023. The surveyor interviewed the MD on 07/07/2023 at approximately 9:59 AM. The surveyor asked the facility to provide the previous inspection for the fire sprinkler system inspections. The MD provided an inspection that was conducted on 12/10/2021 and 07/06/2023. The surveyor asked if there were any other quarterly fire sprinkler system inspections performed between 01/01/2022 and 12/31/2022. The MD said, "No." The facility went twelve (12) months with one (1) Quarterly sprinkler system inspection. On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e) NFPA 25	K 353	Testing Element One – Corrective Actions • The facility contacted the vendor on August 7, 2023 to schedule the third quarterly sprinkler system inspection due in October 2023. The vendor will send a notification per their scheduling system, i.e., within two weeks before the due date for the third quarterly sprinkler inspection. The vendor informed the facility that they cannot schedule at this time as it is too early or too soon to do so as their computer system will not allow scheduling to be done prior to the two-week period preceding the due date. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Re-education was initiated and is ongoing in the maintenance department on the regulations requiring quarterly sprinkler system inspection. Element Four – Quality Assurance • An audit of the facility's documentation of mandatory quarterly sprinkler system inspections will be conducted by the Maintenance Director/Supervisor or designee monthly for three (3) months to ensure that the mandatory inspections are done per required schedule/frequency. Data obtained will be reported at the quarterly QAPI meeting.	

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K 353	Continued From page 14	K 353		
			Completion Date: August 7, 2023	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 07/05/2023 and 07/06/2023 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 2 of 28 portable fire extinguishers, 2) Inspect 1 of 28 portable fire extinguishers annually, 2) Install portable fire extinguishers with-in the required height for 11 of 28 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and	K 355	K355 PORTABLE FIRE EXTINGUISHERS – MONTHLY EXAMINATION Element One – Correction Actions • The facility immediately re-did the monthly visual examination for 2 of 28 portable fire extinguishers. • The monthly visual re-examination was recorded – initialed and dated – on the appropriate tag by the maintenance staff performing the inspection and the record kept on a tag or label attached to the identified 2 of 28 portable fire extinguishers. Element Two – Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Re-education was initiated and is	7/19/23

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K 355	Continued From page 15 thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. The findings include the following, On 07/05/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting at approximately 9:34 AM on 07/05/2023	K 355	ongoing with the maintenance department on the regulation requiring inspection of the fire extinguisher when initially placed in service and thereafter at approximately 30-day intervals, or more frequently when circumstances require. • Re-education was initiated and is ongoing to the maintenance department to take immediate corrective action if the inspection of any fire extinguisher reveals a deficiency in any conditions. Element Four – Quality Assurance • An audit of all portable fire extinguishers in the facility will be conducted by the Maintenance Director/Supervisor or designee for two (2) months to ensure that the monthly visual examinations thereof are done. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: July 19, 2023 K355 continued… PORTABLE FIRE EXTINGUISHERS – INSTALLATION HEIGHT Element One – Corrective Actions • The facility has since corrected the installation height of the identified 12 of 28 portable fire extinguishers to be in accordance with the requirement that the top of the fire extinguisher be installed no more than five (5) feet above the floor. • An audit was completed to ensure the	

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K 355	Continued From page 16 and continued on 07/06/2023 in the presence of the facility's MD a tour of the facility was conducted. During the two day building tour the surveyor observed and inspected twenty eight (28) portable fire extinguishers in various locations. Twenty seven (27) of the twenty eight (28) portable fire extinguishers were last annually inspected August 2022 with the following issues identified: On 07/05/2023: 1) At approximately 10:02 AM, One (1) "ABC-Type" fire extinguisher on the 1st. floor near the locker room was last annually inspected August 2022. There was no evidence of monthly visual examination performed and documented for January, February, March, April May and June 2023. 2) At approximately 10:05 AM, One (1) "ABC-Type" fire extinguisher, next to resident room [redacted] on the 1st. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 6" to the center of the pressure indicating needle. 3) At approximately 10:08 AM, One (1) "ABC-Type" fire extinguisher, next to resident room [redacted] on the 1st. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 7" to the center of the pressure indicating needle. 3) At approximately 10:52 AM, One (1) "ABC-Type" fire extinguisher on the 1st. floor "B"	K 355	other 16 facility portable fire extinguishers are in accordance with the requirements including proper installation height. These 16 other fire extinguishers have been corrected to be at the proper installation height. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Re-education was initiated and is ongoing with the maintenance department on the regulations regarding portable fire extinguishers including installation height requirements. Element Four – Quality Assurance • An audit of the facility's portable fire extinguishers will be completed by the Maintenance Director/Supervisor or designee monthly for two (2) months to ensure installation height is in accordance with the requirements. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: July 19, 2023 K355 continued… PORTABLE FIRE EXTINGUISHERS – ANNUAL INSPECTION Element One – Corrective Actions • The facility scheduled with the vendor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

(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 355	Continued From page 17 wing Nursing station pantry area was last annually inspected September 2019. 4) At approximately 10:56 AM, One (1) "ABC-Type" fire extinguisher, next to resident room [redacted] on the 1st. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 6" to the center of the pressure indicating needle. 5) At approximately 11:17 AM, One (1) "ABC-Type" fire extinguisher, next to resident room [redacted] on the 1st. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 5" to the center of the pressure indicating needle. 6) At approximately 11:30 AM, One (1) "ABC-Type" fire extinguisher, near the cable room on the 1st. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 5" to the center of the pressure indicating needle. 7) At approximately 11:35 AM, One (1) "ABC-Type" fire extinguisher on the 1st. floor near the Residents Salon was last annually inspected August 2022. There was no evidence of monthly visual examination performed and documented for January, February, March, April May and June 2023. On 07/06/2023: 8) At approximately 9:57 AM, One (1) "ABC-Type" fire extinguisher, to the right of	K 355	on August 8, 2023 the annual inspection of the fire extinguishers due in August 2023. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Re-education was initiated and is ongoing in the maintenance department on the regulations requiring annual inspection of the fire extinguishers. Element Four – Quality Assurance • An audit of the facility's documentation of mandatory annual fire extinguisher inspections will be conducted by the Maintenance Director/Supervisor or designee to monitor monthly for three months that the annual inspections are done. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: August 8, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

(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 355	Continued From page 18 Resident room [EX Order 26.4] on the 2nd. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 6" to the center of the pressure indicating needle. 9) At approximately 10:05 AM, One (1) "ABC-Type" fire extinguisher, to the right of Resident room [EX Order 26.4B] on the 2nd. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 7" to the center of the pressure indicating needle. 10) At approximately 10:11 AM, One (1) "ABC-Type" fire extinguisher, to the right of Resident room [EX Order 26.4] on the 2nd. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 6" to the center of the pressure indicating needle. 11) At approximately 10:11 AM, One (1) "ABC-Type" fire extinguisher, to the right of Resident room [EX Order 26.4B] on the 2nd. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 6" to the center of the pressure indicating needle. 12) At approximately 10:50 AM, One (1) "ABC-Type" fire extinguisher, to the right of Resident room [EX Order 26.4] on the 2nd. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 6" to the center of the pressure indicating needle. 13) At approximately 10:53 AM, One (1)	K 355		

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	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 355	Continued From page 19 "ABC-Type" fire extinguisher, to the right of Resident room [EX Order 26.48] on the 2nd. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 6" to the center of the pressure indicating needle. 14) At approximately 11:19 AM, One (1) "ABC-Type" fire extinguisher, to the right of Resident room [EX Order 26.4] on the 2nd. floor appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 6" to the center of the pressure indicating needle. The MD confirmed the finding at the time of observations. On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 521		8/8/23

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	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

(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 521	Continued From page 20 Based on observations on 07/05/2023 and 07/06/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 4 of 9 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 07/05/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is two (2) story building with 73 Resident sleeping rooms and various common areas in the facility.. Starting at approximately 9:14 AM on 07/05/2023 and continued on 07/06/2023 in the presence of the facility's MD a tour of the facility was conducted. Along the two (2) day tour the surveyor inspected and tested nine (9) Resident sleeping rooms bathroom exhaust systems. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 4 of 9 resident bathrooms in the following locations: 1. On 07/05/2023 at approximately 10:48 AM, inside Resident room [redacted] bathroom, when	K 521	K521 HVAC Element One – Corrective Actions • The facility started on August 8, 2023 the process for repair of the ventilation system of 4 of 9 identified resident bathroom exhaust systems to ensure proper function. • An audit was initiated to check that facility resident bathroom ventilations are properly maintained to ensure proper function. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Re-education was initiated and is ongoing in the maintenance department on the regulations regarding installation of the heating, ventilation, and air conditioning (HVAC) in accordance with manufacturer's specifications and properly maintaining the ventilation systems in resident bathroom exhaust systems. Element Four – Quality Assurance • An audit of the resident bathroom ventilation systems will be done by the Maintenance Director/Supervisor or designee monthly for two (2) months to ensure proper function of ventilation. Data obtained will be reported at the quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

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LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 521	Continued From page 21 tested the exhaust system did not function properly. At this time, the surveyor informed the MD that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. On 07/06/2023 at approximately 10:59 AM, inside Resident room #[EX Order 26.4] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. On 07/06/2023 at approximately 11:14 AM, inside Resident room [EX Order 26.4B] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 4. On 07/06/2023 at approximately 11:18 AM, inside Resident room [EX Order 26.4B] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The MD confirmed the findings at the time. On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	Completion Date: August 8, 2023	

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	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 07/05/2023, 07/06/2023 and 07/07/2023, it was determined that the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 (2012 edition) Health Care Facilities Code section 6.3.4.1.3. This deficient practice had the potential to affect all 112 residents. During the survey entrance on 07/05/2023 (day one of survey) at 9:17 AM, a request was made to the Administrator and Maintenance Director	K 914	K914 Electrical Systems – Maintenance and Testing Element One – Correction Actions • Contract was signed on August 2, 2023, and the vendor will come on August 22, 2023 to conduct the electrical outlet testing. • The electrical outlet testing includes testing of receptacles at resident bed locations.	8/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 914	Continued From page 23 (MD) to provide all mandatory inspections from 01/01/22 to 07/04/2023 for review later. On 07/06/2023 during the Documentation review of the Mandatory Inspections for 2022 and 2023, provided by the Maintenance Director, revealed the electrical outlet testing was not completed on the electrical outlets for 2022. During an interview at 9:59 AM on 07/07/2023, the Maintenance Director confirmed that the annual electrical outlet testing for 2022 was not completed on the electrical system. On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e) NFPA 99	K 914	Element Two – Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Re-education was initiated and is ongoing in the maintenance department on the regulation requiring annual inspection of the electrical system including the electrical outlets. Element Four – Quality Assurance • An audit of the facility's documentation of mandatory annual electrical system inspections will be conducted by the Maintenance Director/Supervisor or designee to monitor monthly for three months that the mandatory inspections are done per required schedule/frequency. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: August 2, 2023	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		8/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**07/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 918	Continued From page 24 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/05/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following:	K 918	K918 Electrical Systems – Essential Electric System Maintenance and Testing Element One – Corrective Actions • The facility contacted vendor on August 3, 2023 to purchase and install a remote manual stop station (remote emergency stop button) for the facility's	

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LIMECREST SUBACUTE AND REHABILITATION CENTER	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 918	Continued From page 25 On 07/05/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility and if the facility had an Emergency Generator. The MD told the surveyor, yes we have one Diesel Emergency Generator. . On 07/05/2023 at approximately 9:52 AM, in the presence of the MD an inspection outside of the building where the Emergency Generator is located was performed. The surveyor observed that the emergency stop button was located inside the metal housing and on the front control panel of the generator. At this time the surveyor asked the MD, Do you have a remote emergency stop button for the generator. The MD said, no. The MD confirmed the finding at the time of observation. On 07/07/2023 during the survey exit at approximately 11:01 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	emergency generator, in addition to the emergency stop button located inside the metal housing and on the front control panel of the generator. Element Two - Identification of at-Risk Areas • All Residents have the potential to be affected by this practice. Element Three – Systemic Change • Education was initiated and is ongoing in the maintenance department on the need for a remote emergency stop button for the emergency generator to allow for quicker if not immediate stoppage/shutoff of the emergency generator if needed and to minimize the possibility of damage of the emergency power source. Element Four – Quality Assurance • An audit of the emergency generator system will be conducted by the Maintenance Director/Supervisor or designee to ensure the installation of the remote emergency stop button has been done and is usable. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: August 3, 2023	

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
315044 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/10/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIMECREST SUBACUTE AND REHABILITATION CENTER	1 O'BRIEN LANE LAFAYETTE, NJ 07848

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	08/08/2023	LSC K0281	08/07/2023	LSC K0293	08/07/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	08/07/2023	LSC K0351	08/01/2023	LSC K0353	08/07/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	07/19/2023	LSC K0521	08/08/2023	LSC K0914	08/02/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	08/03/2023	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	
7/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO