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 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	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
F 000	INITIAL COMMENTS Complaint #s: NJ177864, NJ168254 Survey Dates: 11/12/2024 through 11/19/2024 Census: 130 Sample Size: 25 + 3 closed records A Recertification survey was conducted to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facility. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 1 (one) of 25 residents (Resident #46) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following:	F 558	F558 – Reasonable Accommodations Needs/Preferences Element One – Corrective Actions 1. Resident #46's call bell was immediately placed within their reach, ensuring that it is easily accessible to the resident at all times. 2. All nursing staff were immediately	12/9/24

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

Electronically Signed | 12/11/2024

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 558	Continued From page 1 On 11/12/24, at 9:30 AM and 1:32 PM, the same day, the surveyor observed Resident #46 lying in bed, NJ Exec Order 26.4b1. The surveyor observed that the call bell was behind the resident's headboard, between the wall and the bed. On 11/12/24, at 1:35 PM, the surveyor interviewed the US FOIA (b)(6) and the US FOIA (b)(6), who stated that the call bell should be within the residents' reach. The US FOIA (b) placed the call bell next to the resident's right hand. On 11/13/24 at 9:27 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #46, which revealed the following: According to the Admission Record (an admission summary) (AR), Resident #46 was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of the recent quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4b, indicated that the facility assessed the residents' NJ Exec Order 26.4b1 using a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated that the resident had NJ Exec Order 26.4b [redacted] Further review of QMDS, reflected in section NJ Exec O revealed that the resident NJ Exec Order 26.4b on staff NJ Ex Order 26.4(b)(1) [redacted] A review of the comprehensive Care Plan dated NJ Exec Order 26.4 included a focus area: the resident is at risk for NJ Exec O due to NJ Exec Order 26.4b1.	F 558	educated through in-service training regarding the importance of placing the call bell within reach of all residents. This training included both written materials and hands-on demonstration. Training will be documented, and each staff member will sign off on completion. 3. A facility-wide round was conducted to verify that all call bells are within reach of residents. Any instances of inaccessible call bells were corrected 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 1. Education and re-education of staff on all shifts on the reviewed and updated facility policy and procedure regarding call bell accessibility were initiated on 11/20/2024. 2. The Director of Nursing (DON) or designee will oversee the re-education of all nursing staff on the updated facility policy and procedure regarding call bell accessibility. This education will continue for all shifts. New hires will receive this training as part of their orientation.	

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F 558	Continued From page 2 Interventions included, but were not limited to, keeping the call bell within reach. On 11/15/24 at 11:36 AM, the team of surveyors met with the US FOIA (b)(6) [redacted] The US FOIA (b)(6) acknowledged that the call bell should be placed within the resident's reach. The facility policy and procedure titled "Resident Call Bells" was updated on 11/2024, given by the interim DON. It states under "Policy: 2. The call bell must be placed within reach of the resident. Procedure: 7. Staff will ensure that the call bell is within the resident's reach before leaving the room." NJAC 8:39-31.8(c)9	F 558	Element Four – Quality Assurance 1. On 12/03/2024, the facility initiated a QAPI – Performance Improvement Project identifying the problem of call bells not placed within reach of residents. The facility's goal is to ensure that the residents' call device is readily accessible. 2. The DON or designee will conduct unannounced weekly audits of 10% of total census to monitor the accessibility of call bells. 3. Audits and monitoring will be tracked and trended by the DON or designee at weekly QAPI meetings, starting on 12/10/2024, for three (3) months, to establish the baseline and to identify the factors contributing to the call device not being maintained within ready access, and to make the necessary systems correction including the review and update of pertinent facility policies and procedures as well as conducting the staff education/reeducation required. Completion Date: December 9, 2024	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		12/9/24

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F 561	Continued From page 3 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents' bathing choice of a day shower was provided for 1 of 1 resident (Resident #83) reviewed for choices. This deficient practice was evidenced as follows: On 11/12/24 at 10:38 AM, the surveyor interviewed Resident #83 in their room. The resident stated, "I am supposed to and want to get two showers per week, but I have not	F 561	F561 – Self-Determination Element One – Corrective Actions 1. I/DON met with Resident #83 in the morning of 11/13/2024 to discuss shower schedule preferences. 2. Resident #83 was showered on NJ Exec Order 26.4b1 on 3-11 shift. 3. The shower log documentation was reviewed and updated to ensure clear,	

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F 561	Continued From page 4 received a shower [NJ Ex Order 26.4(b)(1] ." A review of Resident #83's Admission Record reflected that the resident had diagnoses that included but were not limited to; [NJ Exec Order 26.4b1 redacted] A review of the Annual Minimum Data Set (MDS) dated [NJ Exec Order 26 redacted], an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Ex redacted] out of 15 which indicated that the resident had a [NJ Exec Order 26.4b1 redacted] Further review of the MDS indicated that the resident required [NJ Exec Orde redacted] with [NJ Exec Order 26.4b redacted] A review of the Order Summary Report did not reflect any physician's order (PO) for showers twice per week. On 11/14/24 at 10:20 AM, the surveyor interviewed the Licensed Practical Nurse Supervisor (LPN#1) who stated all residents would receive showers twice a week on both 7-3 and 3-11 shifts. LPN#1 further stated that there are no PO for showers and all information regarding days, times, and record for showers are kept in a notebook at the nursing station. The surveyor reviewed the shower logbook which revealed, Resident # 83's showers are scheduled for Tuesday and Friday during the day shift. Further review of the shower log revealed that Resident #83 received 2 out of 11 scheduled showers from [NJ Exec Order 26.4b1 redacted]. LPN #1 stated they were not aware that Resident #83 had not been consistently receiving their showers as	F 561	visible notation of each resident's preferred bathing day. Staff have been trained to easily identify the resident's preferences on the log. 4. Staff were educated to offer residents a shower; if resident refuses, to inform the unit nurse who will in turn document and/or update the care plan. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change 1. The CNA/Shower log documentation was reviewed to ensure the format clearly reflects each resident's bathing preferences and allows for easy reference. Any necessary adjustments to the log format will be made to support accurate documentation and implementation. 2. Education and re-education of Nursing staff on all shifts on shower schedule, frequency, and resident preferences was initiated on 12/03/2024 and ongoing. Element Four – Quality Assurance	

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F 561	Continued From page 5 scheduled. On 11/14/24 at 10:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA#1) who stated all resident are supposed to receive showers twice per week and all information regarding resident showers are kept in the shower notebook at the nursing station. A review of the policy titled "Ensuring Residents Choices" with a revision date of 4/2024 revealed, "It shall be the policy of Mohawk Meadows to ensure that the residents residing at our facility make their own choices which will help improve the autonomy and their mental well-being." Under the procedure section of the policy it states, "1. Prioritize and honor resident choice." On 11/18/24 at 1:08 PM, the survey team met with the US FOIA (b)(6) and US FOIA (b)(6) were made aware of the surveyors concerns. No further comments were provide. On 11/19/24 at 11:30 AM, the team of surveyor met with the US FOIA (b)(6) and no further information was provided regarding the resident showers.	F 561	1. On 12/03/2024, the facility initiated a QAPI – Performance Improvement Project identifying the problem of missed showers. The facility's goal is to ensure that the residents' bathing choice is provided. 2. The DON or designee will audit and monitor to ensure that the residents' bathing choice is provided. Audits will include reviewing CNA care plans for accuracy and ensuring the shower schedule is followed. 3. Audits and monitoring will be tracked and trended by the DON or designee at weekly QAPI meetings, starting on 12/10/2024, for three (3) months, to establish the baseline and to identify the factors contributing to the residents' bathing choice not being provided, and to make the necessary systems correction including the review and update of pertinent facility policies and procedures as well as conducting the staff education/reeducation required. Completion Date: December 9, 2024	
F 604 SS=D	NJAC 8:39-4.1(a) 3,12 Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect	F 604		12/9/24

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F 604	Continued From page 6 and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident was NJ Exec Order 26.4b1 [redacted] This deficient practice was identified in 1 of 2 residents reviewed for NJ Exec Order 26.4b1 (Residents #99) and was evidenced by the following:	F 604	F604 – Right to be Free from Physical Restraints Element One – Corrective Actions 1. The NJ Exec Order 26.4b1 was immediately removed from around the [redacted] of Resident #99.	

