STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315106	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

(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 Survey Date: 5/15/23 Census: 78 Sample: 18 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 636		6/10/23

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

Electronically Signed | 05/25/2023

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 636	Continued From page 1	F 636		

(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility

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F 636	Continued From page 2 following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility provided documentation, it was determined that the facility failed to provide a comprehensive nutritional assessment to identify the nutritional needs of newly admitted and re-admitted residents to the facility within a 14 day period as required by Centers of Medicare & Medicaid Services (CMS). This deficient practice was identified for 4 of 9 newly admitted/ re-admitted residents reviewed for nutritional assessments between [redacted] to [redacted] (Resident #231, 232, 233, and 234), and was evidenced by the following: The surveyor reviewed the Resident Admission List supplied by the Admission's Director for residents admitted or re-admitted to the facility from [redacted] to [redacted] with the following findings: 1. On 5/3/2023 at 11:05 AM, the surveyor observed Resident #231 in bed. The resident stated that they were experiencing [redacted] The facility was providing soft food, but the resident stated that they had not been seen by the Registered Dietitian (RD). On 5/3/2023 at 11:15 AM, during review of Resident #231's Electronic Medical Administration Record (e-MAR) and Face sheet (FS) (an admission summary sheet), the documented initial admission date (IAD) was [redacted].	F 636	Element #1. The facility immediately contacted and hired another Registered Dietician (RD) as coverage while the facility RD is on vacation which will ensure that all new admitted and readmitted residents will be seen within the required period Element #2. All residents have the potential to be affected by this deficient practice by way of not completing comprehensive nutritional assessments within the required time frame. Element #3. DON In serviced the Registered Dietician to complete the Comprehensive nutritional assessments within the required time frame. Element #4. DON or designee will perform a weekly audit to all new admitted/re-admitted residents to ensure that the comprehensive nutritional assessment is completed within the required period. All findings will be reported at the next quarterly quality assurance meeting.	

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F 636	Continued From page 3 Continued review of the medical records, revealed that the comprehensive nutritional assessment was created on [NJ Exec Order 26.4b1] 14 days late, after the 14-day period required by CMS. 2. On 5/3/2023 at 11:30 AM, during review of Resident #232's e-MAR and FS, it was revealed that the resident had an IAD of [NJ Exec Order 26.4] and that the comprehensive nutritional assessment was created on [NJ Exec Order 26.4b1], 8 days late, after the 14-day period required by CMS. 3. On 5/3/2023 at 11:50 AM, during review of Resident #233's e-MAR and FS, it was revealed that the resident had an IAD of [NJ Exec Order 26.4] and that the comprehensive nutritional assessment was created on [NJ Exec Order 26.4b1], 9 days late, after the 14-day period required by CMS. 4. On 5/4/2023 at 10:30 AM, during review of Resident #234's e-MAR and FS, it was revealed that the resident had a re-admission date of [NJ Exec Order 26.4b] and the comprehensive nutritional assessment was created on [NJ Exec Order 26.4b1], 3 days late, after the 14-day period required by CMS. On 5/5/23 at 11:32 AM, the surveyor interviewed the RD, who has been working at the facility since 2019. The RD stated they try to get all initial nutrition assessments completed within 72 hours of arrival to the facility regardless of initial or re-admission. The RD further stated she was on vacation from [NJ Exec Order 26] to [NJ Exec Order 26.4b1] The facility failed to have a covering RD during this period of time creating a delay in the comprehensive nutrition assessments for Residents #231, 232, 233, and 234. All the comprehensive nutrition assessments for these residents failed to be completed within the 14-day required period.	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 4 On 5/8/2023 at 11:37 AM, the RD provided the surveyor with a policy titled, "Elizabeth nursing Nutrition Assessment Guidelines" with a revised date of 12/2019. Under the Policy Explanation and Compliance Guidelines, the policy states: 2. "The Dietician will complete a nutrition assessment on residents admitted to the facility." On 5/10/23 at 1:35 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON) to discuss the above mentioned concerns. No further relevant information was provided.	F 636		
F 812 SS=D	N.J.A.C. 8:39-11.2 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		6/10/23

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F 812	Continued From page 5 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) store, label, and date potentially hazardous foods to prevent food-borne illness On 5/3/23 at 9:30 AM, the surveyor entered the facility kitchen and asked to tour with the Food Service Director (FSD), but the FSD was not in the facility, the tour began with the available Chef Supervisor (CS). At this time, the surveyor and CS toured the kitchen and observed the following: 1. In the Refrigerator/Freezer combo located in the dry storage area, the surveyor observed in the refrigerator a 48-ounce container of Ricotta cheese with a written date of 4/24. The CS could not state if that date was the received, open, or discard date. The CS did acknowledge that once opened the Ricotta should be discarded within 5 days but could not explain why the container had not been disposed of. The CS opened the container and upon further inspection the surveyor observed multiple green colored debris inside the container. The CS was unable to state what the debris was, container was discarded. 2. In the freezer section of the Refrigerator/Freezer Combo, the surveyor observed an open bag of frozen mixed vegetables and an open bag of frozen rolls both without any dates. At that time the FSD joined the surveyor and CS on the tour. The FSD could not explain why the two items in the freezer were	F 812	Element #1. The Food Service Director immediately discarded the opened container. The Food Service Director conducted an audit to ensure all food items are properly stored, labeled and dated. Element #2 All residents have the potential to be affected by the deficient practice of failing to store, label, and date potentially hazardous foods to prevent foodborne illness. Element #3. The administrator in-serviced the food service director regarding the importance of storing, labeling and dating all food items. Element #4. The food service director or his designee will monitor daily the food stored in the refrigerator and in the dry storage to ensure that that it has proper storage, label, and date. The Administrator or designee will monitor weekly for the next 2 months, there after monthly spot checks. All findings will be reported at the next quarterly quality assurance meeting.	

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F 812	Continued From page 6	F 812		

not dated, but acknowledged all items need to have a received, opened and discard dates.

The FSD provided a facility policy titled, "Checking Daily Refrigerator For Appropriate Storage" that was reviewed by the surveyor. Under policy, it states, "All foods stored in the daily refrigerator will be checked to ascertain that they are stored in a manner that assures that they are appropriate for use and free from potential cross-contamination."

On 5/10/23 at 1:30 PM, the surveyor discussed the above concerns with the FSD, Director of Nursing (DON), and Assistant Licensed Nursing Home Administrator (ALNHA). No further information was provided.

NJAC 8:39-17.2(g)

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	62007X	A. BUILDING: _____ B. WING _____	05/15/2023

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.	S 560	Element #1. The staffing coordinator continues to utilize all possible means to increase facility staff, including offering bonuses to staff that refer CNA□S. We reached out to our staffing agencies and they assured us that they will make all efforts to supply us with our necessary staff. We also reached out to our neighbor facility offering employment to any CNA that is seeking additional working hours. Element #2. All residents have the potential to be affected by this deficient practice when	6/10/23

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

Electronically Signed | 05/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62007X	A. BUILDING: _____ B. WING _____	05/15/2023

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S 560	Continued From page 1 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of 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	S 560	staffing regulations are not met. Element #3 The staffing coordinator was in-serviced by the Administrator in regards to the minimum staffing requirements and to utilize all possible avenues to increase staffing in the facility. Element #4. The Administrator or designee will monitor daily staffing levels with the staffing coordinator. All findings will be reported at the next quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2	S 560		

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 2-week period beginning 4/16/23 to 4/29/23 revealing that the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 2 of 14 day shifts as follows:

For the 2 weeks of staffing 4/16/2023 to 4/22/2023 and 4/23/2023 to 4/29/2023 the facility was deficient in CNA staffing for residents on 5 of 14 day shifts and 1 of evening shift as follows:

The facility was deficient in CNA staffing for residents on 6 of 14 day shifts and deficient in CNAs to total staff on 6 of 14 day shifts and 1 of 14 evening shifts as follows:

-04/16/23 had 8 CNAs for 80 residents on the day shift, required 10 CNAs.
-04/17/23 had 9 CNAs for 80 residents on the day shift, required 10 CNAs.
-04/18/23 had 9 CNAs for 80 residents on the day shift, required 10 CNAs.
-04/22/23 had 9 CNAs for 81 residents on the day shift, required 10 CNAs.
-04/23/23 had 7 CNAs for 83 residents on the day shift, required 10 CNAs.

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S 560	Continued From page 3 -04/28/23 had 8 CNAS to 18 total staff on the evening shift, required 9 CNAs. -04/29/23 had 9 CNAs for 79 residents on the day shift, required 10 CNAs. On 5/15/23 at 10:00 AM, the surveyor informed the facility's Regional Licensed Nursing Home Administrator, Director of Nursing (DON), as well as the Assistant DON were informed of their deficient practice. No further information was provided.	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
315106 Y1	A. Building B. Wing Y2	6/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

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 F0636	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	06/10/2023	LSC	06/10/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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?
5/15/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62007X Y1	A. Building B. Wing Y2	6/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

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	06/10/2023	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	
5/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315106	A. BUILDING **01** B. WING _____	**05/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	**1048 GROVE STREET** **ELIZABETH, NJ 07202**

(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 The nursing home building construction was stated to be 40s with no current major renovations or noted additions. It is a three story building with the ground floor as floor #1. The construction is Type II (000) with a section of the attic constructed as a wood frame with a fully functional fire sprinkler system. The generator does approximately 30 to 40% of the building and the elevator shafts are stated to have fire sprinkler heads at the top and bottom, as per the Maintenance Director. The building has 6-smoke zones.The heating system has a loop-pipe hot water system and AC units in the walls and windows of the facility. There is supervised smoke detection located in the corridors, spaces open to the corridors. The natural gas generator inside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 102 certified beds. At the time of	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/25/2023

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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K 000	Continued From page 1 the survey the census was 80. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.	K 222		5/19/23

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K 222	Continued From page 2 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/10/23 in the presence of the Maintenance Director, it was determined that the facility failed to ensure that exit doors locked with a delayed egress device were provided with instructional signage as per the requirements of NFPA 101:2012 - Chapter 7.2.1.6.1.1(4). This deficient practice was identified in 4 of 4 egress doors observed and evidenced by the following: 1. At 10:57 AM, the Surveyor and Maintenance	K 222	Element #1. 1) exit/egress double doors (gold color) to the exterior public 2) exit/egress door by resident room 225 3) exit/egress door by resident room 212 4)exit/egress door by the ground floor conference room All doors were provided with a readily visible sign with 1- inch letters indicating "Push Until Alarm Sounds, Door Can Be	

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K 222	Continued From page 3 Director, observed that the exit/egress double doors (gold color) to the exterior public way were provided with a 15-second delayed access feature. The door's were not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The set of door's were provided with a push button keypad and opened with the activation of the fire alarm. 2. At 11:28 AM, the Surveyor and Maintenance Director, observed that the exit/egress door by resident room 225 was provided with a 15-second delayed access feature. The door were not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The set of door's were provided with a push button keypad and opened with the activation of the fire alarm. 3. At 11:40 AM, the Surveyor and Maintenance Director, observed that the exit/egress door by resident room 212 was provided with a 15-second delayed access feature. The door were not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The set of door's were provided with a push button keypad and opened with the activation of the fire alarm. 4. At 11:40 AM, the Surveyor and Maintenance Director, observed that the exit/egress door by the ground floor conference room was provided with a 15-second delayed access feature. The door were not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The set of door's were provided with a push button keypad and opened with the activation of	K 222	Opened in 15-Seconds." Element #2. All residents and Staff have the potential to be affected by this deficient practice of ensuring that exit doors locked with a delayed egress device were provided with instructional signage. Element #3. The maintenance director was in serviced by the administrator regarding the importance of ensuring appropriate signage at exit doors with delayed egress. Element #4. The administrator or designee will monitor the latching of all exit doors locked with delayed egress weekly for two months ensuring that instructional signage is provided at exit doors with delayed egress. All findings will be reported at the next quarterly quality assurance meeting.	

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K 222	Continued From page 4 the fire alarm. The Maintenance Director confirmed the findings at the time of the observations. The Administrator was informed of these findings, during the Life Safety Code exit conference on 5/11/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/10/23 in the presence of facility Maintenance Director (MD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 2 of 4 occupied access areas observed and was evidenced by the following: 1). At 11:14 AM, the surveyor in the presence of the MD, observed in the floor-two occupied TV room, that 2-wall switches shut-off all the light fixtures. The area was not provided with any illumination of the means of egress continuously	K 281	Element #1. Floor-two occupied TV room & Floor-one occupied dining room. Switches were adjusted to provide with illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. Element #2. All residents and staff have the potential to be affected by this deficient practice to provide emergency illumination that would	5/19/23

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K 281	Continued From page 5 in operation or capable of automatic operation without manual intervention. 2). At 12:18 AM, the surveyor in the presence of the MD, observed in the floor-one occupied dining room, that 3-wall switches shut-off all the light fixtures. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The Maintenance Director confirmed the finding's at the time of observations. The Administrator was informed of these findings at the Life Safety Code survey exit conference on 5/11/23. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	operate automatically along the means of egress. Element #3. The maintenance director was in-serviced by the administrator regarding the importance of ensuring appropriate illumination that would operate automatically along the means of egress. Element #4. The administrator or designee will monitor floor-one occupied dining room and floor-two occupied TV room weekly for two months ensuring that there is continuous illumination without manual intervention. All findings will be reported at the next quarterly quality assurance meeting.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 511/23, in the presence of the Maintenance Director, it was determined that the facility failed	K 293	Element #1. Exit signs that included a continuous illumination indicator were installed in the	6/6/23

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K 293	Continued From page 6 to provide exit signs that included a continuous illumination indicator showing the direction of travel, in every location, where the direction of travel to reach the nearest exit was not apparent, in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 3 of 15 exit signs observed and was evidenced by the following: At 9:52 AM, the surveyor and Maintenance Director observed in the main boiler room that 2 occupied open area desks were observed. The area was not provided with any illuminated exit signs. Staff in that area in the event of an emergency evacuation and power outage would not be able to exit safely as the nearest exit was not apparent. The Maintenance Director confirmed the finding's at the time of the observation. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/11/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1.	K 293	Main Boiler Room (Back of Kitchen). Element #2. All staff and residents have the potential to be affected by this deficient practice of ensuring that Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system. Element #3. The maintenance director was in serviced by the administrator regarding the importance of ensuring appropriate Exit Signs. Element #4. The administrator or designee will monitor weekly for two months that all the exit and directional signs are displayed in accordance with continuous illumination. All findings will be reported at the next quarterly quality assurance meeting.	
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	K 321		5/23/23

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K 321	Continued From page 7 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 (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 5/11/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled 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 identified for 5 of 8 hazardous area doors observed and was evidenced by the following: 1). At 9:58 AM, the surveyor and Maintenance	K 321	Element #1. #1 Soiled linen room door and #2 the Kitchen door. Both doors were installed with proper door closers and now fully close. #3. Kitchen door and #4. sprinkler room door. Both Doors were provided with a fire rated label indicating its fire-resistive rating. #5. Staff dining room storage closet. An auto-closing device was installed on the door. Element #2.	

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K 321	Continued From page 8 Director observed that the soiled linen room door to the exit/egress corridor would not fully close due to air pressure from the interior of the room pulling the auto closing door in approximately 2" from fully closing into its frame. 2). At 10:10 AM, the surveyor and Maintenance Director observed that the wooden door to the kitchen to the exit/egress corridor would not fully close due to air pressure from the kitchen exhaust fan. The door remained open approximately 3" due to the kitchen area not having enough makeup air to keep the door closed properly. 3). At 10:12 AM, The surveyor and Maintenance Director observed that the wooden kitchen door was not provided with a label indicating its fire-resistive rating. 4). At 10:18 AM, The surveyor and Maintenance Director observed that the wooden door to the fire sprinkler room was not provided with a label indicating its fire-resistive rating. 5). At 10:29 AM, The surveyor and Maintenance Director observed that the door to the staff dining room storage closet was observed to not have an auto-closing device installed on the door. The room was greater than 50 square feet in size and was storing 50 plus combustible cardboard boxes. The MD confirmed the findings at the time of the observations. The Administrator was notified of the findings at the Life Safety exit conference on 5/11/23.	K 321	All staff and residents have the potential to be affected by this deficient practice of ensuring fire-rated doors to hazardous areas were self-closing and labeled. Element #3. The maintenance director was in serviced by the administrator regarding the importance of ensuring the doors in hazardous areas were self-closing and indicating its fire rated label. Element #4. The administrator or designee will monitor weekly for two months that doors in hazardous areas are self-closing and indicate that its fire rated. All findings will be reported at the next quarterly quality assurance meeting.	

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K 321	Continued From page 9 NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321		
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, interview, and document review on 5/10/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure smoke detection sensitivity testing was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The deficient practice was identified for 5 of 5 inspection reports and was evidenced by the following: At 11:10 AM, the surveyor reviewed all related fire alarm documentation provided by the MD from the fire alarm vendor to determine if the sensitivity test was performed. The reports were dated 1/17/23, 10/4/22, 7/8/22, 4/5/22 and 1/7/22 The reports provided did not indicate any information on the testing of the smoke detector's for sensitivity. An interview was conducted with the Maintenance	K 345	Element #1. Fire Alarm Vendor performed a Sensitivity Test on all Smoke detectors. Element #2. All staff and residents have the potential to be affected by this deficient practice of ensuring that the fire alarm system is tested and maintained in accordance with an approved program. Element #3. The maintenance director was in serviced by the administrator regarding the importance of ensuring appropriate testing of the Fire Alarm System.	5/23/23

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K 345	Continued From page 10 Director and Administrator, during document review who both indicated they were not sure if the required sensitivity test for the facility smoke detectors were performed. The Administrator indicated he contacted the facility fire alarm vendor to see if sensitivity report was performed, and no further documentation was provided. The Administrator was informed of the findings at the Life Safety Code Exit conference on 5/11/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	Element #4. The administrator or designee will monitor monthly that the Fire Alarm System is tested appropriately. All findings will be reported at the next quarterly quality assurance meeting.	
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 5/11/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that 1 of 10 electrical outlets located next to a water source was equipped with a Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the	K 912	Element #1. The hydrocollator was plugged into the required Ground Fault Circuit Interrupter (GFCI) electrical outlet. Element #2.	5/23/23

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K 912	Continued From page 11 following: At 9:38 AM, the surveyor and Maintenance Director observed in the Physical Therapy room that a Hydrocollator was plugged into a regulator duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. The Maintenance Director confirmed the findings at the time of observation. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 5/11/23. NJAC 8:39 -31.2 (e) NFPA 99	K 912	All staff and residents have the potential to be affected by this deficient practice of ensuring electrical outlets located next to a water source were equipped with a Ground-Fault Circuit Interrupter (GFCI) protection. Element #3. The maintenance director was in serviced regarding the importance of ensuring appropriate Ground Fault Circuit Interrupter (GFCI) outlets near a water source. Element #4. The administrator or designee will monitor weekly for two months outlets near a water source to ensure appropriate Ground Fault Circuit Interrupter (GFCI) electrical outlets for wet locations. All findings will be reported at the next quarterly quality assurance meeting.	
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line	K 914		6/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315106	A. BUILDING **01** B. WING _____	**05/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 914	Continued From page 12 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 observations, interview and documentation review on 5/10/23, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally 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 evidenced for 15 of 30 resident rooms observed by the following: From approximately 9:30 AM to 1:30 PM, the surveyor and MD, observed that resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The annual electrical inspection from the facility vendor dated: 8/04/22 did not indicate any testing of resident room outlets and did not indicated the identification of the outlets as hospital or non-hospital grade. The MD confirmed that the facility had hospital grade and non-hospital outlets installed in	K 914	Element #1. The licensed Electrician Started Testing all Receptacles and will complete tomorrow. The Electrician is also installing Hospital Grade Receptacles in all resident rooms. Element #2. All residents and staff have the potential to be affected by this deficient practice of ensuring that the facility functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets. Element #3. The maintenance director was in serviced by the administrator regarding the importance of Hospital Grade Outlets in resident rooms. Element #4. The administrator or designee will monitor weekly for two months that all outlets in	

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K 914	Continued From page 13 resident rooms, but could not provide any documentation or logs indicating where the hospital grade outlets were located and testing process. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/11/23. NJAC 8:39-31.2(e) NFPA 99	K 914	resident rooms are Hospital Grade. All findings will be reported at the next quarterly quality assurance meeting.	
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	K 918		5/19/23

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K 918	Continued From page 14 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 observations, interview, and review of facility documents on 5/10/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was identified for 1 of 1 generator logs provided by the MD and the evidence was as follows: At 10:25 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the Maintenance Director was performing monthly generator load testing, but did not indicate the required transfer times on the provided log dates: 4/24/23, 3/24/23, 2/24/23, 1/24/23, 12/26/22, 11/28/22, 10/24/22, 9/26/22, 8/29/22, 7/4/22, 6/6/22 and 5/9/22. An interview was conducted with the MD, during document review and he stated that currently the transfer time was not provided on the current document. He stated that the current document needed to be updated and required a separate	K 918	Element #1. New Generator Log created to include Transfer Time within 10 seconds. Element #2. All staff and residents have the potential to be affected by this deficient practice of ensuring the generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. Element #3. The maintenance director was in serviced regarding the importance of ensuring appropriate records of generator log test. Element #4. The administrator or designee will monitor monthly for three months that the Monthly Generator Load Test includes transfer time. All findings will be reported at the next quarterly quality assurance meeting.	

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K 918	Continued From page 15 column for identifying monthly transfer times. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/11/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62007X Y1	A. Building B. Wing Y2	6/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

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	06/10/2023	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	
5/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO