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**

(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 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		

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 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	

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 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
	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 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 A-151, 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 A-151, 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
	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 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**

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 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**

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 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.	

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 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	

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 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 A-141. • 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

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 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 A-141, 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	

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 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

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 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.	

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 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

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 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	

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 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 A-143 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 A-152 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 B-116 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 B-101 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 A-239 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 A-241 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 A-252 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 A-252 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 B-216 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		

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 19 "ABC-Type" fire extinguisher, to the right of Resident room B-209 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 B-203 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

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 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 #B-120 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**

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 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 #B-221 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 #B-207 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 #B-203 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	

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 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**

(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 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**

(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 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	

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 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