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F 604	Continued From page 7 On 11/12/24 at 10:20 AM, the surveyor observed Resident #99 awake and was seated in their wheelchair that had a NJ Exec Order 26.4b1 around the resident's NJ Exec Orde. The resident was NJ Exec Order 26.4b1 to the surveyors' inquiry. The surveyor further observed that Resident #99 had NJ Exec Order 26.4b1 The surveyor in the presence of the Licensed Practical Nurse #1 (LPN #1) assessed Resident #99. LPN #1 acknowledged to the surveyor that the resident was wearing a NJ Exec Order 26.4b1 and to prevent the resident from NJ Exec Order 2 On 11/13/24 at 11:49 PM, the surveyor interviewed the Registered Nurse who acknowledged that Resident #99 should not be wearing the NJ Exec Order 26.4b1. A review of the Admission Record revealed that Resident #99 was admitted to the facility with diagnosis that included but not limited to NJ Exec Order 26.4b1 A review of Resident #99's Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate management of care, dated NJ Exec Order 26.4b1 reflected that the resident's Brief Interview for Mental Status was NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 Order Summary Report did not reflect a physician's order for the use of NJ Exec Order 26.4b1. A review of Resident #99's comprehensive	F 604	2. One-to-one education was provided to the CNA who applied the NJ Exec Order 26.4 on Resident #99, that the NJ Exec Order 26.4b being a NJ Exec Order 26.4b1, cannot be applied absent a physician's order. 3. Resident #99 completed NJ Exec Order 26.4b1 evaluation on NJ Exec Order 26.4b1 and was thereafter placed on NJ Exec program for NJ Exec Order 26.4b1 4. A facility-wide round was conducted to verify that no physical restraint was applied on any resident absent a physician's order. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change 1. Education and re-education of staff on all shifts on the reviewed restraint policy and procedures were initiated on 11/20/2024 and ongoing. 2. The Director of Nursing (DON) or designee will oversee the re-education of all nursing staff on the restraint policy and procedure. This education will continue for all shifts. New hires will receive this training as part of their orientation.	

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F 604	Continued From page 8 Interdisciplinary Care Plan (CP) did not reflect the use of NJ Exec Order 26.4b1 On 11/13/24 at 12:45 PM, the surveyor interviewed the facility's US FOIA (b)(6) who stated there was no documentation to determine why the NJ Exec Order 26.4b was used by the resident. On 11/14/24 at 1:30 PM, the survey team met with the facility's US FOIA (b)(6) to discuss the above concerns. There was no further information provided. A review of the facility's policy titled, "Restraint" dated 01/25/23 revealed under Policy "II. The Facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. The Facility will ensure that restraints will not be imposed for purposes of discipline or convenience." Further review of the policy under X. "B. The Attending Physician must be notified of such use and the reason for the order." "C. Orders for emergency restraints may be received by telephone." NJAC 8:39-4.1(6)	F 604	3. All new admissions and readmissions are screened for devices, the use of which could be considered as a restraint, and documented under the Assessment tab on EMR. Element Four – Quality Assurance 1. On 12/03/2024, the facility initiated a QAPI – Performance Improvement Project identifying the problem of unnecessary use of restraints. The facility's goal is to ensure that residents are free from physical restraints. 2. The DON or designee will conduct unannounced weekly unit audits to monitor that any use of physical restraint is per physician's order and reflected in the care plan. 3. Audits and monitoring will be tracked and trended by the DON or designee at weekly QAPI meetings, starting on 12/10/2024, for three (3) months, to establish the baseline and to identify the factors contributing to unnecessary use of physical restraints, and to make the necessary systems correction including the review and update of pertinent facility policies and procedures as well as conducting the staff education/reeducation required.	

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F 604	Continued From page 9	F 604	Completion Date: December 9, 2024	
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to a. ensure	F 607	F607 – Develop/Implement Abuse/Neglect Policies	12/9/24

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F 607	Continued From page 10 reference checks (RC) were completed to seven (7) out of ten (10) newly hired staff (NHS) b. ensure criminal background checks (CBC) were completed to four (4) out of ten (10) NHS and c. ensure a NJ Ex Order 26.4(b)(1)) was performed to 2 (two) out of ten (10) NHS prior to their start date of employment. This deficient practice was evidenced by the following: The surveyor reviewed ten randomly selected new employee files. The review for reference checks for five of the eight new employees revealed the following: -Staff #1's file, a US FOIA (b)(6) who was hired on NJ Exec Order 26.4b revealed no RC in their file. -Staff #2's file, a US FOIA (b)(6) who was hired on NJ Exec Order 26.4, revealed no RC in their file. Further review of Staff #2's did not reveal that a NJ Ex O was completed prior to date of hire. - Staff #3's file, a Registered Nurse #1 (RN #1) who was hired on NJ Exec Order 26.4, revealed no RC in their file. Further review of Staff #3's file revealed no NJ Ex O completed by a physician prior to date of hire. - Staff #4's file, a Certified Nursing Assistant (CNA #1), who was hired on NJ Exec Order 26., revealed no RC in their file. - Staff #5's file, a RN #2, who was hired on NJ Exec Order 26.4b1 revealed no CBC completed prior to date of hire.	F 607	Element One – Corrective Actions 1. Human Resources Department staff were immediately re-educated on the importance of doing reference verification, criminal background checks, and physical examination of staff prior to date of hire. 2. The facility did reference checks and criminal background checks on the staff members identified. 3. The facility did an audit of the personnel files of staff members hired in the past three months and did reference verification, criminal background, and/or arranged for physical examination as needed. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change Human Resources Department staff were re-educated on 11/20/2024 regarding the importance of completing reference verification, criminal background checks, and physical examinations of newly hired staff prior to date of hire.	

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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 607	Continued From page 11 - Staff #6's file, a US FOIA (b)(6), who was hired on NJ Exec Order 2, revealed no CBC completed prior to date of hire. - Staff #7's file, a US FOIA (b)(6), who was hired on NJ Exec Order 26.4b1 revealed only 1 RC in their file. Further review of Staff #7's file revealed that a CDC was not completed prior to date of hire. - Staff #8's file, a US FOIA (b)(6) who was hired on NJ Exec Order 26.4, revealed no RC in their file. - Staff #9's file, a CNA #2 who was hired on NJ Exec Order 26.4, revealed no RC in their file. Further review of Staff #9's file revealed that a CDC was not completed prior to date of hire. On 11/18/24 at 12:19 PM, the surveyor interviewed the facility's US FOIA (b)(6) who confirmed that the above employees did not have a completed reference verification and/or criminical background check prior to their date of hires. On 11/18/24 at 1:08 PM, the surveyor informed the US FOIA (b)(6) regarding the above concern. There was no additional information provided by the facility. The surveyor reviewed the facility's policy titled "Hiring Process" dated 10/2024 revealed under Procedure, "C. All new applicants before hire will be subject to criminal background investigation (CBI), with their authorization, to determine whether they have been convicted of a felony	F 607	Element Four – Quality Assurance 1. On 12/03/2024, the facility initiated a QAPI – Performance Improvement Project identifying the problem of deficient pre-employment screening. The facility's goal is to ensure that pre-employment verification requirements pertaining to newly hired staff are completed prior to date of hire. 2. The Administrator or designee will audit and monitor new hires on 11/20/2024 onwards to ensure that reference verification, criminal background check, and physical examination of newly hired staff are done prior to date of hire. 3. Audits and monitoring will be tracked and trended by the Administrator at weekly QAPI meetings, starting on 12/10/2024, for three (3) months, to establish the baseline and to identify the factors contributing to failure to complete pre-employment screening requirements, and to make the necessary systems correction including the review and update of pertinent facility policies and procedures as well as conducting the staff education/reeducation required. Completion Date: December 9, 2024	

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	315044	A. BUILDING _____ B. WING _____	C 11/19/2024

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F 607	Continued From page 12 within the last five (5) years. Reference checks will be made for all applicants prior to employment. All new licensed personnel and licensed nursing personnel will complete a criminal background check." Under "II. New Hire A. Prior to the first day of employment, the prospective employee is seen by the employee health nurse. B. The new hire will also obtain a physical examination by employee health physician or advanced nurse practitioner."	F 607		
F 684 SS=D	N.J.A.C. 8:39-9.3 (a), (b) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined that the facility failed to ensure a resident received a medication according to the physician's order (PO) that was indicated for [redacted] in accordance with professional standards of practice and facility policies and procedures for one (1) of 25 residents, (Resident #131), reviewed for medication administration.	F 684	F684 – Quality of Care Element One – Corrective Actions 1. The facility called the pharmacy provider for the [redacted] (ordered by physician from transferring facility) and was referred to their alternate pharmacy. The facility called the alternate pharmacy and was then informed that they did not have the medication in stock and referred	12/9/24

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F 684	Continued From page 13 This deficient practice was evidenced by the following: On 11/14/24 at 8:45 AM, during the medication administration observation with Licensed Practical Nurse (LPN #2), the surveyor observed Resident #131 in their room seated in a wheelchair. LPN #2 prepared the eight (8) medications for Resident #131 and stated that one of the medications was NJ Exec Order 26.4b1 which was indicated for the resident's diagnosis of NJ Exec Order 26.4b1 were not available because the facility's pharmacy had not yet delivered the medication. On 11/14/24 at 9:20 AM, the surveyor interviewed Resident #131, who stated that they had not received the NJ Exec Order 26.4b1 since they were admitted to the facility on NJ Exec Order 26.4b1. On 11/14/24 at 9:26 AM, the surveyor reviewed the hybrid medical records (paper and electronic) of Resident #131, which revealed the following: A review of the Admission Record (an admission summary) reflected that Resident #131 was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of the NJ Exec Order 26.4b1 Order Summary Report revealed a PO dated NJ Exec Order 26.4b for NJ Exec Order 26.4b1 one tablet by mouth twice daily for NJ Exec Order 26.4b1. A review of the Progress Notes dated NJ Exec Order 26.4b at 12:30 PM, revealed the facility's pharmacy was	F 684	the facility yet to another alternative pharmacy. The facility contacted the second alternative pharmacy and obtained confirmation that the medication was available and would be delivered the following day. The medication was in fact delivered the following day. 2. I/DON immediately educated/re-educated nurse staff on all shifts on the facility policy and procedure regarding physician orders and when medication ordered by physician is unavailable. 3. A facility-wide audit of ordered medications was conducted to verify that all medications ordered are available for administration. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change 1. Education and re-education of Nurse staff on the reviewed and updated facility policy and procedures regarding physician orders and when medication ordered is unavailable were initiated on 11/20/2024 and ongoing.	

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F 684	Continued From page 14 aware of the PO for the medication [NJ Exec Order 26.4b1] The physician was also made aware. On 11/15/24 at 11:45 AM, the survey team met with the [US FOIA (b)(6)] [redacted]. The [US FOIA (b)(6)] stated that the [NJ Exec Order 26.4b1] was unavailable at pharmacy where they faxed the PO but was referred to another pharmacy who had the medication in stock. The [US FOIA (b)(6)] also stated that the facility was expecting to receive the medication on [NJ Exec Order 26.4b]. On 11/15/24 at 12:10 PM, the surveyor interviewed the pharmacy's customer service agent over the phone, who stated that on 11/12/24 at 11:24 PM, they received the prescription for [NJ Exec Order 26.4b1] On 11/13/24 at 11:33 AM, the pharmacy informed the facility that they did not have the medication [NJ Exec Order 26.4b1] and were subsequently referred to another pharmacy. On 11/18/24 at 10:07 AM, the survey team interviewed Resident #13 [US FOIA (b)(6)] who stated he was made aware on 11/14/24 that the resident had not received five doses of [NJ Exec Order 26.4b1] On 11/19/24 at 10:40 AM, the survey team met with the [US FOIA (b)(6)] presented the packing slip from the pharmacy which revealed that the [NJ Exec Order 26.4b1] medication had an estimated shipped date of [NJ Exec Order 26.4b]. The [US FOIA (b)(6)] further stated the medication was received on [NJ Ex Order 26.4(b)(1)] A review of the facility policy titled, "Physician Orders" indicated under "Policy: Nursing	F 684	2. The Director of Nursing (DON) or designee will oversee the re-education of all nursing staff on the policy and procedure regarding physician orders and when medication ordered is unavailable. This education will continue for all shifts. New hires will receive this training as part of their orientation. 3. Pharmacy provider likewise educated / re-educated Nurse staff on 11/19/2024 on the pharmacy's policy and procedure in case of medication unavailability. Element Four – Quality Assurance 1. On 12/03/2024, the facility initiated a QAPI – Performance Improvement Project identifying the problem of failure to administer medication in a timely manner. The facility's goal is to ensure that residents receive medication according to physician's order in a timely manner. 2. The DON or designee will audit five (5) charts weekly and monitor to ensure that the facility policy and procedure is followed when medication ordered by physician is unavailable. 3. Audits and monitoring will be tracked and trended by the DON or designee at weekly QAPI meetings, starting on 12/10/2024, for three (3) months, to establish the baseline and to identify the factors contributing to residents not receiving medication according to	

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F 684	Continued From page 15 Department will verify that physician orders are complete, accurate, and clarified as necessary and that residents receive their medication timely." NJAC 8:39-27.1(a)	F 684	physician's order, and to make the necessary systems correction including the review and update of pertinent facility policies and procedures as well as conducting the staff education/reeducation required. Completion Date: December 9, 2024	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		12/9/24

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F 690	Continued From page 16 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to record and document the NJ Exec Order 26.4b1 of resident's with an NJ Exec Order 26.4b1 per Physician Orders (PO). This deficient practice was noted in 1 of 2 resident's reviewed with an NJ Exec Order 26.4b1 (Resident #68). This deficient practice was evidenced by the following: On 11/12/24 at 10:18 AM, the surveyor observed Resident #68 awake in their bed. Resident stated they have a NJ Exec Order 26.4b for NJ Exec Order 26 problems. The resident had a NJ Exec Order 26.4b1 on side of their bed. The surveyor reviewed Resident #68's hybrid (combination of paper and electronic) medical records. The resident was admitted to the facility with diagnoses that included but were not limited to, NJ Exec Order 26.4b1 [redacted]).	F 690	F690 – Bowel/Bladder Incontinence, Catheter, UTI Element One – Corrective Actions 1. Resident #68's medical record was corrected to add NJ Exec Order 26.4b1 to supplementary documentation on the EMR. 2. A facility-wide audit of the medical records of all other residents with indwelling urinary catheters was conducted to add supplementary documentation to record urinary output on the EMR. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change	

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F 690	Continued From page 17 A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4b], reflected that the resident had a Brief Interview for Mental Status (BIMS) score [NJ] out of 15 that indicated the resident had NJ Exec Order 26.4b1 . A review of the active PO revealed a PO dated [NJ Exec Order 26.4], to record the residents NJ Exec Order 26.4b1 A review of the Treatment Administration Record (TAR) revealed the NJ Exec Order 26.4b1 was last recorded on [NJ Exec Order 26.4]. On 11/13/24 at 10:53 AM, the surveyor interviewed Licensed Practical Nurse (LPN#2), who is the regular day shift nurse for Resident #83. LPN#2 reviewed the PO for the resident and stated they did not see any recorded [NJ Exec Order 26.4] in the electronic or paper chart. LPN#2 further stated that the PO had been entered incorrectly. On 11/15/24 at 9:24 AM, the US FOIA (b)(6) provided the surveyor with facility policy titled Foley Catheter with a revised date of 2/1/24, under the procedure section of the policy revealed, "3. Monitor resident's output. 4. Document the following in the medical record, a. amount of output." A second facility policy title, "Telephone and Verbal Physicians Orders" with a revised date of 2/2024 revealed, "1. When a physicians' verbal or telephone order is received, the nurse is to read back the order to the doctor before entering the order into Point Click Care (PCC) to ensure accuracy." On 11/18/24 at 1:08 PM, the survey team met	F 690	1. Education and re-education of licensed staff on entering the active physician orders correctly was initiated on 12/03/2024 and ongoing. 2. Education and re-education of licensed staff on adding the necessary supplementary documentation to orders for residents requiring measurement of urinary output was initiated on 11/20/2024 and ongoing. 3. The Director of Nursing (DON) or designee will oversee the education of all nursing staff on entering active physician orders and supplementary documentation on the EMR to record the urinary catheter output of residents with indwelling urinary catheters. This education will continue for all shifts. New hires will receive this training as part of their orientation. Element Four – Quality Assurance 1. On 12/03/2024, the facility initiated a QAPI – Performance Improvement Project identifying the problem of failure to record and document the urinary output of resident with an indwelling urinary catheter. The facility's goal is to ensure the recording and documenting of the urinary output of residents with indwelling urinary catheters per physician orders. 2. The DON or designee will audit weekly five (5) charts and monitor to ensure that	

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F 690	Continued From page 18 with the US FOIA (b)(6) and were made aware of the the findings. The US FOIA (b)(6) stated that it was a mistake. On 11/19/24 at 11:30 AM, the survey met with the US FOIA (b)(6) and no further information or comments were provided. NJAC 8:39-19.4 (a)4,5,6	F 690	the above facility's goal is implemented. 3. Audits and monitoring will be tracked and trended by the DON or designee at weekly QAPI meetings, starting on 12/10/2024, for three (3) months, to establish the baseline and to identify the factors contributing to failure to record urinary catheter output per physician order, and to make the necessary systems correction including the review and update of pertinent facility policies and procedures as well as conducting the staff education/re-education required. Completion Date: December 9, 2024	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		12/9/24

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F 842	Continued From page 19 (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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F 842	Continued From page 20 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for 1 of 28 residents reviewed (Resident # 86). This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #86. According to the Admission Record (a summary of important information about the resident), Resident #86 had diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted]. A quarterly Minimum Data Set (MDS) assessment, dated [redacted], indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #86 scored a [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) [redacted].	F 842	F842 – Resident Records – Identifiable Information Element One – Corrective Actions 1. Provider was immediately contacted to send the [redacted] consult notes on Resident #86 post [redacted]. 2. Provider immediately sent [redacted] consult notes re Resident #86 dated NJ Exec Order 26.4b1 [redacted] 3. A facility-wide audit of the medical records of all the other patients of Provider was conducted to identify any other patients with incomplete medical records. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice.	

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F 842	Continued From page 21 A physician's order dated [NJ Exec Order 26.] documented [NJ Exec Order 26.4b1], give 1 tablet by mouth in the evening for [NJ Exec Order 26.4b1]. A physician's order dated [NJ Exec Order 26.] documented [NJ Exec Order 26.4b1], give 1 tablet by mouth at bedtime for [NJ Exec Order 26.4b1] A physician's order dated [NJ Exec Order] documented [NJ Exec Order 26.4b1], give 1 tablet by mouth one time a day for [NJ Exec Order 26.4b1] A physician's order dated [NJ Exec Order 26.4] documented [NJ Exec Order 26.4b1] give 1 tablet by mouth in the morning for [NJ Exec Order 26.4b1]. A physician's order dated [NJ Exec Order 26.] documented [NJ Exec Order 26.4b1] give 3 tablets by mouth for a total of [NJ Exec Order 26.] at bedtime. A care plan with an initiation date of [NJ Exec Order 26.] included a focus that Resident #86 was at risk for side effects due to use of [NJ Exec Order 26.4b1] medications. An intervention of the care plan indicated [NJ Exec Order 26.4b1] consult as needed/as scheduled". A review of physician progress notes in the hybrid medical record revealed the most recent [NJ Exec Order 26.4b1] consult notes found in the paper chart, were from [NJ Exec Order 26.4b1]. On 11/14/24 at 11:01 AM, the surveyor interviewed the [US FOIA (b)(6)] on the unit about [U.S. FOIA (b) (6)] visits. The [US FOIA (b)] stated the [US FOIA (b)(6)] visited the facility weekly. The [US FOIA (b)] further	F 842	Element Three – Systemic Change 1. Administration educated / re-educated Provider on 11/14/2024 to send/upload their psychiatry consult notes on the EMR in a timely manner. 2. Education of other providers is ongoing. 3. Provider engaged the services of another psychiatry provider to assist with ensuring all psyche notes are made available in a timely manner. 4. The facility engaged the services of an additional provider to ensure visits and documentation are done timely. Element Four – Quality Assurance 1. On 12/03/2024, the facility initiated a QAPI – Performance Improvement Project identifying the problem of incomplete and inaccessible medical records. The facility's goal is to maintain complete and readily accessible medical records for the residents. 2. The DON or designee will audit weekly five (5) charts and monitor to ensure that complete and readily accessible medical records are maintained for the residents. 3. Audits and monitoring will be tracked and trended by the DON or designee at weekly QAPI meetings, starting on 12/10/2024, for three (3) months, to	

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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 842	Continued From page 22 explained the [US FOIA] would follow up with routine residents every three to six months and more frequently if needed. The [US FOIA (b)] reviewed with the surveyor the hybrid medical records and confirmed the last [US FOIA] note was in [NJ Exec Order 26.4b1]. The [US FOIA (b)] stated she recalled the [US FOIA] visiting the resident in [NJ Exec Order 26.4b1] and could not speak why there were no notes after [NJ Exec Order 26.4b1] in Resident #86's medical record. On 11/14/24 at 12:30 PM, the acting [US FOIA (b)(6)] provided the surveyor with the facility's [NJ Exec Order 26.4b1] consult policy. A review of the facility's policy titled "Psychiatric Consult" dated 2024, did not address [U.S. FO] documentation. On 11/14/24 at 1:30 PM, the surveyor informed the [US FOIA (b)(6)] of the concern that there were no [NJ Exec Order 26.4b1] progress notes found after [NJ Exec Order 26.4b1]. The surveyor asked how soon it was expected for the [US FOIA] to have visit notes in a resident's medical records. The [US FOIA (b)(6)] stated their documentation should be in the resident's medical records within three days. The facility to review and provide additional information. The surveyor requested any facility policies related to physician or consultant documentation. On 11/15/24 at 11:35 AM, the [US FOIA (b)(6)] and the acting [US FOIA (b)] met with the survey team. The [US FOIA (b)(6)] stated that they spoke with the [US FOIA] who thought he had left his notes in Resident #86's medical record. The [US FOIA] sent the notes ot the facility that were not in the resident's medical record. The [US FOIA (b)(6)] further explained they reviewed with the	F 842	establish the baseline and to identify the factors contributing to incomplete and/or not readily accessible medical records, and to make the necessary systems correction including the review and update of pertinent facility policies and procedures as well as conducting the staff education/reeducation required. Completion Date: December 9, 2024	

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 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	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
F 842	Continued From page 23 [redacted] the importance of their notes being in the residents' medical records. The [redacted] provided the surveyor with the physician's visits policy and the notes received from the [redacted] A review of the [redacted] visit notes included notes dated [redacted] which were not found in the Resident #86's medical record during surveyor review. A review of the facility's policy titled "Physician Visits and Documentation", with a reviewed date of 11/14/24 under Policy and Procedure revealed: 2. The physician must write, sign, and date progress notes at each visit. These progress notes may be done in a paper chart or electronic format per facility practices. N.J.A.C. 8:39-35.2(d)	F 842		

New Jersey Department of Health

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 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined 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	S 560	S560 – Mandatory Access to Care Element One – Corrective Actions 1. The certified nurse aides (CNA) staffing issue has been and is being addressed by placing sponsored ads online on job platforms as well as posting within the facility. 2. Currently, five (5) CNAs are on vacation and one (1) CNAs are on medical leave of absence. 3. The staffing coordinator was	12/9/24

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

Electronically Signed | 12/11/24

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 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

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S 560	Continued From page 1 effective 2/1/21. 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	S 560	re-educated on 11/20/2024 on the minimum staffing requirements for nursing homes: One Certified Nursing Assistant to every eight residents for the day shift. One Direct care staff member to every 10 residents for the evening shift, provided that no fewer than of all staff members shall be CNA, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. Element Two – Identification of at-Risk Areas All residents have the potential to be affected by this practice. Element Three – Systemic Change 1. Staff re-education was initiated on 11/20/ 2024 by the Administrator 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	

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	061902	A. BUILDING: _____ B. WING _____	C 11/19/2024

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S 560	Continued From page 2 certified nurse aides, for a shift, the number of 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 two-week staffing prior to survey beginning 10/27/2024 and ending 11/9/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 4 of 14 day shifts as follows: - 11/01/24 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs. - 11/02/24 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. - 11/08/24 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. - 11/09/24 had 14 CNAs for 129 residents on the day shift, required at least 16 CNAs. On 11/19/24 at 11:55 AM, the survey met with the facility's Licensed Nursing Home Administrator, Interim Director of Nursing and Administrative	S 560	the acuities of residents in-house, and facility will continue to staff according to State mandatory regulations. 2. The facility continues to hire and offer overtime to maintain at least minimum staffing levels. 3. Wage increases were awarded to CNA staff on July 1, 2024 to improve staff retention. 4. The Administrator and the Human Resources office are proactively exploring other means of recruiting such as partnering up with local colleges that may have a CNA program. 5. Regular meetings are held including the Administrator, Interim Director of Nursing, and Human Resources to review direct care staffing and develop strategies for recruitment and retention of direct care staff. Element Four – Quality Assurance Staffing levels will be monitored once a week for three months, starting 12/10/2024, through the staffing reports that are given to the Administrator and DON. These reports will specify the number of CNAs and professional nurses on each shift. Staffing will be according to the acuities of residents in house. The Administrator and the DON will monitor and ensure that the required minimum direct-care staff-to-resident ratios are met.	

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S 560	Continued From page 3 Assistant to discuss the above concern. There was no additional information provided by the facility.	S 560	Data obtained will be reported at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 9, 2024	
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility	S1405	S1405 – Mandatory Infection Control and Sanitation	12/9/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1405	Continued From page 4 failed to ensure that all newly hired employees had completed the required NJ Ex Order 26.4(b)(1) [redacted]) by the physician or advanced practice nurse within two weeks prior to the first day of employment or upon employment. This deficient practice was identified for 2 of 10 new hired employees whose personnel record were reviewed, as was evidenced by the following: On 11/11/24 at 9:20 AM, the surveyor reviewed the health records for 10 employees hired since August 2023 that revealed the following information: 1.) A review of staff #1's employee records who was a Maintenance Director with a date of hire (DOH) on [redacted] revealed no [redacted] that was performed by the employee health nurse (EHN) nor by a physician prior to DOH . 2.) A review of staff #2's employee records who was a Registered Nurse with a DOH on [redacted] revealed no [redacted] that was performed by a EHN nor by a physician prior to DOH. On 11/15/24 at 1:20 PM, the surveyor met with the Interim Director of Nursing (I/DON) to discuss the above concern. On 11/18/24 at 12:25 PM, the I/DON stated to the surveyor that one of her responsibilities was to perform RN assessment that included vital signs (blood pressure, heart rate, respiratory rate, height and weight) as indicated in the form but could not provide an explanation as to why the two staff did not have their [redacted] done in a timely fashion.	S1405	Element One – Corrective Actions 1. Staff #2 resigned on [redacted]. Regardless, staff #2 had a [redacted] done by their PCP on 06/17/2024. 2. Human Resources Department staff as well as Employee Health Nurse (EHN) were immediately re-educated to ensure that a physical examination is performed on the newly hired staff by the EHN or a physician prior to date of hire. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change Human Resources Department staff and EHN were re-educated on 11/20/2024 to ensure that physical examination is had by newly hired staff prior to date of hire. Element Four – Quality Assurance 1. On 12/03/2024, the facility initiated a QAPI – Performance Improvement Project identifying the problem of deficient pre-employment screening. The facility's goal is to ensure that pre-employment	

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S1405	Continued From page 5 A review of the facility's policy dated 10/2024 titled, "Hiring Process" which revealed under "II. New Hire A. Prior to the first day of employment, the prospective employee is seen by the employee health nurse.... B. The new hire will also obtain a physical examination by employee health physician or advanced nurse practitioner." There was no additional information provided. On 11/19/24 at 11:55 AM, the survey team met with the Licensed Nursing Home Administrator, I/DON and Administrative Assistant. All agreed that the the PE was not done in a timely manner. There was no further information provided.	S1405	verification requirements pertaining to newly hired staff are completed prior to date of hire. 2. The Administrator or designee will audit and monitor new hires on 11/20/2024 onwards to ensure that reference verification, criminal background check, and physical examination of newly hired staff are done prior to date of hire. 3. Audits and monitoring will be tracked and trended by the Administrator at weekly QAPI meetings, starting on 12/10/2024, for three (3) months, to establish the baseline and to identify the factors contributing to failure to complete pre-employment screening requirements, and to make the necessary systems correction including the review and update of pertinent facility policies and procedures as well as conducting the staff education/reeducation required. Completion Date: December 9, 2024	

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	1/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	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 F0558	Correction	ID Prefix F0561	Correction	ID Prefix F0604	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(f)(1)-(3)(8)	Completed	Reg. # 483.10(e)(1), 483.12(a)(2)	Completed
LSC	12/09/2024	LSC	12/09/2024	LSC	12/09/2024
ID Prefix F0607	Correction	ID Prefix F0684	Correction	ID Prefix F0690	Correction
Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	12/09/2024	LSC	12/09/2024	LSC	12/09/2024
ID Prefix F0842	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(h)(1)-(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/09/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/19/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061902 Y1	A. Building B. Wing Y2	1/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	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 S1405	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. #	Completed
LSC	12/09/2024	LSC	12/09/2024	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	
11/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING **01** B. WING _____	**11/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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E 000	Initial Comments Mohawk Meadows 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		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 11/13/2024 to 11/15/2024, and Mohawk Meadows was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. The facility is a 2-story building that was built in 60's, It is composed of Type I fire resistant. The facility is divided into 10- smoke zones. The generator does approximately 80% of the building.	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required	K 223		11/20/24

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

Electronically Signed | 12/12/2024

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 _____	**11/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 223	Continued From page 1 smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/13/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that a door with a self-closing device was kept in the closed position in accordance with NFPA 101:2012 Edition, Sections 7.2.1.8 and 19.2.2.2.7. This deficient practice had the potential to affect 21 residents and was evidenced by the following: An observation on 11/13/2024 at 2:58 PM revealed that the A-1 central bathroom door with self-closing device was held open with plastic bucket. This room had been converted to a storage room for combustible products measured greater than 50 square feet. In an interview at that time, the US FOIA confirmed the finding. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. N.J.A.C 8:39-31.2(e)	K 223	K223 Doors with Self-Closing Devices Element One – Corrective Actions • The A-1 central bathroom door, which was held open by a plastic bucket, was immediately released and returned to the closed position to ensure compliance with the self-closing door requirement. • The Maintenance Director (MD) conducted an inspection of all self-closing doors throughout the facility to ensure they are functioning properly and are not obstructed. • All combustible products in this room have been immediately removed. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Education was given on 12/06/2024 to the maintenance department that a door with a self-closing device must be kept in the closed position. • A policy will be implemented to prevent the propping open of fire-rated or self-closing doors, including signage near all such doors.	

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K 223	Continued From page 2	K 223	Element Four – Quality Assurance • An audit of the doors with self-closing devices will be completed monthly for three (3) months by the Maintenance Director or designee to ensure that these doors are kept in the closed position. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting on 01/21/2025. Completion Date: November 20, 2024	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that exit stair landings and exit stair handrails were marked in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3, 7.2.2.5.5.2, and 7.2.2.5.5.3. This deficient practice had the potential to affect all 130 residents and was evidenced by the following:	K 225	K225 Stairways and Smokeproof Enclosures Element One – Corrective Actions • Marking stripes were applied to all exit stair steps, and the upper surfaces of all exit stair handrails were marked as required by NFPA 101:2012. This was completed immediately to bring the facility into compliance.	12/6/24

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K 225	Continued From page 3 Observations during the tour between 9:15 AM and 3:45 PM in the presence of the [US FOIA] revealed 4 of 4 exit stairways had no marking stripes on the steps and the upper surface of the handrails were not marked as required by the Code. In an interview at that time, the [US FOIA] confirmed the observation. The facility's [US FOIA (b)(6)] was notified of the deficient practice at Life Safety Code exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39 31.2 (e)	K 225	Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Maintenance staff were educated on 12/06/2024 that exit stair landings and exit stair handrails must be marked. • A maintenance schedule will be established for periodic checks to ensure markings remain visible and intact. Element Four – Quality Assurance • An audit of the facility's exit stair landings and exit stair handrails will be completed monthly for three (3) months by the Maintenance Director or designee to ensure that the exit stair landings and exit stair handrails are marked. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting on 01/21/2025. Completion Date: December 06, 2024	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination	K 293		12/6/24

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K 293	Continued From page 4 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 observations and interview on 11/14/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that exit signs had continuous illumination and were served by the emergency lighting system. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: Observations with the US FOIA (b)(6) from 9:15 AM to 3:06 PM revealed the following: A) The exit signs above the corridor doors on A-1 and B-1 hallways were not illuminated. B) The exit signs above the corridor doors on A-2 and B-2 hallways were not illuminated. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.1(c)	K 293	K293 Exit Signage with Continuous Illumination Element One – Corrective Actions • The exit signs above the corridor doors of B1, A2, B2, A1 now have continuous illumination and are served by the emergency lighting system. 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 given on 12/06/2024 to 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. • A maintenance schedule will be established for periodic checks to ensure exit signs are continuously illuminated. Element Four – Quality Assurance • An audit of the exit signages will be completed monthly for three (3) months by the Maintenance Director or designee	

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K 293	Continued From page 5	K 293	to ensure exit signs are illuminated at all times. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting on 01/21/2025. Completion Date: December 06, 2024	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		12/6/24

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K 321	Continued From page 6 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/14/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to protect hazardous areas with doors and was separated by smoke resisting partitions in accordance with NFPA 101: 2012 Edition, Sections 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3,8.3.5.1, 8.4,8.5.6.2 and 8.7. This deficient practice had the potential to affect 45 residents in the identified area, was observed for 1 of 1 door in the facility's laundry and was evidenced by the following: An observation with the US FOIA (b)(6) at 2:20 PM revealed the facility's laundry room was not provide with a door. The door had been removed leaving no resistance of smoke and/or fire to the exit corridor. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.2 (e)	K 321	K321 Hazardous Areas – Enclosures Element One – Corrective Action • The door to the facility's laundry room was immediately re-installed. 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 given on 12/06/2024 to the maintenance department on protecting hazardous areas with doors and separated by smoke-resisting partitions. • A policy will be implemented to protect hazardous areas with doors and keep separated by smoke-resisting partitions. • A maintenance schedule will be established for periodic checks to ensure hazardous areas are protected with doors and separated by smoke-resisting partitions. Element Four – Quality Assurance • An audit of the exit signages will be completed monthly for three (3) months by the Maintenance Director or designee	

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K 321	Continued From page 7	K 321	to ensure that hazardous areas are protected and separated by smoke-resisting partitions. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting on 01/21/2025. Completion Date: December 06, 2024	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * 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	K 324		12/13/24

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K 324	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 11/14/2024 in the presence of US FOIA (b)(6) [redacted] it was determined that the facility failed to A) ensure that 1 of 4 kitchen cooking equipment's wet chemical fire suppression systems nozzles was in the proper position to protect against equipment fire and B) ensure that 1 of 1 kitchen hood suppression systems was inspected monthly in accordance with NFPA 101: 2012 Edition, Section 19.3.2.5.1 and NFPA 96, 17 and 10. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: At 12:12 PM, the surveyor and US FOIA [redacted] observed in the facility kitchen, that the monthly inspection tag was blank and no required monthly inspection of the hood suppression system was logged. At 12:14 PM, the surveyor and US FOIA [redacted] observed 1 of 4 suppression spray nozzles was not positioned to protect the cooking equipment. In an interview at the time, the US FOIA [redacted] confirmed and acknowledged the findings. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 17, 96	K 324	K324 Cooking Facilities – Cooking Equipment Protected Element One – Corrective Actions • The facility contacted vendor on 12/06/2024 to correct the position of the kitchen cooking equipment's wet chemical fire suppression system's nozzle to properly align above the griddle. Vendor will come on 12/13/2024 to correct the nozzle position. • The kitchen hood suppression system was inspected and logged monthly. • In addition, a vendor comes to clean the kitchen hood. 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 given to the maintenance department on 12/06/2024 and to the food service (dietary) department 12/09/2024 that the kitchen cooking equipment's wet chemical fire suppression system's nozzles must be in the proper position to protect against equipment fire. • Education was likewise given to the maintenance department on 12/06/2024	

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K 324	Continued From page 9	K 324	and food service (dietary) department on 12/09/2024 about monthly inspection of the hood suppression system and logging of these inspections. • A maintenance schedule has been established for monthly checks of the kitchen hood suppression system and documentation thereof. Element Four – Quality Assurance • An audit of the facility's documentation of mandatory fire suppression system inspections will be conducted monthly for three (3) months by the Maintenance Director or designee to ensure that the kitchen cooking equipment's wet chemical fire suppression system's nozzles are in the proper position to protect against equipment fire and that the hood suppression system is inspected and logged monthly. Results will be tracked by and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting on 01/21/2025. Completion Date: December 13, 2024	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied,	K 341		12/10/24

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K 341	Continued From page 10 detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/13/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 enclosed courtyard in accordance with NFPA 101: 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72: 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: An observation at 1:06 PM in the presence of the US FOIA [redacted] revealed there was no fire alarm system horn/strobe installed in the enclosed courtyard. In an interview at the time, the US FOIA [redacted] confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 11/15/2024 at 2:23 PM. N.J.A.C. 8:39-31.2(a) NFPA 72	K 341	K341 Fire Alarm System – Installation Element One – Corrective Actions • The facility contacted vendor on 12/10/2024 to do an ocular inspection, take measurements and specifications, procure and install the fire alarm system horn/strobe in the enclosed courtyard. The vendor will come to the facility on 12/13/2024. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Education was given to the maintenance department on 12/06/2024 that the facility must provide fire alarm notification by audible and visible signals for the enclosed courtyard. • A policy will be implemented to provide	

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K 341	Continued From page 11	K 341	fire alarm notification by audible and visible signals for the enclosed yard. Element Four – Quality Assurance • An audit of the enclosed courtyard will be done monthly for three (3) months by Maintenance Director or designee to ensure there is fire alarm notification by audible and visible signals for the enclosed courtyard. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 10, 2024	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 11/13/2024 and 11/14/2024 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that smoke detection sensitivity testing of the smoke	K 345	K345 Fire Alarm System – Testing and Maintenance Element One – Corrective Actions • The facility contacted the vendor on	12/9/24

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K 345	Continued From page 12 detectors were completed in accordance with NFPA 72 National Fire Alarm and Signaling Code [2010 Edition] Section 14.4.5.3.2. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: 1. Observations on 11/13/2024 from 9:10 AM to 3:45 PM revealed smoke detectors were provided in the corridors, the resident rooms, and other concealed areas throughout the building. 2. A review of the facility's Fire Alarm Inspection and Testing Reports for 12/04/2022, 05/15/2023 and 06/03/2024, provided by the US FOIA on 11/14/2024, revealed the reports had no reference to a smoke detection sensitivity test. In an interview at the time of the observations, the US FOIA confirmed the smoke sensitivity testing was not completed on the smoke detectors. The facility's US FOIA (b)(6) and was notified of the deficient practice at Life Safety Code survey exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70,72	K 345	12/09/2024 to do smoke detection sensitivity testing of the smoke detectors in the corridors, resident rooms, and other areas throughout the building. The facility is waiting from vendor for a definite date for the smoke detection sensitivity testing to be done on the smoke detectors. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Education was given to the maintenance department on 12/06/2024 that the facility must have smoke detection sensitivity testing done on the smoke detectors in the corridors, resident rooms, and other areas throughout the building. • A maintenance schedule will be established for periodic checks to ensure smoke detection sensitivity testing is done on the smoke detectors throughout the building. Element Four – Quality Assurance • An audit of the maintenance logs will be done monthly for three (3) months by Maintenance Director or designee to ensure that the mandatory testing and inspections are done in a timely manner. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025.	

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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
K 345	Continued From page 13	K 345		
			Completion Date: December 09, 2024	
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 review of other facility documentation in the presence of US FOIA (b)(6) on 11/14/2024, it was determined that the facility failed to maintain the sprinkler system by not performing an electric fire pump monthly test in accordance with NFPA 101:2012 Edition, Section 19.3.5.1, 4.6.12 and 9.7.5 and NFPA 25. This deficient practice had the potential to affect all 130 residents and was evidenced by the following:	K 353	K353 Sprinkler System – Maintenance and Testing Element One – Corrective Actions • The facility scheduled with the vendor this month's fire pump test. • Monthly fire pump test has been scheduled with the vendor to be done automatically.	12/10/24

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	315044	A. BUILDING **01** B. WING _____	**11/19/2024**

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K 353	Continued From page 14 A documentation review at 10:22 AM revealed no record or log indicating monthly electric fire pump churn testing was conducted as required. In an interview at 11:15AM, the US FOIA stated that the fire pump was tested and inspected quarterly by the facility fire sprinkler vendor and provided the following dates: 03/07/24, 04/26/24, 06/03/24 and 07/24 (Fire Pumps Weekly/Monthly Operating Tests). The missed monthly tests of 9/23, 10/23, 11/23, 1/24, 2/24, 5/24, 8/24, 9/24 and 10/24 were not provided. The US FOIA stated that he did not have documents on the missed months. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-312(e) NFPA 25	K 353	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 given to the maintenance department on 12/06/2024 that the fire pump test must be done and logged monthly. • A maintenance schedule will be established for periodic checks to ensure monthly fire pump tests are completed timely. Element Four – Quality Assurance • An audit of the facility's documentation of mandatory inspections and tests will be conducted monthly for three (3) months by the Maintenance Director or designee to ensure that the mandatory monthly inspections are done. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 10, 2024	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355		12/6/24

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K 355	Continued From page 15 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 observations and interview on 11/13/2024 and 11/14/2024 in the presence of US FOIA (b)(6) it was determined that the facility failed to perform and document on the tag attached to the fire extinguishers, a monthly visual examination for 35 of 35 fire extinguishers in accordance with NFPA 101:2012 Edition, Section 19.3.5.12,9.7.4.1 and NFPA 10:2010 Edition, Sections 7.2.2(3) and 7.2.3. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: Observations between 9:15 AM to 3:45 PM with the US FOIA revealed 35 of 35 portable fire extinguishers were overdue for monthly inspection. The last date was 10/02/2024. In an interview at that time, the US FOIA confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 10	K 355	K355 Portable Fire Extinguishers – Monthly Examination Element One – Correction Actions • Visual examination of the 35 of 35 portable fire extinguishers has been done and documented on the tag attached to the 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 given to the maintenance department on 12/06/2024 regarding the regulation requiring visual inspection of the fire extinguisher when initially placed in service and thereafter at approximately 30-day intervals, or more frequently when circumstances require. • Maintenance schedule has been re-established to conduct the visual inspection of portable fire extinguishers every 30 days. Element Four – Quality Assurance • An audit of all portable fire extinguishers	

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K 355	Continued From page 16	K 355	in the facility will be conducted for three (3) months by the Maintenance Director or designee to ensure that the required monthly visual examinations thereof are done every 30 days. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 06, 2024	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by:	K 362		12/10/24

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K 362	Continued From page 17 Based on observations and interview on 11/13/2024 and 11/14/2024 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that 2- hour rated corridor walls were maintained in accordance with NFPA 101: 2012 Edition, Section 19.3.6.2. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: 1. During documentation review on 11/13/2024 at 10:10 AM, the surveyor observed that facility's building plan indicated corridor walls were 2-hours fire-rated. 2. Observations with US FOIA on 11/14/2024 revealed penetrations in 8 of 8 corridor walls above corridor doors in the ceiling were sealed with Non-fire rated material (spray foam). In an interview at the time, the US FOIA stated spray foam should not be used but it was done before his time and acknowledged the findings. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.1(c)	K 362	K362 Corridors – Construction of Walls Element One – Corrective Actions • The facility started sealing the corridor walls above corridor doors in the ceiling with fire-rated material on 12/06/2024 and completed the re-sealing on 12/10/2024. • All the corridor walls above corridor doors in the ceiling have been sealed with 2-hour fire-rated material on 12/10/2024. Element Two - Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Education was given to the maintenance department on 12/06/2024 that corridor walls above corridor doors in the ceiling must be sealed with fire rated material and on maintaining 2-hour rated corridor walls. • A policy will be implemented to protect hazardous areas with doors and keep separated by smoke-resisting partitions. Element Four – Quality Assurance • An audit of the building will be conducted monthly for three (3) months by the Maintenance Director or designee to check that the corridor walls above corridor doors in the ceiling are sealed with fire-rated material. Results will be tracked and reported to the Administrator	

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K 362	Continued From page 18	K 362	who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 10, 2024	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In	K 363		12/6/24

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K 363	Continued From page 19 sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 11/13/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Sections 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: During the tour from 9:15 AM to 3:45 PM, the surveyor, US FOIA (b)(6) observed the following: 1) The set of corridor doors between the A-2 solarium and the A-2 hallway had a gap between the meeting edges when tested by US FOIA (b) [redacted] 2) The set of corridor doors between the B-2 solarium and the B-2 hallway had a gap between the meeting edges when tested by US FOIA (b) [redacted] 3) The set of corridor doors between the B-1 solarium and the B-1 hallway had a gap between the meeting edges when tested by US FOIA (b) [redacted] 4) The set of corridor doors between the B-1 solarium and the B-1 hallway had a gap between	K 363	K363 Corridor - Doors Element One – Corrective Actions • The gap between A2 solarium and the A2 hallway, B2 solarium and the B2 hallway, A1 solarium and A1 hallway and B1 solarium and B1 hallway have been closed. Element Two – Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • Education was given to the maintenance department on 12/06/2024 that there must be no gaps between the meeting edges of the set of corridor doors so that corridor doors are able to resist the passage of smoke. • A maintenance schedule will be established for periodic checks to ensure there is no gap between the meeting	

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K 363	Continued From page 20 the meeting edges when tested by US FOIA (b) The gaps between the meeting edges of these 4 sets of doors measured greater than 1/4-inch. In an interview at the time, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	edges of the set of corridor doors to resist the passage of smoke. Element Four – Quality Assurance • An audit of the building will be completed monthly for three (3) months by the Maintenance Director or designee to ensure that there is no gap between the meeting edges of the set of corridor doors in order to resist the passage of smoke. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 06, 2024	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/13/2024 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure 4 of 78 residents bathroom ventilation systems	K 521	K521 HVAC Element One – Corrective Actions • The facility replaced parts for the repair	12/12/24

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K 521	Continued From page 21 and 78 of 78 Air Conditioning units (AC) were functionally maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: Observations in the presence of the US FOIA revealed the following: 1. In room B-122, B-124, B-221 and B-223, the ventilation in the bathrooms were not working when it was tested by the MD. 2. All 78 residents Air Condition Units (AC units) had dirty filters with an accumulation of dust and debris. In an interview at the time, the US FOIA (b)(6) confirmed that the exhaust vents in the resident room bathrooms were not functioning when tested and acknowledged that all 78 AC unit filters were dirty. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.2(e) NFPA 90 A	K 521	of the ventilation system of 4 of 78 identified resident bathroom ventilation systems to ensure proper function. All 78 resident bathroom ventilation systems are now functioning. • All the 78 Air Condition Units have been immediately cleaned. 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 given to the maintenance department on 12/06/2024 about properly and functionally maintaining the ventilation systems in resident bathroom exhaust systems as well as the AC units. • A maintenance schedule will be established for periodic checks to ensure bathroom exhaust systems in all resident bathrooms are functioning at all times. Element Four – Quality Assurance • An audit of the resident bathroom ventilation systems will be completed monthly for three (3) months by the Maintenance Director or designee to monitor that facility resident bathroom ventilations are properly maintained to ensure proper function. • An audit of the AC units will be completed monthly for three (3) months by the Maintenance Director or designee	

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K 521	Continued From page 22	K 521	to ensure the AC unit filters are clean and the AC units are functionally maintained. • Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 12, 2024	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 11/14/2024 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire conditions in accordance with NFPA 101; 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 12 of 12 fire drills, had the potential to affect all 130 residents in the facility and was evidenced by the following: At 10:19 AM, the surveyor reviewed the facility's	K 712	K712 Fire Drills Element One – Corrective Actions • Education was given to facility staff that fire drills: o include the transmission of a fire alarm signal and simulation of emergency fire conditions, and o are held at expected and unexpected times under varying conditions, at least quarterly on each shift.	12/6/24

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K 712	Continued From page 23 fire drill reports which revealed the following: a) Duplicate copies for 12 of 12 months were provided without variation. b) No records indicating staff participated in the drills for 12 of 12 months. c) Records provided did not indicate fire drills were conducted with varying activation types and simulation of a specific emergency for the fire condition. In an interview at that time, the US FOIA confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit on 11/15/2024 at 2:23 PM. NJAC 8:39-31.2(e)	K 712	• Staff were educated that staff participation is included in the facility's fire drill reports. • Staff were educated that they must be familiar with fire drill procedures and should be aware that fire drills are part of established routine. Element Two – Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • The facility policy and procedure on fire drills has been reviewed and updated to indicate that: o Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions, o Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. o Staff participation is included in the facility's fire drill reports. • Staff must be familiar with fire drill procedures and should be aware that fire drills are part of established routine. • Staff education was initiated on 12/06/2024 on the reviewed and updated policy regarding fire drills and ongoing. Element Four – Quality Assurance • An audit of the fire drill reports will be done monthly for three (3) months by Maintenance Director or designee to	

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K 712	Continued From page 24	K 712	ensure that fire drills are provided (a) with variation, (b) with varying activation types and simulation of a specific emergency for the fire condition, and (c)that fire drill reports indicate staff who participated in the fire drill. • Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 06, 2024	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 11/13/2024 and 11/14/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that	K 761	K761 Maintenance, Inspection & Testing – Doors Element One – Corrective Actions	12/10/24

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K 761	Continued From page 25 the fire doors assemblies were inspected, tested and documented annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101:2012 Edition, Section 19.7.6,8.3.3.1 and NFPA 80: 2010 Edition, Section 5.2,5.2.3. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: Observations with US FOIA (b)(6) during the tour on 11/13/2024 from 9:15 AM to 3:45 PM, revealed fire rated doors at various locations including, horizontal exit, hazardous enclosures and exits. A documentation review on 11/14/2024 at 9:25 AM revealed that facility did not provide a policy and procedures for fire door assemblies and no documentation to indicate fire door assemblies were inspected and tested annually. In an interview at the time, the [redacted] confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	• The facility developed a policy and procedures for fire door assemblies that includes documentation to indicate fire door assemblies are inspected and tested annually. • On 12/10/2024 the facility contacted a vendor who can demonstrate knowledge and understanding of the operating components of fire doors assemblies, inspect, test, and document annually. Element Two – Identification of at-Risk Areas • All residents have the potential to be affected by this practice. Element Three – Systemic Change • The facility will implement the policy to inspect, test annually, and document fire door assemblies. • Education was given to the maintenance department on 12/06/2024 that fire doors assemblies are inspected, tested and documented annually by an individual who could demonstrate knowledge and understanding of the operating components. Element Four – Quality Assurance • An audit of the fire doors will be completed by the Maintenance Director/Supervisor by mid-January 2025 to determine which fire door assemblies need to be inspected, tested and documented annually. • Results will be tracked and reported to	

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 _____	**11/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	**1 O'BRIEN LANE** **LAFAYETTE, NJ 07848**

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K 761	Continued From page 26	K 761	the Administrator who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 10, 2024	
K 914 SS=F	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, documentation review and interview on 11/13/2024 and 11/14/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to functionally	K 914	K914 Electrical Systems – Maintenance and Testing Element One – Correction Actions	12/15/24

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	315044	A. BUILDING **01** B. WING _____	**11/19/2024**

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K 914	Continued From page 27 test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was identified in 75 of 78 resident rooms observed, had the potential to affect all 130 residents and was evidenced by the following: A documentation review beginning on 11/13/2024 at 09:15 AM, revealed there were annual electrical reports for 2022, 2023 and 2024 on non-hospital grade outlets. This documentation did not indicate who performed the inspection, what tests were performed or the result values. In an interview, the US FOIA confirmed that the facility had non-hospital outlets installed in resident rooms and other locations but could not provide any further documentation. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.2(e) NFPA 99	K 914	• The facility purchased hospital-grade outlets on 12/05/2024 to replace the non-hospital grade outlets in the building. • The facility started the hospital-grade outlet installation process and will complete on 12/15/2024. 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 given to the maintenance department on 12/06/2024 on the regulation requiring annual inspection of the electrical system including the electrical outlets as well as documentation of the annual electrical report including what tests were performed or the result values. • A maintenance schedule will be established for periodic checks to ensure mandatory inspections, including the annual electrical inspection, are completed and adequately documented. Element Four – Quality Assurance • An audit of the facility's documentation of mandatory annual electrical system inspections will be conducted every December 1st by the Maintenance Director/Supervisor to ensure that the mandatory inspections are done per required schedule/frequency. Results will be tracked and reported to the	

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K 914	Continued From page 28	K 914	Administrator who will provide the results in aggregate at the quarterly QAPI meeting. Completion Date: December 15, 2024	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		12/10/24

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K 918	Continued From page 29 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 observations, interviews, and record review of facility documents on 11/13/2024 and 11/14/2024 in the presence of US FOIA (b)(6) [redacted] it was determined that the facility failed to a) Perform a weekly non-load test or inspection, b) conduct fuel quality test for emergency generator, c) ensure the emergency generator assumed the building load within 10 seconds of a power failure and d) ensure a remote manual stop station for the generator was provided in accordance with NFPA 99: 2012 Edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 Edition, Section 5.6.5, 5.6.5.1, 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, 8.4.9.1 to 8.4.9.7. These deficient practices had the potential to affect all 130 residents and were evidenced by the following: 1. On 11/13/2024 at 12:18 PM, the Surveyor, US FOIA [redacted] observed that the emergency generator was outside and encased. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. An interview at the time, the US FOIA (b)(6) both confirmed the finding. 2. A documentation review on 10/14/2024 for the emergency generator provided by the US FOIA [redacted] revealed the following:	K 918	K918 Electrical Systems – Essential Electric System Maintenance and Testing Element One – Corrective Actions • The facility performed a weekly non-load test or inspection on 12/03/2024, which included checking that the emergency generator assumed the building load within 10 seconds of a power failure. • The facility ordered a diesel fuel quality testing kit for the emergency generator on 12/10/2024. • The facility ordered the relay on 12/06/2024 for the remote manual stop station (remote emergency stop button) for the facility's 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 given to the maintenance department on the following: o The generator must be capable of supplying service within 10 seconds. o Maintenance and testing of the	

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K 918	Continued From page 30 a) The provided inspection document from the US FOIA did not indicate any weekly generator inspection or testing. b) There was no record that a diesel fuel sample analysis test had been conducted. No further documentation was provided regarding a diesel fuel sample analysis test. c) The monthly generator records for 9/1/2024 and 9/7/2024 did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. In an interview at the time, US FOIA (b)(6) confirmed and acknowledged the findings. The facility's US FOIA (b)(6) was informed of the deficient practices during the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	generator and transfer switches are performed. o 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. o The remote manual stop station is necessary to prevent inadvertent or unintentional operation. o Written records of maintenance and testing are maintained and readily available. • A maintenance schedule will be established for periodic checks to ensure the weekly non-load test or inspections are completed timely, that the diesel fuel quality testing is done as needed, and that there is a functioning remote manual stop station. Element Four – Quality Assurance • An audit of the emergency generator system will be completed by the Maintenance Director/Supervisor monthly to ensure (a) the generator must be capable of supplying service within 10 seconds; (b) maintenance and testing of the generator and transfer switches are performed; (c) 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; (d) the installation of the remote emergency stop button has been completed and is usable to prevent inadvertent or unintentional operation. Results will be tracked and reported to the Administrator who will	

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K 918	Continued From page 31	K 918	provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 10, 2024	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3,	K 921		12/6/24

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K 921	Continued From page 32 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 11/13/2024 in the presence of the [US FOIA (b)(6)] [redacted], it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, and 10.5.8. This deficient practice had the potential to affect all 130 residents and was evidenced by the following: A documentation review on 11/13/2024 revealed there was no policy on patient care related electrical equipment. In an interview at the time, the [redacted] stated they checked all PCREE equipment but could not provide a policy and procedure for testing of the equipment or evidence of annual testing and maintenance program for PCREE. The facility's [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	K921 Electrical Equipment – Testing and Maintenance Element One – Corrective Actions • The facility developed an electrical policy for all the patient care-related electrical equipment (PCREE), which provides for annual testing of the equipment and documentation of the annual testing and maintenance program for the PCREE. • The facility is taking an inventory of all PCREE in the building to identify all PCREE that need documented annual testing and maintenance. Element Two - Identification of at-Risk Areas • All Residents have the potential to be affected by this practice. Element Three – Systemic Change • Education was given to the maintenance department on 12/06/2024 on the facility policy and procedure on the maintenance program for the PCREE and ongoing. • The facility will conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs. • A maintenance schedule will be established for periodic checks to ensure that all PCREE in the building are annually tested and maintained.	

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K 921	Continued From page 33	K 921	Element Four – Quality Assurance • An audit of the PCREE will be completed monthly for three (3) months by the Maintenance Director or designee to ensure that the PCREE in the facility are annually tested under the PCREE maintenance program and documented/logged. Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI meeting scheduled on 01/21/2025. Completion Date: December 06, 2024	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923		12/6/24

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K 923	Continued From page 34 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/13/2024 and 11/14/2024 in the presence of the US FOIA (b)(6) it was determined that the facility failed to a) store cylinders of compressed oxygen in a manner that would protect it against tipping and rupture and b) separate full portable oxygen cylinders from empty portable oxygen cylinders to avoid confusion in an emergency in accordance with NFPA 99: 2012 Edition, Sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. This deficient practice was evidenced for 1 of 1 oxygen storage rooms observed, 1 of 76 resident's rooms observed and was evidenced by the following: 1) An observation with US FOIA on 11/13/2024 at 1:06 PM in resident room NJ Exec Order, revealed one full portable oxygen tank was free standing not	K 923	K923 Gas Equipment – Cylinder and Container Storage Element One – Corrective Actions • The facility immediately removed the free-standing oxygen tank from resident room NJ Exec Orde and put away to storage. • The main oxygen storage room was immediately organized to separate full portable oxygen cylinders from empty portable oxygen cylinders. • Full portable oxygen cylinders are now on one rack with the label identifying the cylinders as full, and empty portable oxygen cylinders on another rack with label identifying these cylinders as empty.	

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K 923	Continued From page 35 secured against tipping and rupture. In an interview at the time, the US FOIA confirmed the observation. 2) Observations with US FOIA on 11/14/2024 at 2:16 PM in main oxygen storage room revealed 13 Empty tanks were in Full tank storage racks. In an interview at the time, the US FOIA confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/15/2024 at 2:23 PM. NJAC 8:39-31.2(e) NFPA 99	K 923	Element Two - Identification of at-Risk Areas • All Residents have the potential to be affected by this practice. Element Three – Systemic Change • Education was given to the maintenance department on 12/06/2024 about checking that full oxygen tanks in the building are not free standing and are secured against tipping and rupture. • Education was also given to the maintenance department on 12/06/2024 to separate full portable oxygen cylinders from empty portable oxygen cylinders to avoid confusion in an emergency. • A maintenance schedule will be established for periodic checks to ensure that portable oxygen cylinders are (a) secured against tipping and rupture, and (b) full portable oxygen cylinders are stored separately and distinctly from empty portable oxygen cylinders. Element Four – Quality Assurance • An audit of the portable oxygen cylinders will be completed monthly for three (3) months by the Maintenance Director or designee to ensure that (a) full oxygen tanks in the building are not free standing and are secured against tipping and rupture, and (b) full portable oxygen cylinders are stored separately from empty portable oxygen cylinders to avoid confusion in an emergency. • Results will be tracked and reported to the Administrator who will provide the results in aggregate at the quarterly QAPI	

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K 923	Continued From page 36	K 923	meeting scheduled on 01/21/2025. Completion Date: December 06, 2024	

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	1/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	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 K0223	11/20/2024	LSC K0225	12/06/2024	LSC K0293	12/06/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	12/06/2024	LSC K0324	12/13/2024	LSC K0341	12/10/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	12/09/2024	LSC K0353	12/10/2024	LSC K0355	12/06/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0362	12/10/2024	LSC K0363	12/06/2024	LSC K0521	12/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0712	12/06/2024	LSC K0761	12/10/2024	LSC K0914	12/15/2024

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

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	1/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	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	ID Prefix	Reg. #	LSC	DATE Y5	Correction Completed
		NFPA 101	K0918		12/10/2024
		NFPA 101	K0921		12/06/2024
		NFPA 101	K0923		12/06/2024

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

FOLLOWUP TO SURVEY COMPLETED ON 11/19/2024

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