STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING _____ B. WING _____	02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS STANDARD SURVEY: 02/06/23 CENSUS: 74 SAMPLE: 18+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		2/13/23

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

Electronically Signed | 02/15/2023

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

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F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure a comprehensive care plan was developed for a resident who was NJ ex order 26.4b1 NJ ex order 26.4b1 (Resident #18). This deficient practice was identified for 1 of 18 residents reviewed for care plans and was evidenced by the following:	F 656	Resident number 8 care plan NJ Ex Order 26.4b was immediately initiated. A facility wide care plan audit was completed on all residents on pain medications or at risk of pain. The Regional IP reeducated all staff responsible for completion of care plans and the policy on comprehensive care plans was reviewed. All residents in the facility have the	

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F 656	Continued From page 2 On 01/24/2023 at 11:30 AM, Resident #18 was observed awake and in bed. Resident #18 stated that the staff NJ ex order 26.4b1 [redacted] According to the Admission Record, Resident #18 was admitted to the facility in NJ ex order 26.4b1 with diagnoses which included but were not limited to; NJ ex order 26.4b1 [redacted] A review of the Quarterly Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b1 revealed that the resident had a Brief Interview for Mental Status (BIMS) of NJ ex which indicated that the resident NJ ex order 26.4b1. An additional review of the MDS revealed that the resident NJ ex order 26.4b1 [redacted] A review of Resident #18's Physician's Progress notes dated, NJ ex order 26.4b1 at 8:52 PM, NJ ex order 26.4b1 at 8:16 AM, NJ ex order 26.4b1 at 3:29 PM, NJ ex order 26.4b1 at 8:01 PM, and NJ ex order 26.4b1 at 7:18 PM, revealed that the resident had NJ ex ord NJ ex order 26.4b1 " NJ ex order 26. [redacted] A review of the resident's Order Summary Report which listed active physician's orders (PO) as of NJ ex order 26.4b1 reflected the following POs: An order dated NJ ex order 26.4b1, for NJ ex order 26.4b1 [redacted]	F 656	potential to be affected by the deficient practice. The DON or designee will conduct random daily audits on all care plans for all in house residents at risk of pain or on pain medications. Audits will be monitored for completion by the Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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F 656	Continued From page 3 An order dated NJ ex order 26.4b1, for NJ ex order 26.4b1 [redacted] An order dated NJ ex order 26.4b1 [redacted] and An order dated NJ ex order 26.4b1, for NJ ex order 26.4b1 [redacted] A review of the resident's NJ ex order 26.4b1 NJ ex order 26.4b1, and NJ ex order 26.4b1 Electronic Medical Administration Record (EMAR) reflected the above physician's orders. A review of Resident #18's care plans from the Electronic Medical Record (EMR) revealed there was no care plan developed for the resident's NJ ex order 26.4b1. On NJ ex order 26.4b, the US FOIA (B) (6) [redacted] (who was covering for the US FOIA (B) (6) [redacted] provided an updated care plan for Resident #18 which was created on NJ ex order 26.4b. The care plan included the resident was at risk for NJ ex order 26.4b1, and interventions were added which NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted] During an interview with the surveyor on NJ ex order 26.4b1 at 10:20 AM Licensed Practical Nurse (LPN #1) stated Resident #18 NJ ex order 26.4b1 and should have a care plan for NJ Ex Ord because the	F 656		

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F 656	Continued From page 4 resident used [NJ Ex Ord] medication. During an interview with the surveyor on 02/02/23 at 10:32 AM the US FOIA (B) (6) stated that she was primarily responsible to complete resident care plans, but the nurses could also complete them. She stated care plans were reviewed quarterly unless there were any changes. The surveyor reviewed Resident #18's care plan, PO, and EMAR with the [U.S. FOI]. She stated Resident #18 was on NJ ex order 26.4b1 and confirmed that the care plan was initiated for [NJ ex ord] on [NJ ex order 26.4b1]. The [US FOIA] stated the NJ ex order 26.4b1 should have been initiated prior to [NJ ex order 26.4b1]. During an interview with the surveyor on 02/02/23 at 11:43 AM the US FOIA (B) (6) stated care plans were updated 48 hours after a change, reviewed quarterly, or when there was a change in condition. She stated the [US FOIA] was responsible for updating care plans. The surveyor reviewed Resident #18's care plan and EMAR with the US FOIA (B) (6). The US FOIA (B) (6) stated that [NJ ex order 26.4b1] should have been on Resident #18's care plan. During a follow up interview with the surveyor on 02/03/23 at 12:34 PM, the US FOIA (B) (6) confirmed that Resident #18's care plan was not in place prior to surveyor inquiry and was completed by a regional U.S. FOIA (b) (6). A review of the facility's "Comprehensive Care Plans" policy, revised on 09/2022, included that it was the facility policy to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and	F 656		

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F 656	Continued From page 5 psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will describe at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial well-being. The comprehensive care plan will be prepared by an interdisciplinary team that includes but is not limited to: the attending physician, a registered nurse with responsibility for the resident. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. NJAC 8:39-11.2(e)	F 656		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to a.) maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey for 14 of 14-day shifts reviewed and b.) ensure staff NJ ex order 26.4b1 [redacted] for the NJ ex order 26.4b1 season as per statute and facility policy. This deficient practice was evidenced by the following: Findings include: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	The facility continues to follow a recruitment plan to attract Certified Nurse assistants' staff and licensed nurses to meet the ratio requirement. Leadership has met and will continue to meet on an ongoing basis to identify staffing challenges and areas of improvement for licensed certified nursing needs. All residents in the facility have the potential to be affected by the deficient practice. Ongoing efforts to recruit and retain staff are in place: Bonus shifts, referral bonus program and CAN school programs.	2/13/23

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

Electronically Signed | 02/15/23

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility for the weeks of 01/08/2023 to 01/14/2023 and 01/15/2023 to 01/21/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -01/08/23 had 5 CNAs for 85 residents on the day shift, required 11 CNAs. (17 residents per CNA) -01/09/23 had 7 CNAs for 84 residents on the day shift, required 10 CNAs. (12 residents per CNA) -01/10/23 had 9 CNAs for 84 residents on the day shift, required 10 CNAs. (9.33 residents per CNA) -01/11/23 had 6 CNAs for 83 residents on the day shift, required 10 CNAs. (13.83 residents per CNA) -01/12/23 had 7 CNAs for 80 residents on the day shift, required 10 CNAs. (11.42 residents per CNA) -01/13/23 had 8 CNAs for 80 residents on the	S 560	The facility continues to conduct job fairs with immediate interviews and contingency offers. The facility will began expedited but robust onboarding process to new hires. The DON/designee meets with the staffing coordinator daily to review call outs and facility census vs staffing needs. The DON/designee will monitor ratios weekly until the requirement is met. The results of the audits will be forwarded to the facility administrator and monthly QAPI committee for further recommendations.	

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S 560	Continued From page 2 day shift, required 10 CNAs. (10 residents per CNA) -01/14/23 had 5 CNAs for 76 residents on the day shift, required 9 CNAs. (15.2 residents per CNA) -01/15/23 had 5 CNAs for 75 residents on the day shift, required 9 CNAs. (15 residents per CNA) -01/16/23 had 7 CNAs for 75 residents on the day shift, required 9 CNAs. (10.71 residents per CNA) -01/17/23 had 7 CNAs for 75 residents on the day shift, required 9 CNAs. (10.71 residents per CNA) -01/18/23 had 6 CNAs for 75 residents on the day shift, required 9 CNAs. (12.5 residents per CNA) -01/19/23 had 6 CNAs for 75 residents on the day shift, required 9 CNAs. (12.5 residents per CNA) -01/20/23 had 7 CNAs for 75 residents on the day shift, required 9 CNAs. (10.71 residents per CNA) -01/21/23 had 7 CNAs for 75 residents on the day shift, required 9 CNAs. (10.71 residents per CNA) During an interview with the surveyor on 2/3/23 at 10:08 AM with the Administrator, he stated that he was aware of the staffing requirements. When asked if he is meeting the requirements, the Administrator stated "yes, we are." During an interview with Staffing Coordinator (SC) on 2/3/23 at 10:10 AM, she confirmed that she was aware of the staffing requirements. The SC also reported that they staff based on the census, needs of the facility, and availability. The facility was unable to provide any requested Policy or Procedures regarding Daily Staffing. 2. Reference: New Jersey Department of Health (NJDOH) memo, dated 10/7/2020, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 26:2H-18.79, Influenza vaccination in health care facilities", indicated the New Jersey Governor	S 560		

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S 560	Continued From page 3 signed into law P.L. 2019 c. 330 (codified at N.J.S.A. 26:2H-18.79 and referred to hereafter as "the Statute") effective 1/13/2020, in which healthcare facilities are required to: For the purposes of its annual influenza vaccination program, each health care facility shall:(1) annually provide an on-site or off-site influenza vaccination to each of its employees;(2) require that each employee at the facility receive an influenza vaccination annually, no later than December 31 of the current influenza season as determined by the federal Centers for Disease Control and Prevention, which vaccination shall be provided by the health care facility, except that an employee may, in lieu of receiving the influenza vaccination at the facility, present acceptable proof, comprising:(a) an attestation from the employee, which shall be submitted in a form and manner designated by the facility, of a current influenza vaccination if the employee receives the vaccination from another vaccination source, which attestation shall include the lot number of the vaccination the employee received or;(b) a medical exemption, which shall be submitted using a form designated by the Department of Health, stating that the influenza vaccination for that employee is medically contraindicated, as enumerated by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention. An attestation of a medical exemption shall be subject to approval by the facility following a review by the facility to confirm the medical exemption is consistent with standards enumerated by the Advisory Committee on Immunization Practices;(3) maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee and report to the Department of Health,	S 560		

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S 560	Continued From page 4	S 560		

in a manner and according to a schedule prescribed by the commissioner, the vaccination percentage rate of its workforce in receiving influenza vaccinations as part of the facility's annual vaccination program or by other means as attested to by the workforce, as applicable. The report may also include other information that the facility deems relevant to its vaccination percentage rate, including, but not limited to, the number of employees who received medical exemptions.

During the entrance conference on 01/24/23 at 10:36 AM, the surveyor requested the NJ ex order 26.4b1 NJ ex order 26.4b1 record for the facility staff.

On 02/02/22, the surveyor reviewed the updated document titled "Ashbrook Employee Influenza Vaccination Audit" provided by the Infection Preventionist (IP) which reflected 3 out of 131 staff members were NJ ex order 26.4b1 .

On 02/03/23 at 10:21 AM, the surveyor interviewed the administrator who stated he was aware of the New Jersey directive for all staff to have received the NJ ex order 26.4b1 by NJ ex order 2 of each year. The administrator stated that the facility had provided free NJ Ex Order 26.4(b)(1) clinics and had given the staff the opportunity to provide their NJ Ex from an outside source. The administrator further stated that all staff should have been NJ ex order 26.4b1 by NJ ex order 26.4b1 .

On 02/03/23 at 11:21 AM, the surveyor interviewed the IP who confirmed that 131 staff members were eligible for the NJ ex order 26.4b1 . The IP stated that the facility was in a NJ ex order 26.4b1 that started on NJ ex order 26.4b1 and they had to NJ ex order 26 a NJ ex order 26.4b1 clinic that was scheduled on

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S 560	Continued From page 5 NJ ex order 26.4b1 but NJ ex order 26.4b1. The IP stated that the staff that were not NJ Ex Order 26.4(b)(1) for the NJ E were educated and disciplined. A review of the facility's policy titled, "Influenza Vaccination", with a revised date of 09/15/2020, revealed that staff members are required to receive an influenza vaccination annually, no later than December 31 of the current influenza season as determined by the Centers for Disease Control and Prevention. In lieu of receiving the influenza vaccination at the facility, the employee may present acceptable proof, comprising: (a) of a copy of vaccination record from another vaccination source for the current influenza season or: (b) of a medical exemption, which shall be submitted using a form designated by the New Jersey Department of Health, stating that the influenza vaccination for the employee is medically contraindicated.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315064 Y1	A. Building B. Wing Y2	3/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

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 F0656	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/13/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062002 Y1	A. Building B. Wing Y2	3/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/13/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/6/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD** **SCOTCH PLAINS, NJ 07076**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 1/25/2023 and 1/26/2023 and Ashbrook Care and Rehabilitation Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Ashbrook Care and Rehabilitation Center is a Single-story, Type II Un-Protected building that was built in January 1965. The facility is divided into 8 smoke zones. The facility has a Natural Gas and a Diesel Emergency Generators.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/25/2023 and 1/26/2023, in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light above one (1) of one (1) emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the	K 291	A battery backup emergency light has been installed for the [redacted] transfer switch located in the basement. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 months. The completion of audits will be monitored	2/14/23

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

Electronically Signed | 02/16/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD** **SCOTCH PLAINS, NJ 07076**

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K 291	Continued From page 1 following: On 01/25/2023 (day one of survey) during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments and if the facility had an Emergency Generator. The US FOIA told the surveyor, "yes we have two (2), a Natural Gas Emergency Generator and a Diesel Emergency Generator." On 1/26/2023 (day two of survey) at approximately 10:42 AM an inspection in the basement where the NJ Ex Order 2 (natural gas) emergency generator transfer switch is located was performed. The surveyor observed no evidence of a battery back up emergency light in the area for the NJ Ex Order 2 generator transfer switch. At that time, the surveyor asked the U.S. FOI "Do you have a battery back up emergency light for the transfer switch?" The U.S. FO told the surveyor, "no we don't." The US FOIA confirmed the finding at the time. The surveyor informed the U.S. FOIA (b) (6) of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	
K 293 SS=E	Exit Signage	K 293		2/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD** **SCOTCH PLAINS, NJ 07076**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 2 CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/25/2023 in the presence of facility management, it was determined that the facility failed to provide 6 illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction	K 293	An illuminated exit signs has been installed by the corridor double smoke door next to room 34, room 62, room 1, room 31, 2 illuminated exit sign has been installed in the front outside courtyard. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 months. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD** **SCOTCH PLAINS, NJ 07076**

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K 293	Continued From page 3 Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 01/25/2023 (day one of survey) during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of facility provided lay-out identified there is a North wing and a South wing in the building and two (2) outside enclosed (surrounded by the building)courtyards. Starting at approximately 9:43 AM, in the presence of the facility's US FOIA [redacted] a tour of the building was conducted. Along the tour the surveyor observed six (6) locations that failed to have	K 293	reported to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

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K 293	Continued From page 4 illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, 1) At approximately 10:42 AM, one (1) illuminated exit sign by the corridor double smoke doors next to resident room #34. 2) At approximately 11:18 AM, one (1) illuminated exit sign by the corridor double smoke doors next to resident room #62. 3) At approximately 12:01 PM, two (2) illuminated exit signs in the front outside enclosed courtyard. 4) At approximately 1:49 PM, one (1) illuminated exit sign by the corridor double smoke doors next to resident room #1. 5) At approximately 2:08 PM one (1) illuminated exit sign by the corridor double smoke doors next to resident room #1. The US FOIA confirmed the finding at the time. The surveyor informed the US FOIA (b)(6) of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101	K 311		2/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

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K 311	Continued From page 5 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 1/25/2023, in the presence of facility management it was determined that the facility failed to ensure that 2 of 2 exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This deficient practice was evidenced by the following: On 01/25/2023 (day one of survey) during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of facility provided lay-out identified there is a North wing and a South wing in the building and two (2) outside enclosed (surrounded by the building)courtyards. Starting at approximately 9:43 AM, in the presence of the facility's US FOIA [redacted] a tour of the building was conducted. Along the tour the surveyor	K 311	Both interior stairwell door leading to and from the basement was equipped with new doorknobs and latching mechanism installed. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 months to assure that doors are positively latching into the frame. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive	

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K 311	Continued From page 6 observed six (6) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, On 01/25/2023 (day one of survey) during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the basement level had one interior stairwell and two outside stairwells leading out of the basement. During the building tour in the presence of the US FOIA the surveyor observed and conducted closure test of two interior stairwell doors with the following results; 1) At approximately 9:45 AM during a closure test of the first floor interior stairwell door leading into the basement when tested and allowed to self-close into its frame, the door did not positive latch into its frame. The surveyor observed that door had no means to positive latch. 2) At approximately 9:47 AM during a closure test of the basement level interior stairwell door leading up to the first floor when tested and allowed to self-close into its frame, the door did not positive latch into its frame. The surveyor observed that door had no means to positive latch. The stairwell doors would need to positive latch	K 311	months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

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K 311	Continued From page 7 into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The [redacted] confirmed the finding at the time. The surveyor informed the [redacted] of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
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	K 321		2/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

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K 321	Continued From page 8 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 1/25/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 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 practiced was evidenced by the following: On 01/25/2023 (day one of survey) during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of facility provided lay-out identified the facility is a single story building with a North wing and a South wing. Starting at approximately 9:43 AM, in the presence of the facility's [redacted] a tour of the building was conducted. Along the tour of the facility the surveyor observed the following hazardous areas that failed to have smoke resisting doors, 1) At approximately 10:55 AM, an inspection of	K 321	New self-closer has been installed on Room 46 and a medical record room's door. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 months to assure that doors are self-close. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	

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K 321	Continued From page 9 resident room #46 identified this room was being used as a storage room. The surveyor observed inside the room approximately 50 combustible cardboard boxes, boxes of diapers and papers. The surveyor observed the corridor door had no means to self-close and the room was larger than 50 square feet. 2) At approximately 11:45 AM, an inspection inside the South Wing Medical Records room was performed. The surveyor observed multiple combustible paper files, three filing cabinets filled with medical records and boxes in the room. The surveyor recorded the room to 6' by 16'-6" (99 square feet) which is larger than 50 square feet. The surveyor observed the corridor door had no means to self-close. With these corridor doors not self-closing this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The [redacted] confirmed the finding at the time. The surveyor informed the [redacted] of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation	K 341		3/3/23

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ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076**

(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 341	Continued From page 10 A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 1/25/2023, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 2 outside enclosed courtyards 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 The deficient practice was evidenced by the following: On 01/25/2023 (day one of survey) during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments.	K 341	NJ Ex Order 26.4b1 will install horn/strobe by March 3rd, 2023. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 months. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

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K 341	Continued From page 11 A review of facility provided lay-out identified there is a North wing and a South wing in the building and two (2) outside enclosed (surrounded by the building) center courtyards in the facility. Starting at approximately 9:43 AM, in the presence of the facility's US FOIA a tour of the building was conducted. At approximately 11:33 AM, the surveyor observed in the "Back" enclosed outside courtyard that the facility failed the have an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the buildings fire alarm system. At that time the surveyor asked the US FOIA, "Do you have an audio and visual alarm tied into the buildings fire alarm system?" The US FOIA looked around and told the surveyor, "no." The US FOIA confirmed the finding at the time. The surveyor informed the U.S. FOIA (b) (6) of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. NJAC 8:39-31.2(a) 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	K 341	months. This plan will be amended when indicated. Adverse finding will be immediately address.	
K 345 SS=E	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	K 345		2/7/23

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K 345	Continued From page 12 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 observations and review of facility provided documentation in the presence of facility management on 1/25/2023, it was determined that the facility failed to ensure 3 of 166 smoke detectors for the fire alarm system were maintained in accordance with the National Fire Protection Association (NFPA) 72. This deficient practice was evidenced by the following: On 1/25/2023 a review of the fire alarm and detection systems semi-annual inspection identified there are 166 smoke detectors in the facility. Starting at approximately 9:43 AM in the presence of the facility's US FOIA (B) (6) a tour of the facility was conducted. The surveyor observed the basement was under renovations due to a flood. The surveyor observed the following, 1) At approximately 9:50 AM, the surveyor observed in the basement janitors closet a smoke detector base plate that had no evidence of a smoke detector with a sensing chamber. 2) At approximately 10:12 AM, the surveyor observed in the basement one smoke detector had a rubber glove covering the smoke detectors	K 345	The door company was working in the basement and put covers on the smoke detectors to keep dust from the triggering the smoke detectors. Immediately removed the cover from smoke detector on the same day of the inspection and replaced the missing the smoke detector in the basement janitor closet. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 months to assure that all smoke detectors are not covered and function properly, and make sure no smoke detector left covered after the construction work. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated.	

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K 345	Continued From page 13 sensing chamber. 3) At approximately 10:26 AM, the surveyor observed in the basement one smoke detector had a plastic cover over the smoke detectors sensing chamber. The surveyor observed no construction being done at the time of inspection. During an interview with the U.S. FC the surveyor asked if the facility does daily rounds after contractors are finished for the day. The U.S. FC told the surveyor, no. The U.S. FC confirmed the finding at the time. The surveyor informed the U.S. FOIA (b) (6) of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. NJAC 8:39 -31.1 (c), -31.2 (e) NFPA 72	K 345	Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and	K 351		3/23/23

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K 351	Continued From page 14 sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/25/2023 and 01/26/2023, it was determined that the Facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice was evidenced by the following, On 01/25/2023 (day one of survey) during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments and does the facility have a basement. The US FOIA told the surveyor, "yes there is a basement" and provided a copy of the facility lay-out. A review of the facility provided lay-out identified the facility is a single story building with a North wing, South wing and basement.	K 351	NJ Ex Order 26.4b1 will install a sprinkler head in the basement closet, electrical closet, and main entrance overhead by 3/23/2023. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 months. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	

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K 351	Continued From page 15 Starting on 01/25/2023 at approximately 9:43 AM, in the presence of the US FOIA a tour of the facility was conducted. Along the tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: 1) At approximately 9:50 AM, the surveyor observed in the basement level a 22" by 3'-6" closet had no evidence of fire sprinkler coverage. At that time, the surveyor asked the US FOIA do you see a fire sprinkler. The US FOIA told the surveyor, no. 2) At approximately 10:06 AM, the surveyor observed inside the basement level a 16" by 12'-6" electrical closet had no evidence of fire sprinkler coverage. 3) At approximately 10:31 AM, the surveyor observed no evidence of fire sprinkler coverage under the main entrance nine (9) feet by twelve (12) feet outside combustible over hang. The US FOIA confirmed the finding at the time. The surveyor informed the U.S. FOIA (b) (6) of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	K 355		2/7/23

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K 355	Continued From page 16 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 on 01/25/2023 in the presence of facility management, it was determined that the facility failed to failed: 1) install portable fire extinguishers with-in the required height for 4 of 18 fire extinguishers, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. This deficient practice was evidenced by the following: Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. During the building tour on 01/25/2023 in the presence of the facility US FOIA (B) (6) [redacted] the surveyor observed and inspected Eighteen (18) portable fire extinguishers in various locations with the following, 1) At approximately 10:20 AM, one (1) ABC type portable fire extinguisher in the basement kitchen area. This fire extinguisher appeared to be	K 355	All fire extinguisher has been adjusted to required height, not exceeding more than 5 feet above the floor. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 months. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	

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K 355	Continued From page 17 mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'-7 3/4" to the center of the pressure indicating needle. 2) At approximately 10:48 AM, one (1) ABC type portable fire extinguisher next to resident room #38. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'-5-1/2" to the center of the pressure indicating needle. 3) At approximately 11:40 AM, one (1) ABC type portable fire extinguisher in the Courtyard Cafe serving area. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'-3-1/2" to the center of the pressure indicating needle. 4) At approximately 2:08 PM, one ABC type portable fire extinguisher in the Physical Therapy area. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'-2-1/2" to the center of the pressure indicating needle. The U.S. FO confirmed the finding at the time. The surveyor informed the U.S. FOIA (b) (6) of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 371 SS=E	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke	K 371		2/7/23

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K 371	Continued From page 18 Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 1/25/2023, in the presence of facility management it was determined the facility failed to provide a smoke compartment that was less than 22,500 square feet. This deficient practice was evidenced by the following: On 1/25/2023 during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the building is a single story building divided into a North and South Wings with eight (8) smoke zones and ten (10) sets of corridor double smoke doors in the facility. Starting at 9:43 AM, in the presence of the facility's US FOIA a tour of the building was performed. During the building tour at approximately 1:58	K 371	Immediately installed 3-self closer for all doors in north wing dayroom. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 months. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	

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K 371	Continued From page 19 PM, the surveyor observed in the North Wing Day room a curtain in the middle of the room to divide the room into two rooms. The surveyor also observed two corridor doors (one for each half of the room) had no means to self-close. The surveyor observed in the corridor a set of double smoke doors that was located between the two corridor doors of the North Wing Day room. With the two corridor doors North Day room spanning two smoke compartments corridor doors with no means to self-close this would allow fire, smoke and poisonous gases to pass from one smoke compartment to another smoke compartment. NFPA 101, 2012 edition 19.3.7.1, 19.3/7.2 NJAC 8:39 -31.1(d)	K 371		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	K 374		2/7/23

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K 374	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 1/25/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 2 of 10 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 1/25/2023 during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the building is a single story building with ten (10) sets of corridor double smoke doors in the facility. Starting at 9:43 AM, in the presence of the facility's US FOIA a tour of the building was performed. The surveyor performed closure tests of the ten (10) sets of smoke barrier doors in the corridors with the following results, 1. At approximately 10:44 AM, during a closure test of one set of double smoke doors next to	K 374	Immediately installed door sweeps on all smoke barrier doors which did not meet the requirement. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	

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K 374	Continued From page 21 resident room #34, when both doors were release from their magnetic hold open devices and allowed to self close into their frame, the surveyor observed and measured a 1 inch gap along the bottom edge of the doors. This test was repeated two additional times with the same results. 2.At approximately 11:10 AM, during a closure test of one set of double smoke doors next to the South wing Conference room, when both doors were release from their magnetic hold open devices and allowed to self close into their frame, the surveyor observed and measured a 1 inch gap along the bottom edge of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The [US FOIA] confirmed the findings at the time of observations. The surveyor informed the [U.S. FOIA (b) (6)] of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. N.B. 8:39-31.1(c), 31.2(e)	K 374		
K 521 SS=D	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	K 521		2/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations on 1/25/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 1 of 8 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During the survey entrance on 1/25/2023 (day one of survey) at approximately 9:10 AM, a request was made to the US FOIA (B) (6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are, sixty three (63) Resident sleeping rooms in the facility. Starting on 1/25/2023 at approximately 9:43 AM, in the presence of the facility's US FOIA [redacted] during the building tour the surveyor inspected 8 Resident sleeping rooms. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 1 of 8 resident bathrooms in the following locations:	K 521	Room 61's exhaust fan replaced, and all other bathroom's exhaust fan checked. Room 61 and 63's residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2 The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	

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	315064	A. BUILDING **02** B. WING _____	**02/06/2023**

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K 521	Continued From page 23 1. At approximately 11:39 AM, inside Resident room #61 bathroom, when tested the exhaust system did not function properly. At that time, the surveyor informed the US FOIA that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The US FOIA confirmed the finding at the time. The surveyor informed the U.S. FOIA (b) (6) of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 1/25/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 5 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection.	K 911	GFCI outlet in north wing soil linen room was install. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will	2/15/23

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K 911	Continued From page 24 This deficient practice was evidenced by the following: Starting on 01/25/2023 at approximately 9:43 AM, a tour of the building with the US FOIA (B) (6) [redacted] was performed. During tour, the surveyor observed and tested five (5) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following, 1. At approximately 2:23 PM, the surveyor observed in the North wing soiled linen room one (1) Duplex electrical outlet 28 inches to the right of the sink in the room. When the surveyor tested the Duplex electrical outlets with a GFCI tester to de-energize, the Duplex electrical outlets did not de-energize as required by code. The US FOIA [redacted] confirmed the finding at the time. The surveyor informed the U.S. FOIA (b) (6) of the deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	check daily x 2 The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this	K 918		3/20/23

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K 918	Continued From page 25 capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/25/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 2 of 2 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following:	K 918	NJ Ex Order 26.4b1 will install the remote manual stop station for 2 emergency generators. All residents in the facility have the potential to be affected by the deficient practice. Director of Maintenance or designee will check daily x 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 26 On 01/25/2023 (day one of survey) during the survey entrance at approximately 9:10 AM, a request was made to the US FOIA (B) (6) [redacted] if the facility had an Emergency Generator. The US FOIA told the surveyor, yes we have two (2), a Natural Gas Emergency Generator and a Diesel Emergency Generator. Starting at approximately 9:43 AM, in the presence of the facility's US FOIA a tour of the building was conducted. During the tour the surveyor observed the following: 1) At approximately 1:28 PM, during an inspection outside of the building where the "NJ Ex Order 26.4 [redacted] Natural Gas Emergency Generator is located, the surveyor observed that the emergency stop button was located on the housing of the generator. Art this time the surveyor asked the US FOIA, "Do you have a remote emergency stop button for the generator?" The US FOIA said, "no." 2) At approximately 2:28 PM, during an inspection outside of the building where the "NJ Ex Order 26.4(c [redacted] Diesel Emergency Generator is located, the surveyor observed that the emergency stop button was located on the control panel. At this time the surveyor asked the US FOIA, "Do you have a remote emergency stop button for the generator?" The US FOIA said, "no." The US FOIA confirmed the findings at the times of observations. The surveyor informed the US FOIA (B) (6) of the	K 918	The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance Performance Improvement Committee. QAPI committee will determined if continued auditing is necessary once 100% compliance threshold is met for 2 consecutive months. This plan will be amended when indicated. Adverse finding will be immediately address. Findings and trends will be reported to QAPI.	

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K 918	Continued From page 27 deficiency at the Life Safety Code exit conference on 1/26/2023 at approximately 12:50 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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
315064 Y1	A. Building 02 - BUILDING B. Wing Y2	3/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

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 K0291	02/14/2023	LSC K0293	02/07/2023	LSC K0311	02/07/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	02/15/2023	LSC K0341	03/03/2023	LSC K0345	02/07/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	03/23/2023	LSC K0355	02/07/2023	LSC K0371	02/07/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	02/07/2023	LSC K0521	02/15/2023	LSC K0911	02/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	03/20/2023	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	
2/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO