STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	**1777 LAWRENCE STREET RAHWAY, NJ 07065**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: 171414, 175944, 176124, Survey Date: 11/06/2024-11/13/2024 Census: 113 Sample: 24 + 2 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		12/27/24

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

Electronically Signed | 11/27/2024

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

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to provide a resident's activities of daily living (ADL) care in a dignified manner. This deficient practice was identified for 1 of 3 residents reviewed for activities of daily living (Resident #102), and was evidenced by the following: On 11/07/2024 at 10:58 AM, the surveyor observed Resident #102 in their private room accompanied by Certified Nursing Assistant (CNA #1), who assisted the resident transfer from a wheelchair to the bed. While laying in bed, the surveyor observed CNA #1 remove Resident #102 [redacted] exposing the resident's [redacted] At that time, the surveyor left and asked the RN Supervisor-in-training (RN #1) to check on	F 550	F550- RESIDENT RIGHTS / EXERCISE OF RIGHTS I: IMMEDIATE ACTION 11/7/2024 Resident #102 was interviewed by the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) and stated that [redacted] was [redacted] was resting in bed, covered with a blanket. 11/7/2024 CNA #1, in charge of resident # 102, was immediately in serviced by the acting Director of Nursing on proper resident transfer procedure which included maintaining resident□s dignity at all times by ensuring the privacy curtain is drawn for the procedure. II: IDENTIFICATION OF OTHERS All residents have the potential of being affected when privacy curtain is not drawn	

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F 550	Continued From page 2 Resident #102. Upon returning to the room, Resident #102 was under the blankets and covered. When CNA #1 exited the room, the surveyor inquired how ADLs are to be performed in the room. CNA #1 acknowledged that the curtain was not pulled for privacy. RN #1 confirmed that all ADL care should be provided in the room with either the door shut or curtain pulled for privacy. The surveyor reviewed Resident #102's medical Record: A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] reflected the resident was admitted to the facility with diagnoses which [redacted]. The MDS also reflected that the resident brief interview for mental status (BIMS) score of [redacted] which indicated that the resident had [redacted]. On 11/12/2024 at 12:19 PM, in the presence of the [redacted] the [redacted] acknowledged it was the expectation of staff to have the door closed or close the privacy curtain closed to ensure privacy and dignity to the residents. A review of the facility policy titled, "Resident Rights", last reviewed June 11, 2024, revealed that: Resident's Rights include, but are not limited to the following: treated with respect, dignity [...] NJAC 8:39-4.1(a)12	F 550	during resident transfer. III: SYSTEMIC CHANGES 11/26/24 Nursing staff were in serviced by the Facility Educator on importance of maintaining resident□s dignity at all times during Activities of Daily Living (ADL) care (including transfers) by drawing the privacy curtain. 11/26/24 Administrator and acting Director of Nursing reviewed the Policy and Procedure on Resident Rights, no changes were made. IV: QA MONITORING Director of Nursing or designee will conduct rounds and observe 10 residents on 2nd and 3rd floor being provided ADL care (including transfers) to ensure privacy curtains are drawn during the procedure daily x 2 weeks then weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing or designee COMPLETION DATE: 12/27/24	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		12/27/24

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F 584	Continued From page 3 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. 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 maintain a clean and sanitary environment for 2 of 2 shower rooms. The deficient practice was evidenced by the following: On 11/06/2024 at 10:58 AM, the surveyor entered the shower room on the second floor and observed tiles on the floor and various hygienic products left in the whirlpool tub. On 11/07/2024 at 09:49 AM, the surveyor entered the shower room on the second floor and observed tiles picked up and placed on the window sill, and items remained in the whirlpool tub. On 11/07/2024 at 1:05 PM, the surveyor entered the shower room on the third floor and observed brown stains on the wall and floor tiles, an empty can of aftershave on the floor, a leaking shower head in a plastic bag, and a broken faucet. On top of the linen cart was one loose, blue incontinent pad and one open bag of incontinence briefs. On 11/08/2024 at 09:35 AM, the surveyor entered the shower room on the third floor and observed in the shower area a leaking shower head in a plastic bag with towels around it. Clothing on the shower bed and tissues on the floor under the shower bed. Trash in the trash can with no bag	F 584	F584- SAFE ENVIRONMENT I: IMMEDIATE ACTION COMPLETION DATE: 11/8/24 1) 2ND Floor Shower Room: Tiles were removed and discarded; hygienic products removed from the whirlpool tub and discarded, tab cleaned and sanitized 2) 3rd Floor Shower Room: Brown stains from hard water on the wall and floor tiles were removed; empty can of after shave on the floor was removed and discarded, leaking shower head was repaired, broken faucet was repaired; all product from on top of linen cart was removed and discarded, clothing on shower bed was removed and send to laundry, tissues on the floor under the shower bed were removed and discarded, trash can was emptied and lined with plastic bag. 11/8/24 Housekeeping staff responsible for cleaning the 2nd and 3rd floor shower rooms and nursing staff who provide showers on 2nd floor and 3rd floor were in serviced by the Facility Educator on maintaining a clean and sanitary environment in the shower rooms. II: IDENTIFICATION OF OTHERS All residents have the potential of being affected when the shower rooms are not maintained clean and sanitary. III: SYSTEMIC CHANGES 11/26/24 Nursing staff were in serviced by	

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F 584	Continued From page 5 lining. On 11/08/2024 at 09:39 AM during an interview with the housekeeper (HK # 1), the surveyor asked who is responsible for cleaning the shower rooms. HK # 1 replied, "Housekeeping is responsible for emptying the trash, mopping the floors, and cleaning the shower room. Certified Nurse Aides (CNAs) are responsible to clean up behind the residents after showering." On 11/08/2024 at 09:44 AM during an interview with the U.S. FOIA (b)(6) the surveyor asked what are the brown stains in the shower area on the third floor, who is responsible to clean the shower rooms, and do the residents use the shower area. The U.S. FOIA (b) replied, "The staining in the shower area is caused by the harshness of the water. Housekeeping is responsible for cleaning the area. The area is difficult to maintain due to the water quality. The U.S. FOIA (b)(6)) was notified yesterday for guidance on addressing the water stains. The U.S. FOIA (b)(6) brought in lime spray today to clean the area, and the stains have now been removed. The shower area is currently non-functional and has not been used for the resident showers in over a year." On 11/12/2024 at 12:27 PM during an interview with the U.S. FOIA (b)(6) , the surveyor asked what are the brown stains in the shower area on the third floor. The U.S. FOIA (b)(6) replied, "The staining in the shower area is due to the harshness of the water, and the shower area should have been cleaned." A review of a facility provided policy, with a review date of 06/04/2024, titled "Environmental	F 584	the Facility Educator on importance of maintaining shower rooms clean and sanitary as per facility policy 11/26/24 Housekeeping staff were in serviced by the Facility Educator on importance of maintaining shower rooms clean and sanitary as per facility policy 11/26/24 Administrator and acting Director of Nursing reviewed the Policy and Procedure on Environmental Services, no changes were made. IV: QA MONITORING Administrator or designee will conduct rounds and observe the shower rooms on 2nd floor and 3rd floor to ensure a clean and sanitary environment Daily x 2 weeks then weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing or designee COMPLETION DATE: 12/27/24	

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F 584	Continued From page 6 Services" revealed under the section titled "Procedure Bathroom and Toilets #4" that, "Sanitation: Bathrooms are high-risk areas for pathogen transmission, so extra attention is needed. Toilets, sinks, and faucets should be sanitized with appropriate disinfectants. Shower Areas: Cleaning and disinfecting showers, bathtubs, and other wet areas to prevent mold and mildew buildup is essential." A review of a facility provided policy, with a review date of 06/04/2024, titled "Environmental Services" revealed under the section titled "Environmental Cleaning Audits #11" that, "Monitoring and Evaluation: Facilities should implement regular audits or inspections to assess the effectiveness of cleaning practices. These audits can be used to identify areas for improvement and ensure that standards are met. Feedback Loop: Providing ongoing feedback to housekeeping staff is crucial for continuous improvement and maintaining high standards of cleanliness."	F 584		
F 658 SS=D	§ 8:39-31.4 (a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint # NJ00176124 Based on observations, interviews, record review,	F 658	F658- SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	12/27/24

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F 658	Continued From page 7 and review of pertinent facility documentation, it was determined that the facility failed to maintain treatment records that were complete with staff signatures according to professional standards of clinical practice for Resident # 72, 1 of 24 residents reviewed for professional standards. The deficient practice was evidenced by the following: A review of Resident # 72's Admission Record indicated Resident # 72 was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted] A Review of Resident #72's comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate care, dated NJ Exec Order 26.4b1 revealed a Brief Interview for Mental Status score of NJ Exec Orde, indicating Resident #72 was NJ Exec Order 26.4b1 A review of Resident #72's Treatment Administration Record (TAR) for the months of NJ Exec Order 26.4b1 [redacted] revealed several blanks. For the treatment to the [redacted] blanks were noted for: NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift	F 658	I: IMMEDIATE ACTION 11/9/2024 Resident #72's Treatment Administration Record (TAR) for NJ Exec Order 26 [redacted] care was reviewed by the acting director of nursing and there were no missing signatures found for the month of NJ Exec Order 26.4b1 [redacted]. 11/9/24 The acting Director of Nursing and Regional Nurse reviewed the Quality Assurance and Improvement Plan (QAPI) for Electronic Medical Record documentation completed on NJ Exec Order 26 [redacted] (and ongoing) which included "MARs (Medication Administration Record) and TARs (Treatment Administration Record) noted with blanks, nurses not documenting the care which was provided timely and accurately", no changes made. II: IDENTIFICATION OF OTHERS All residents have the potential of being affected when the wound care provided is not accurately documented as evidenced by missing signatures in the Treatment Administration Record. III: SYSTEMIC CHANGES 11/26/24 Nursing staff on all shifts were in serviced by the Facility Educator on importance of accurately documenting in the Treatment Administration Record all wound care provided, ensuring there are no signature blanks by the end of the shift. 11/26/24 Administrator and acting Director of Nursing reviewed the Policy and Procedure on Documentation in the Electronic Medical Record, no changes were made.	

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F 658	Continued From page 8 NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift For the treatment to the NJ Exec Order 26.4b1 blanks were noted for: NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift For the treatment to the NJ Exec Order 26.4b1 blanks were noted for: NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift For the treatment to the NJ Exec Order 26.4b1 blanks were noted for: NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift	F 658	IV: QA MONITORING Director of Nursing or designee will conduct audits of 10 residents with wounds on the 2nd and 3rd floor to ensure there are no missing signatures in the Treatment Administration Record daily x 2 weeks then weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing or designee COMPLETION DATE: 12/27/24	

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NJ Exec Order 26.4b1 day shift
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F 658	Continued From page 10 were noted for: NJ Exec Order 26.4b1 day shift NJ Exec Order 26.4b1 day shift During an interview on 11/08/2024 at 09:56 AM with the surveyor, Resident #72 said they feel like when there are only 2 nurses on the floor their U.S. FOIA (b)(6) care doesn't get done. During an interview on 11/12/2024 at 12:19 PM with the surveyor, The U.S. FOIA (b)(6)) said when there are blanks on the TAR it means the nurse didn't sign it and you don't know if it was done. The U.S. FOIA (b) also said there should not be any blanks on the TARS. A review of a facility provided policy last reviewed 06/04/2024 titled "Documentation in the EMR" revealed under section "Purpose" that, "To maintain all information regarding the resident's care and treatment in an organized manner to ensure residents receives appropriate medical care with appropriate documentation." The also revealed under "General information" that, "Documentation about treatments received will be located in the TAR. This will include the treatment ordered, frequency and location to administer treatment as well as the date/time administered and who performed the treatment. Any refusal should be documented accordingly, and MD should be informed."	F 658		
F 761 SS=D	NJAC 8:39-27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		12/27/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 11 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that expired vaccines were removed from active inventory upon expiration. The deficient practice was identified in 1 of 2 medication rooms and was evidenced by the following: On 11/08/2024 at 11:30 AM, in the presence of the Licensed Practical Nurse Unit Manager (LPNUM #1), the surveyor inspected the second floor medication room on the sub-acute unit. In the refrigerator, the surveyor observed a brown bag that had identification stickers which	F 761	F761- LABELING AND STORAGE OF DRUGS AND BIOLOGICALS I: IMMEDIATE ACTION 11/8/24 The expired NJ Exec Order 26.4b1 prefilled syringes were immediately discarded. 11/8/24 2nd and 3rd floor Medication room refrigerators were checked for any expired items, no negative findings. 11/9/24 The Regional nurse provided the Infection Preventionist Nurse with in service on proper storage of COIVID 19 vaccines	

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F 761	Continued From page 12 identified it as [redacted] with an expiration date o[redacted]. Inside the bag were NJ Exec Order 26.4b1 [redacted] with an expiration date of [redacted]. At this time, LPNUM #1 stated that the overnight shift is responsible for checking the expiration dates and confirmed that the bag should not be in refrigerator. On 11/08/2024 at 1:40 PM during an interview with the surveyor, the U.S. FOIA (b)(6) [redacted] confirmed that the [redacted] were expired and should not have been in the refrigerator. On 11/12/2024 at 11:12 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) confirmed that the overnight staff are responsible for checking expiration dates in the medication rooms and that the NJ Exec Order 26.4b1 should have been removed from the medication room. When asked why it is important to remove [redacted] that are expired, the [redacted] responded that [redacted] might not be effective past that date. On 11/12/2024 at 12:19 PM, in the presence of the U.S. FOIA (b)(6) U.S. FOIA (b)(6) acknowledged that the expired [redacted] in the medication room refrigerator. A review of the facility policy titled, "Medication Storage", last reviewed June 4, 2024, revealed under, "Responsibility" that: 1.[Licensed Nurse] Checks medication storage at least monthly to ensure all meds and supplies are checked for labels, expiration dates and to ensure the labels are legible. 2. Any meds that will be expiring should be removed before the expiration date. If	F 761	II: IDENTIFICATION OF OTHERS All residents have the potential of being affected when the expired vaccines are not removed from active inventory upon expiration III: SYSTEMIC CHANGES 11/26/24 Nursing staff on all shifts were in serviced by the Facility Educator on proper vaccine storage. 11/26/24 Nursing staff on the night shift were in serviced by the Facility Educator on importance on daily checks (during the night shift) of the Medication room refrigerator for any expired items. 11/26/24 Regional nurse in serviced the acting Director of Nursing and Infection Preventionist Nurse on importance of keeping the COVID vaccines in the Infection Preventionist Nurse□s office for closer and safer monitoring of the COVID vaccine stock. 11/26/24 Administrator and acting Director of Nursing reviewed the policy on Medication storage, no changes were made. IV: QA MONITORING Director of Nursing or designee will conduct rounds and check the Medication Room refrigerators on 2nd floor, 3rd floor and Infection Preventionist□s office for any expired vaccines daily x 2 weeks then weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of	

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F 761	Continued From page 13 pending expiration, it will determine if the supply will be completed before expiration date". NJAC-8:39-29.4	F 761	Nursing or designee COMPLETION DATE: 12/27/24	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		12/27/24

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F 880	Continued From page 14 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide a sanitary and comfortable environment that helped prevent the development and transmission of	F 880	F880- INFECTION CONTROL I: IMMEDIATE ACTION 11/6/24 Room [redacted] Personal Protective Equipment (PPE) was removed from the	

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F 880	Continued From page 15 communicable diseases and infections. The deficient practice was evidenced by the following: On 11/06/24 at 10:58 AM, upon initial tour of the second-floor sub-acute unit, the surveyor observed Room [redacted] with an NJ Exec Order 26.4b1 [redacted] sign along the doorframe. The surveyor observed inside the room Personal Protective Equipment (PPE) Gown discarded in the resident's personal trash bin. On the same date and time, the surveyor observed Room [redacted] with a NJ Exec Order 26.4b1 Sign along the doorframe. The surveyor observed inside the room a discarded Personal Protective Gown on the resident's floor. On 11/07/2024 at 11:13 AM, during an interview with the surveyor, Licensed Practical Nurse Unit Manager (LPNUM #1) stated that facility expectation was to bring a red biohazard disposable bag into the resident room and place all discarded PPE into the bag and throw it away in the soiled trash room. LPNUM #1 confirmed that PPE is not to be discarded in the resident trash bin or on the floor. On 11/12/24 at 10:22 AM, the surveyor observed in room [redacted] with an NJ Exec Order 26.4b1 Sign along the doorframe. The surveyor observed inside the room PPE discarded in the resident's personal trash bin. On 11/12/2024 at 10:26 AM, during an interview with the surveyor, Certified Nursing Assistant (CNA #1) stated that upon the start of their day, they receive report of residents with a change in status and any resident that is on NJ Exec Order 26.4b1 [redacted] and/or NJ Exec Order 26.4b1.	F 880	resident□s trash can and properly discarded in a red bag. 11/6/24 Room [redacted] Personal Protective Equipment (PPE) was removed from the floor and properly discarded in a red bag. 11/12/24 Room [redacted] Personal Protective Equipment (PPE) was removed from the resident□s trash can and properly discarded in a red bag. 11/12/24 The Regional nurse provided the Infection Preventionist Nurse with in service on proper Personal Protective Equipment (PPE) disposal (taking off Personal Protective Equipment (PPE) and placing it into a red bag which needs to be taken to the soiled utility room once the staff exits the room). 11/12/24 All isolation rooms were checked for proper disposal of Personal Protective Equipment (PPE), no negative findings. II: IDENTIFICATION OF OTHERS All residents have the potential of being affected when the Personal Protective Equipment (PPE) is not disposed properly. III: SYSTEMIC CHANGES 11/26/24 Nursing staff on all shifts were in serviced by the Facility Educator on proper Personal Protective Equipment (PPE) disposal. 11/26/24 Administrator and acting Director of Nursing reviewed the policy titled Infection control Mannual, no changes were made. IV: QA MONITORING Director of Nursing or designee will	

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F 880	Continued From page 16 CNA #1 confirmed that upon entering a room with a precaution sign, they are to bring a red trash bag and discard the PPE in that bag upon exiting the room then bring the bag to the soiled trash room. CNA #1 confirmed that PPE is not to be discarded in resident trash bin or on the floor. On 11/12/2024 at 11:12 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) acknowledged that PPE disposal was to be in a red bag and brought to the trash room. The U.S.F confirmed that PPE is not to be discarded in resident trash bin or on the floor. On 11/12/2024 at 12:19 PM, in the presence of the U.S. FOIA (b)(6) acknowledged that the PPE should not be discarded on the floor or in resident trash bins. A review of the facility document titled "Infection Control Manual", last reviewed June 4, 2024, revealed under "Isolation- Initiating Transmission Based Precautions" that "When transmission based precautions are implemented, the infection preventionist or designee shall: C. Ensure that appropriate linen barrel/hamper and waste container with appropriate liner are placed in or near the resident's room". A review of the facility document titled "Infection Control Manual", last reviewed June 4, 2024, revealed under "Personal Protective Equipment-Using Gown" that "After completing the treatment or procedure, gowns must be discarded in the appropriate container located in the room". A review of the facility document titled "Certified Nursing Assistant Job Description", revealed	F 880	conduct random rounds of 10 isolation rooms for proper disposal of Personal Protective Equipment (PPE) on 2nd and 3rd floor, daily x 2 weeks then weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing or designee COMPLETION DATE: 12/27/24	

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F 880	Continued From page 17 under "safety and sanitation" to "follow established procedures in the use and disposal of personal protective equipment". A review of the facility document titled "Licensed Practical Nurse Job Description", revealed under "safety and sanitation" to "Ensure that CNAs and other nursing personnel follow established procedures in the use and disposal of personal protective equipment". NJAC 8:39-33.1(b)	F 880		

New Jersey Department of Health

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	062018	A. BUILDING: _____ B. WING _____	C 11/13/2024

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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. Census: 113 Sample Size: 24 + 2 closed TYPE OF SURVEY: Recertification and Complaint 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 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	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced	S 560		12/27/24

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

Electronically Signed — 11/27/24

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S 560	Continued From page 1 by: Compliant: # 175944, 171414 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Findings include: A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 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. 1. For the 2 weeks of Complaint staffing from 02/11/2024 to 02/17/2024, the facility was deficient in CNA staffing for residents on 7 of 7	S 560	S560 MANDATORY ACCESS TO CARE I. Immediate Action The facility submits that staff to resident ratios were reviewed on 11/26/24 to ensure compliance with New Jersey minimal staffing requirements. Staffing coordinator was re in-serviced on 11/26/24 on staffing ratio requirements. II. Identification of Others: The facility respectfully submits that all residents may be affected by this practice. III. System Changes Policy and Procedure for Staffing was reviewed on 11/26/24 by Administrator and Acting Director of Nursing, no changes made. Director of Nursing and Administrator will review open positions and applications plus results of any interviews weekly to look for opportunities to hire. The Administrator and Director of Nurses will continue to utilize all possible means to increase the facility staff. This will include continued timely interviews, job fairs, reaching out to agencies for supplemental staff, setting up booths at nursing schools, utilization of all possible avenues to increase staffing in the facility. IV. Quality Assurance Audits will be completed by the Director of Nursing or designee to ensure that all staffing complies with staffing ratios. Audits will be done weekly x 4 weeks, monthly x 2 months and quarterly x 2 quarters.	

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S 560	Continued From page 2 day shifts as follows: -02/11/24 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -02/12/24 had 8 CNAs for 108 residents on the day shift, required at least 13 CNAs. -02/13/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -02/14/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -02/15/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -02/16/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -02/17/24 had 8 CNAs for 113 residents on the day shift, required at least 14 CNAs. 2. For the 2 weeks of Complaint staffing from 07/28/2024 to 08/03/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -07/28/24 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/29/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -07/30/24 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -07/31/24 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/03/24 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. 3. For the 2 weeks of staffing prior to survey from 10/20/2024 to 11/02/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -10/20/24 had 7 CNAs for 106 residents on the	S 560	The results of all audits will be brought to the QAPI committee quarterly x 2 quarters. V. Responsibility 1. Director of Nursing 2. Staffing coordinator 3. Administrator COMPLETION DATE: 12/27/24	

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S 560	Continued From page 3 day shift, required at least 13 CNAs. -10/20/24 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs. -10/21/24 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. -10/22/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -10/23/24 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/24/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/25/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -10/26/24 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -10/27/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/28/24 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/29/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/31/24 had 7 CNAs for 105 residents on the day shift, required at least 13 CNAs. -11/01/24 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -11/02/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. During an interview on 11/13/2024 at 9:00 AM with the surveyor, the Staffing Coordinator (SC) was asked if she felt they were meeting the staff requirements. The SC replied, "The facility does not always meet staffing requirements, but actively works to address shortages by using recruiters for nurses and CNAs and reaching out to sister facilities for additional support when needed."	S 560		

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S 560	Continued From page 4 A review of a facility provided policy, with a review date of 08/14/2024, titled "Staffing Policy and Procedure" revealed under the section titled " Policy Interpretation and Implementation" that, " Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of residents care services. Certified nursing assistants will be available on each shift to provide the needed care and service of each resident as outlined on the resident's comprehensive care plan. Our facility furnishes information from payroll records setting forth average numbers and types of personnel (in full equivalents) on each shift during at least one (1) week of each quarter to appropriate state agencies as required. Such worksheet is selected by the state survey agency."	S 560		
S2345	8:39-31.6(o) Mandatory Physical Environment The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 11/13/24 in the presents of the Administrator, it was determined the facility failed to ensure municipal, county and state emergency	S2345	S2345 – EVACUATION DRILL I. Immediate Action The facility submits that The Emergency Preparedness Binder was reviewed on	12/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062018	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSIN	1777 LAWRENCE STREET RAHWAY, NJ 07065

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S2345	Continued From page 5 management officials were invited 10 working days in advance to at least 1 evacuation drill each year. This deficient practice had the potential to affect all 113 residents and was evidenced by: A record review at 10:30 AM revealed the facility conducted 2 functional full scale Emergency Preparedness (EP) drills on 04/05/24 and 06/11/24. There were no records of the municipal, county and state Office of Emergency Management (OEM) officials being invited to or attending the two EP drills conducted in the last 12 months. In an interview on at 12:55 PM, the Administrator confirmed the documentation review. The Administrator, Regional Maintenance Director and Maintenance Director were informed of the deficient practice at 2:27 PM during the Life Safety Code survey exit conference.	S2345	11/26/24 to ensure compliance with the requirement. Director of Maintenance was re in-serviced by the Administrator on 11/26/24 on the requirement for 1 Evacuation drill per year where as the facility needs to invite state, county and municipal Emergency management officials at least 10 working days in advance. II. Identification of Others: The facility respectfully submits that all residents may be affected by this practice. III. System Changes The Administrator and Maintenance Director scheduled an Evacuation drill for December 10th, 2024. 11/27/24, the Administrator and Maintenance Director sent invitation to state, county and municipal Emergency management officials for the Evacuation drill scheduled for December 10th, 2024. IV. Quality Assurance Audits of the Emergency Preparedness Manual referring to the Evacuation drill will be completed by the Regional Administrator or designee to ensure that the facility is in compliance with the yearly Evacuation drill requirements. Audits will be done weekly x 4 weeks, monthly x 2 months and quarterly x 2 quarters. The results of all audits will be brought to the QAPI committee quarterly x 2 quarters. V. Responsibility: Administrator and Director of Maintenance or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S2345	Continued From page 6	S2345	COMPLETION DATE: 12/27/24	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315198	A. Building B. Wing	1/14/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 12/27/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/13/2024

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

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
315198 Y1	A. Building B. Wing Y2	1/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

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FOLLOWUP TO SURVEY COMPLETED ON 11/13/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
062018	A. Building B. Wing	1/14/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/27/2024	ID Prefix S2345 Reg. # 8:39-31.6(o) LSC	Correction Completed 12/27/2024	ID Prefix Reg. # LSC	Correction Completed
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FOLLOWUP TO SURVEY COMPLETED ON 11/13/2024	☐ 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 062018 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 1/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. BUILDING **01** B. WING _____	**11/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	**1777 LAWRENCE STREET** **RAHWAY, NJ 07065**

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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		
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 11/07/24, 11/08/24 and 11/13/24 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Adroit Care Rehabilitation and Nursing Center is a three-story building with a partial basement that was built in 1983. It is composed of Type II construction. The facility was fully sprinklered and was divided into eight smoke compartments. The generator powers 100% of the building per the Maintenance Director. The number of occupied beds was 113 out of 122. .	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	K 222		1/12/25

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

Electronically Signed | 12/03/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 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. 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	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. BUILDING 01 B. WING _____	11/13/2024

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K 222	Continued From page 2 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 11/08/2024 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that doors in a required means of egress were not equipped with a latch or lock in accordance with NFPA 101: 2012 Edition, Sections 19.2, 19.2.2.2.1, 7.2.1.5 and 7.2.1.5.3 This deficient practice had the potential to affect all 113 residents and was evidenced by the following: An observation at 1:25 PM revealed the front lobby main entrance/exit had 1 of the 2 exterior exit automatic sliding doors provided with a hook bolt type turn latch. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/13/2024 at 2:27 PM. N.J.A.C 8:39-31.2(e)	K 222	K222 Corrective Actions The hook bolt type turn latch was removed from the front lobby main entrance automatic sliding doors on 11/26/24. Identification of Others Potentially Affected The Maintenance Director, or designee, will perform a facility-wide assessment of the other egress doors to ensure no other turn latches were present. The facility acknowledges all residents could be potentially affected by this condition, but respectfully submits that no residents were affected. Systemic Changes The Maintenance Director, or designee, will perform documented monthly	

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K 222	Continued From page 3	K 222	inspections of all exterior egress doors to ensure they are locked in a compliant manner on an ongoing basis as part of the facility□s life safety program. Quality Assurance Results of the monthly inspections will be presented at the monthly QA meetings ongoing for 6 months . If substantial compliance is not met after 2 months, inspections will continue and results of the monthly inspections will be brought to QA meetings until substantial compliance is met. Responsible Party and Date of Correction The Administrator is responsible for the oversight of this process. As requested please find pictures attached. Substantial compliance is expected to be met by 01/12/2025.	
K 321 SS=F	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.	K 321		1/12/25

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K 321	Continued From page 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 11/08/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2, 19.3.2.1.3, 8.4 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all 113 residents and was evidenced by the following: An observational tour at basement level between 10:50 AM and 11:00 AM revealed: 1. The door to the storage room by the dryer room containing combustible boxes was not self-closing or automatic closing because the self	K 321	K321 Corrective Actions The following hazardous area doors had the following corrections finished by 11/26/2024: A. The door to the storage room by the dryer room had its self-closer arm reconnected so that it is self-closing and positive latching. B. The door to the second storage room in laundry was adjusted so that it is self-closing and positive latching. C. The door to the 3rd entrance to the	

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K 321	Continued From page 5 closer arm was disconnected. 2. The door to the second storage room in laundry did not close to latch when opened to 90 degrees and released. The room contained combustible storage. The test was repeated 2 times with the same result. 3. The 3rd entrance door to the laundry from the corridor by the double smoke doors did not latch when opened to 90 degrees and released. The latch hardware was stuck inside the mechanism preventing operation of the positive latching hardware. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 11/13/2024 at 2:27 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 321	laundry department was adjusted so that it is self-closing and positive latching. Identification of Others Potentially Affected The Maintenance Director, or designee, will perform a facility wide assessment of the other doors to hazardous areas to ensure the doors are self-closing and positive latching. The facility acknowledges all residents could be potentially affected by this condition, but respectfully submits that no residents were affected. Systemic Changes The Maintenance Director, or designee, will perform documented weekly inspections X 8 weeks of all facility hazardous areas to ensure their doors are self-closing and positive latching. Quality Assurance Results of the weekly inspections will be presented at the monthly QA meetings X for 6 months. Responsible Party and Date of Correction The Administrator is responsible for the oversight of this process. As requested please find pictures attached.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	**1777 LAWRENCE STREET** **RAHWAY, NJ 07065**

(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 321	Continued From page 6	K 321	Substantial compliance is expected to be met by 01/12/2025.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/08/2024 in the presence of the U.S. FOIA (b)(6) [redacted] was a determined that the facility failed	K 324	K324 Corrective Actions	1/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. BUILDING 01 B. WING _____	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 7 to perform monthly inspections of the range-hood fire suppression system wet chemical cylinder in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect all 113 residents and was evidenced by the following: An observation at 1:40 PM of the kitchen range-hood fire suppression system wet chemical tank inspection tag, revealed the semi-annual inspection was performed on July of 2024 and the monthly inspection documentation spaces on the back of the tags were filled out for 4 of the last 8 months going back 12 months. The tag had the monthly inspections filled out for: October, September, August and July 2024. The rest of the tag was blank indicating the monthly inspection had not been performed for the months of: June, May, April, March, February, January of 2024, and December and November 2023. No further documentation was provided. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference at 2:27 PM. NJAC 8:39-31.2(e) NFPA 17 A, 96	K 324	The kitchen hood□s wet chemical tank had its monthly inspection performed on 11/1/24 and its tag was filled out for November. Identification of Others Potentially Affected The facility only has one kitchen hood wet chemical tank so no further evaluation is needed. The facility acknowledges all residents could be potentially affected by this condition, but respectfully submits that no residents were affected. Systemic Changes The Maintenance Director, or designee, will continue to perform monthly inspections of the kitchen hood□s wet chemical tank and fill in the tag on an ongoing basis as part of the facility's life safety program. Quality Assurance Results of the monthly inspections will be presented at the monthly QA meetings ongoing for 6 months. Responsible Party and Date of Correction The Administrator is responsible for the oversight of this process. As requested please find pictures attached.	

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	315198	A. BUILDING **01** B. WING _____	**11/13/2024**

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K 324	Continued From page 8	K 324	Substantial compliance is expected to be met by 01/12/2025.	
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 and interview on 11/08/24 and 11/13/24, in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure the inspection, testing and maintenance of single station battery operated smoke alarms in the residents rooms in accordance with NFPA 72: 2010 Edition, Section 14.4.1.1, 14.4.2.2, Table 14.4.2.2(14.)(4), 14.5.1, and 14.6 and NFPA 70: 2011 Edition . This deficient practice had the potential to affect all 113 residents and is evidenced by the following: An observation tour of the second and third floor resident rooms between 10:17 AM and 2:00 PM revealed single station battery operated smoke alarms mounted on the ceilings of all the residents rooms. In an interview at 12:15 PM at room [redacted], the surveyor asked the NJ Exec Order 26.4b1 if there were	K 345	K345 Corrective Actions Per the Code of Federal Regulations 42 CFR 483.90(a)(5) and its allowable exception (iii)(B) for a fully sprinklered facility, the battery powered single-station smoke alarms in the resident rooms are not required. Because they are not required, as of 11/24/2024 the battery powered single-station smoke alarms were removed from all resident rooms per the allowances of NFPA 101 (2012 edition) 4.6.12.3. Identification of Others Potentially Affected All single-station smoke alarms were	1/12/25

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	315198	A. BUILDING **01** B. WING _____	**11/13/2024**

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K 345	Continued From page 9 documents of the manufacturers requirements for testing, testing frequency and a record of the tests and if the device installation date and initial test were recorded. The U.S. FOIA stated he started in February 2024 and there were no documents or records kept of testing the battery operated smoke detectors yet. In an interview on 11/13/24 at 12:35 PM the U.S. FOIA provided a 10 year battery operated combination Smoke/Carbon Monoxide detector package with the manufacturers specification sheet that stated the device requires annual cleaning and weekly testing to ensure proper operation. The U.S. FOIA stated he will do the annual cleaning and weekly testing with a written record. The U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 11/13/24. N.J.A.C 8:39-31.2 (e) NFPA 70, 72	K 345	removed from the resident rooms so no further evaluation is needed. The facility acknowledges all residents could be potentially affected by this condition, but respectfully submits that no residents were affected. Systemic Changes All single-station smoke alarms were removed from the resident rooms so no systematic changes are needed. Quality Assurance All single-station smoke alarms were removed from the resident rooms so no oversight is needed. Responsible Party and Date of Correction The Administrator is responsible for the oversight of this process. Substantial compliance is expected to be met by 01/12/2025	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		1/12/25

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	315198	A. BUILDING 01 B. WING _____	11/13/2024

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K 353	Continued From page 10 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/08/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined the facility failed ensure fire system sprinkler heads were maintained and ceiling smoke barriers in accordance with NFPA 101: 2012 edition, Sections 9.7.5, 19.3.5.1, and NFPA 25: 2011 edition. This deficient practice had the potential to affect all 113 residents and was evidenced by the following: Observations during a tour of the facility between 10:17 AM and 2:00 PM revealed the following: 1. In the basement food storage room, one sprinkler escutcheon was 2-1/4 inches down in the back corner sheet rock ceiling by door and one escutcheon was down 1 inch by the refrigerator. 2. In Room 330, the sprinkler head escutcheon had a 1/2-inch space around the side of the plate on the drop ceiling. 3. In the second floor supervisors office, the escutcheon on 1 of 2 sprinkler heads was down	K 353	K353 Corrective Actions 1. The following locations had ceiling tiles replaced as of 11/26/2024: A. Basement storage room. B. Maintenance storage room, by the boiler room. C. Paint room. D. Basement storage room #13. 2. By 12/06/2024, the facility□s third party fire sprinkler contractor will ensure sprinkler head escutcheons in the following locations fit properly: A. Basement food storage room. B. Room 330. C. Second floor supervisor□s office. D. First floor electrical room. E. First floor janitor□s closet. 3. By 12/31/2024, the following locations will have drywall repairs completed: A. Main boiler room ceiling. 7 openings will be closed. 12-inch by 18-inch opening	

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K 353	Continued From page 11 or missing bottom piece. 4. In the first floor phone electrical room, the sprinkler head escutcheon was coming down. 5. In the first floor janitors closet, the sprinkler escutcheon was coming down. 6. In the basement laundry room, there were penetrations through the ceiling with orange foam. 7. In the laundry dryer room, there were 8 wires and main conduit to the electrical panel passing through the drop ceiling causing an opening in the ceiling that was sealed with orange foam. There were also openings in the ceiling tiles around the dryer ducts to allow the passage of smoke that would affect the sprinkler head response time. 8. In the basement storage room, there were ceiling tiles missing and coming down in the back next to the sprinkler head. In an interview at the time, the [redacted] stated it was due to a leak. 9. The maintenance storage room was missing a ceiling tile by the boiler room. 10. In the paint room, drop ceiling tiles were missing on vertical edge of ceiling by sprinkler head that would affect sprinkler activation. 11. In the basement storage room #13, there were two 12 -inch by 48-inch and one 2-foot by 4-foot ceiling tiles missing, and 3 pipes on left penetrating through the drop ceiling with open space around them.	K 353	by door, 26-inch by 7-foot between the boilers, 2-foot by 26-inch across from 1st boiler, 42-inch by 28-inch across from 2nd boiler, 2-foot by 28-inch with a pipe, 2-foot by 2-foot across from boiler, and 53-inch by 76-inch opening on drywall drop by the back end door 4. By 12/31/2024, the following locations will have penetrations sealed with fire caulk or better fitting drop ceiling tile: A. Basement laundry room. Ceiling penetrations. B. Laundry dryer room. 8 wires and main conduit to the electrical panel passing through the drop ceiling and openings in the ceiling tiles around the dryer ducts C. Basement storage room #13. 3 pipes on left penetrating through the drop ceiling with open space around them. D. Main boiler room. 7 holes with wires struts or pipes going through the ceiling. E. Kitchen storage room. Wire penetrations above the electrical panels and along the wall Identification of Others Potentially Affected The Maintenance Director, or designee, will perform a facility wide assessment to ensure the following: 1. Spaces with a drop-ceiling are not missing any ceiling tiles. 2. Sprinkler head escutcheons fit properly. 3. Drywall is complete and no holes or missing sections are present. 4. Drop-ceiling and drywall penetrations are appropriately sealed.	

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K 353	Continued From page 12 12. In the main boiler room, there were the following openings in the sheet rock ceiling: 12-inch by 18-inch opening by door, 26-inch by 7-foot between the boilers, 2-foot by 26-inch across from 1st boiler, 42-inch by 28-inch across from 2nd boiler, 2-foot by 28-inch with a pipe, 2-foot by 2-foot across from boiler, 53-inch by 76-inch opening on drywall drop by the back end door, and 7 holes with wires struts or pipes going through the ceiling. 13. In the kitchen storage room, there were wire penetrations above the electrical panels and along the wall with an unknown fire rated substance sealing the space around the wires. The openings would allow smoke and hot gases to flow into the space above preventing the sprinklers from being activated at their designed time and temperature. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code survey exit conference on 11/13/24 at 2:27 PM. N.J.A.C 8:39-31.2(e) NFPA 13, 25	K 353	The facility acknowledges all residents could be potentially affected by this condition, but respectfully submits that no residents were affected. Systemic Changes The Maintenance Director, or designee, will perform the following: 1. Documented monthly inspections X 2 months of all facility spaces with a drop-ceiling to ensure they are not missing any ceiling tiles. Inspections will continue annually thereafter on an ongoing basis as part of the facility□s life safety program. 2. Documented monthly inspections X 2 months of all sprinkler heads to the escutcheons fit properly. Inspections will continue annually thereafter on an ongoing basis as part of the facility□s life safety program. 3. Documented monthly inspections X 2 months of all facility areas to ensure the drywall has no holes or missing sections. Inspections will continue annually thereafter on an ongoing basis as part of the facility□s life safety program. 4. Documented monthly inspections X 2 months to ensure all drop-ceiling and drywall penetrations are appropriately sealed. Inspections will continue annually thereafter on an ongoing basis as part of the facility□s life safety program. Quality Assurance Results of the monthly inspections, for all four systematic changes, will be	

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K 353	Continued From page 13	K 353	presented at the monthly QA meetings for 6 months If substantial compliance is not met after 2 months, inspections will continue and results of the monthly inspections will be brought to QA meetings until substantial compliance is met. The Administrator is responsible for the oversight of this process. As requested please find pictures attached. Substantial compliance is expected to be met by 01/12/2025. Substantial compliance is expected to be met by 01/12/2025.	
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	K 918		1/12/25

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K 918	Continued From page 14 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 documentation review and interview on NJ Exec Order 26.4b1 in the presence of the U.S. FOIA (b)(6) it was determined the facility failed to ensure the diesel fueled Emergency Power Supply (EPS) was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Section 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect all 113 residents and was evidenced by the following: A record review on 11/07/24 at 9:30 AM of the emergency power generator logs revealed the	K 918	Corrective Actions 1. The facility□s third-party generator vendor performed a 4-hour load bank test on 11/13/2024. The 1.5 hour load bank test was combined with the 4 hour load bank test per the allowance of NFPA 110 (2010 edition) 8.4.9.6 and performed the requirements of 8.4.9.7. 2. The Maintenance Director performed the monthly load test on the emergency generator on 11/19/2024 and documented the exercise load percentage. Identification of Others Potentially Affected	

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K 918	Continued From page 15 facility did not record the percentage of the EPS nameplate kW rating that the generator was exercised monthly to determine if the load met the 30% or greater of the nameplate rating requirement or perform a 90 minute annual load bank test for the last 12 months. In an interview on 11/08/24 at 2:24 PM, the MD confirmed the record review findings. The U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code survey exit conference on 11/13/24 at 2:27 PM. NJAC 8:39-31.2 (e) NFPA 99, 110	K 918	The facility only has one emergency generator so no further evaluation is needed. The facility acknowledges all residents could be potentially affected by this condition, but respectfully submits that no residents were affected. Systemic Changes 1. The Maintenance Director, or designee, will continue to coordinate with a third-party generator vendor to perform annual load bank testing on an ongoing basis as part of the facility□s life safety program. 2. The Maintenance Director, or designee, will continue to perform monthly load testing of the emergency generator and document the exercise load percentage. Quality Assurance Results of the monthly load tests, as well as results of the third-party load bank test, will be presented at the monthly QA meetings for 6 months . If substantial compliance is not met after 2 months, inspections will continue, and results of the monthly inspections will be brought to QA meetings until substantial compliance is met. Responsible Party and Date of Correction The Administrator is responsible for the	

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K 918	Continued From page 16	K 918	oversight of this process. As requested please find pictures attached. Substantial compliance is expected to be met by 01/12/2025.	

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
315198 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	01/12/2025	LSC K0321	01/12/2025	LSC K0324	01/12/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	01/12/2025	LSC K0353	01/12/2025	LSC K0918	01/12/2025
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?
11/13/2024	☐ YES ☐ NO