STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD** **OXFORD, NJ 07863**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/22/2023 and 09/25/2023, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 2-story with a ground floor building that was built in 90's, It is composed of Type I fire resistant construction. The facility is divided into 14 smoke zones. The generator does 100% of the building.	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	K 222		10/25/23

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

Electronically Signed | 10/13/2023

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K 222	Continued From page 1 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: REPEAT Deficiency from 07/18/2023 Re-Certification survey. Based on observation and review of facility provided documentation on 09/22/2023 and 09/25/2023 in the presence of facility management, it was determined that the facility failed to provide 1 of 5 designated exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story building with five (5) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility MD a tour of the building was conducted. During the building on 09/25/2023 at approximately 10:34 AM, the surveyor observed	K 222	K-222 – Egress Doors. 1) An electric lock tied into the fire alarm system was installed at the main entrance to replace the current locking mechanism. 2) All residents have the potential to be affected by this deficient practice. An audit was conducted of all Egress doors by the Director of Maintenance to assure compliance. 3) Maintenance staff were re-educated on Egress doors and the requirements of K-222. The means of egress throughout the building will be monitored by the maintenance staff daily on the 24-hour report to ensure compliance. 4) Results of the daily checks will be reported to QAPI quarterly.	

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K 222	Continued From page 3 the main entrance two (2) sets of automatic sliding exit discharge doors (internal and external set of doors) revealed thumb turn lock on the egress side of the inner sliding doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The MD confirmed the findings at the times of observations. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		10/25/23

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K 321	Continued From page 4 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 review of facility provided documentation on 09/22/2023 and 09/25/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility MD a tour of the building was conducted. During the building tour the of the facility the	K 321	331 – Hazardous areas – Enclosure 1) The Medical Records room and the Central Supply room have been equipped with an automatic door closure. 2) All residents have the potential to be affected by this deficient practice. All hazardous areas were audited to ensure that there were automatic door closures in place. 3) A quarterly audit will be completed by the Maintenance Director to ensure that all Hazardous areas are equipped with automatic door closures. 4) Results of the audits will be submitted to the QAPI committee quarterly.	

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K 321	Continued From page 5 surveyor observed the following hazardous area that failed to have smoke resisting doors, On 09/22/2023: 1) At approximately 10:30 AM, an inspection inside the second (2nd.) floor Medical Records room was performed. The surveyor observed that when the corridor door leading into the Medical Records room was tested and allowed to self-close, the door did not close into its frame. This left an approximately 1-1/4 inch gap between the door and the doors frame. This test was repeated two additional times with the same results. The surveyor observed multiple combustible medical records and 15 filling cabinets filled with medical records in the room. The Medical Records room was larger then 50 square feet. With this corridor door not closing into its frame all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 10:49 AM, an inspection inside the second (2nd.) floor Central Supply room was performed. The surveyor observed that when the corridor door leading into the Central Supply room had no means to self-close the door into its frame. This left an approximately 33 inch opening between the door and the doors frame. The surveyor observed multiple combustible boxes and products in the room. The Central Supply room was larger then 50 square feet. With this corridor door not closing into its frame	K 321		

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K 321	Continued From page 6 all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted in the area identified to pass the Medical Records room and Central Supply room is the primary and/ or secondary egress route in the event of a fire. The MD confirmed the finding at the time of observations. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2 (e) Life Safety Code 101	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 interview and documentation review on 09/22/2023 and 09/25/2023, in the presence of the facility management, it was determined that the facility failed to inspect the fire alarm system on a semi-annual (every 6 months) inspection in accordance with NFPA 72. This deficient practice	K 345	– Fire Alarm System - Testing and Maintenance 1) The Fire Alarm System had its semiannual inspection on 9/ 15/23 and 9/ 18/23. The next inspection has been scheduled for 3/13/24.	10/25/23

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K 345	Continued From page 7 was identified for 1 of 1 fire alarm systems and was evidenced by the following: On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator (Admin) and Maintenance Director (MD) to provide all Mandatory inspections from June 1, 2022 through September 21, 2023 for review later. The surveyor also asked the MD, how long have you worked here. The MD told the surveyor five (5) months. On 09/22/2023 at approximately 12:50 PM, a review of the facility provided semi-annual (every 6 months) kitchen suppression system inspections for the previous 15 months revealed that the system was inspected by a licensed vendor on, 06/14/2022, 09/15/2023 and 09/18/2023. On 09/22/2023 at approximately 1:50 PM, the surveyor made a request to the Admin. and MD to provide any additional semi-annual (every 6 months) kitchen suppression system inspections from 06/14 2022 through 09/15/2023 that had been conducted. On 09/25/2023 (day two of survey) at approximately 9:49 AM, the surveyor made a request to the Admin. if the facility could provide any additional semi-annual kitchen suppression system inspections. The Admin. told the surveyor that the inspection had not been done, because it was in between two Maintenance Directors. The Admin. confirmed the finding at the time. On 09/25/2023 during the survey exit at	K 345	2) All Residents have the potential to be affected by this deficient practice. 3) The Director of Maintenance was re-educated on requirements of K-345. The Life Safety inspections QAPI spreadsheet was updated to include the semi-annual Fire Alarm System inspection. 4) The Life Safety Inspections QAPI spreadsheet will be submitted to the Administrator monthly and to the QAPI committee quarterly.	

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K 345	Continued From page 8 approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 09/22/2023 and 09/25/2023, in the presence of facility management it was determined that: Failed to provide fire sprinkler coverage to all areas of the facility as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of	K 351	Sprinkler System – Installation 1) A contract was signed and sprinkler heads were installed on the upper landing and the lower landing of stairwell #4. 2) Stairwells will be audited by the Maintenance Director to ensure that ensure that no additional sprinkler heads are missing. 3) Maintenance staff were re-educated on NFPA 13 and the sprinkler	10/25/23

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K 351	Continued From page 9 Sprinkler Systems 2012 Edition The deficient practice is evidenced by the following, On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story building with six (6) designated exit stairwells (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility's MD a tour of the building was conducted. Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 09/22/2023: 1) At approximately 10:54 AM, the surveyor observed no evidence of fire sprinkler coverage inside the 17'-6" by 7'-6" stairwell #4 upper landing. At this time a request was made to the MD, do you see a fire sprinkler in the lower landing area. The MD said, no. 2) At approximately 12:26 AM, the surveyor observed no evidence of fire sprinkler coverage inside the 6' by 7'-6" stairwell #4 lower landing. At this time a request was made to the MD, do	K 351	requirement. Sprinklers will be monitored monthly by the Maintenance Staff. 4) Results of the sprinkler audit rounds will be reported to QAPI monthly.	

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K 351	Continued From page 10 you see a fire sprinkler in the lower landing area. The MD said, no. The facility failed to provide fire sprinkler coverage to all areas in the facility. The MD confirmed the finding at the time of observations. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 09/06//2023, in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 2 of 47 portable fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70.	K 355	Portable Fire Extinguishers 1) The Fire Extinguishers in the kitchen and the maintenance shop were inspected and signed off for September 2023. 2) A review of all Fire Extinguishers was completed by the Maintenance Director to ensure that all had been inspected for September 2023. 3) Maintenance staff were re-in serviced the requirements under NFPA 10 Fire Extinguisher inspections.	10/25/23

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K 355	Continued From page 11 Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following, On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility MD a tour of the building was conducted. During the building tour of the facility the surveyor	K 355	Maintenance Director will audit all Fire Extinguishers monthly to ensure that inspections are completed timely. 4) Results of Maintenance Directors audit of Fire Extinguishers will be submitted to the Administrator monthly and the QAPI committee Quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD** **OXFORD, NJ 07863**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 12 observed and inspected forty-seven (47) portable fire extinguishers in various locations that were last annually inspected in June 2023 with the surveyor observing the following issues that were identified: On 09/22/2023: 1) At approximately 11:16 AM, One (1) "ABC-Type" fire extinguisher in the Main Kitchen, last annually inspected June 2023. There was no evidence of monthly visual examination performed and documented for July and August 2023. 2) At approximately 12:17 PM, One (1) "ABC-Type" fire extinguisher in the Maintenance shop, last annually inspected June 2023. There was no evidence of monthly visual examination performed and documented for July and August 2023. The MD confirmed the finding at the time of observations. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		10/25/23

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K 521	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations on 09/22/2023 and 09/25/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 5 of 7 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with forty-eight (48) Resident sleeping rooms and common areas. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility's MD a tour of the building was conducted. During the two (2) day building tour the surveyor inspected inside seven (7) Resident sleeping rooms. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not	K 521	HVAC 1) Exhaust fans in rooms [redacted], [redacted] and [redacted] have been repaired and are now functional. 2) The Maintenance Director will audit all resident area exhaust fans to ensure that they are operational and complete repairs as needed. 3) Maintenance staff were re-in serviced on the importance of working exhaust fans. The Maintenance Director will audit all exhaust fans month and submit results to the administrator. 4) Results of the audit will be submitted to QAPI committee quarterly.	

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	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

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WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD** **OXFORD, NJ 07863**

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K 521	Continued From page 14 function properly in 5 of 7 resident bathrooms in the following locations: On 09/25/2023: 1. At approximately 10:33 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the MD that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:19 AM, inside Resident room #[redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 10:50 AM, inside Resident room #[redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 4. At approximately 10:55 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 11:15 AM, inside Resident room #[redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on	K 521		

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K 521	Continued From page 15 mechanical ventilation. The MD confirmed the findings at the time. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		

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
315304 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

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	10/25/2023	LSC K0321	10/25/2023	LSC K0345	10/25/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	10/25/2023	LSC K0355	10/25/2023	LSC K0521	10/25/2023
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	
9/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO