New Jersey Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		62203		B. WING		07/2	7/2021
		02203				0712	.772021
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
FOREST	HILL HEALTHCARE	CENTER		ROSPECT A' , NJ 07104	VE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	COMPLETE DATE	
S 000	Initial Comments			S 000			
	WITH THE STAND ADMINISTRATIVE STANDARDS FOR TERM CARE FACII SUBMIT A PLAN O INCLUDING A CON DEFICIENCY AND IMPLEMENTED. FA DEFICIENCIES MA ENFORCEMENT A WITH THE PROVIS	MPLETION DATE, FO ENSURE THAT THE AILURE TO CORRE BY RESULT IN COTION IN ACCORD BIONS OF THE NEV FRATIVE CODE, TIT IFORCEMENT OF	JERSEY 3:39, DNG TY MUST OR EACH E PLAN IS CT ANCE V				
S 560		ory Access to Care comply with applica local laws, rules, an		S 560			9/27/21
	by: Based on observati pertinent facility dod determined the faci required minimum or ratios as mandated This deficient practi following: Reference: NJ Stat 112. An Act concern nursing homes and Revised Statutes. E	on, interview, and recumentation, it was lity failed to maintain direct care staff-to-reby the state of New ice was evidenced by the requirement, CHAI ing staffing requirement supplementing Title it enacted by the State of New ice it enacted by the State of New ice was evidenced by the State of Ne	the esident Jersey. The esident series of the esident series for the series for		Corrective Action: The center has an active recruitme program for attracting and hiring C Nursing Assistants (CNA). Three C were recently hired and are curren participating in the center sorient program. The center will continue efforts to recruit and employ CNAs order to comply with the recently eminimum staffing requirements for Identifications: The center s Nursing Administration identified that the week-end CNAs schedules were affected by this desired.	Certified CNAs atly tation its in enacted CNAs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/12/21

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMPI	
			A. BUILDING.	·		
		62203	B. WING		07/2	7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FOREST	HILL HEALTHCARE	CENTER	ROSPECT A NJ 07104	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
S 560	Continued From pa	ge 1	S 560			
	C.30:13-18 Minimunursing homes effect. 1. a. Notwithstandir requirements as many every nursing homes. P.L.1976, c.120 (C. to P.L.1971, c.136 (C. to P.L.1971, c	um staffing requirements for ctive 2/1/21. Ing any other staffing any be established by law, as defined in section 2 of 30:13-2) or licensed pursuant (C.26:2H-1 et seq.) shall ang minimum direct care staff curse aide to every eight y shift; a staff member to every 10 ening shift, provided that no ll staff members shall be so, and each staff member to work as a certified nurse form certified nurse aide duties; a staff member to every 14 ght shift, provided that each mber shall sign in to work as a and perform certified nurse and		practice. 5 of the 5 shifts identified Statement of Deficiencies were we shifts. Each shift was 1 CNA below minimum CNA staffing requirement. Preventive Measures: The Administrator and Director of shall continue to review the daily C staffing schedules to ensure compwith the state sminimum CNA starequirement. In addition, the center continue its recruitment and hiring as well as its CNA staff retention prin order to meet the staffing requirement. The center shall offer overtime, incompay, and bonuses to current staff staffing shortage is identified or octhroughout the day. The center als maintains a contract with a nursing contracted agency in the event of prolonged CNA and/or nursing vacuality Assurance: The Director of Nurses and Admin or designee shall review the CNA schedule daily for four weeks and weekly for an additional two month.	eek-end v the v the nt. Nursing CNA bliance affing or shall efforts, brograms ements. centive when a ccurs of any cancies. istrator staffing then ns to	
	ratios for a period of the date of the expa	crease in direct care staffing if nine consecutive shifts from ansion of the resident census.		determine compliance with the sta minimum CNA staffing requiremer Administrator shall continue to mo	nt. The nitor the	
	c. (1) The computar staffing ratios shall place. (2) If the applications subsection a. of this a whole number of certified nurse aider required direct care rounded to the next	tion of minimum direct care be carried to the hundredth ation of the ratios listed in a section results in other than direct care staff, including s, for a shift, the number of a staff members shall be a higher whole number when carried to the hundredth place,		center shiring and retention practidentify potential areas of improved Upon the completion of the three review, the QAPI committee shall on a quarterly basis the center staffing levels. Findings shall be reto the Administrator for any addition corrective actions.	ment. nonth review CNA eported	

TACW CCI	sey Department of I	ICAILII				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		62203	B. WING		07/2	7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FOREST	HILL HEALTHCARE	CENTER	ROSPECT A' , NJ 07104	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
S 560	is fifty-one hundred (3) All computa midnight census for begins. d. Nothing in this s affect any minimum nursing homes as r Commissioner of H care staff, including restrict the ability of staffing levels, at an established minimum On 07/16/21, 07/19 07/22/21 and 07/27 nine to ten Certified working on the throughout the facil the resident's who is A review of "New Je Long Term Care As Program Nurse Sta June 27th, 2021 ref Sunday, 6/27/21 the resident's who resident's who resident's who resident's who resident's who resident's who resident's manumber) / (divided of 7:00 AM - 3:00 PM number) / (divided of 71/8 = (equals) 8.8 assignment. (not minimum)	ths or higher. ations shall be based on the relations shall be based on the rethe day in which the shift section shall be construed to a staffing requirements for may be required by the lealth for staff other than direct governing the certified nurse aides, or to fa nursing home to increase my time, beyond the lim. 1/21, 07/20/21, 07/21/21, 1/21	S 560	DEFICIENCY)		
	11:00 PM - 7:00 AN (met)	A shift, 5 CNA's 71/8 = 8.88				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
71101211	or correction.	BERTH 10, THE IT TO MEET.	A. BUILDING:		0011111	
		62203	B. WING		07/2	7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FOREST	HILL HEALTHCARE	CENTER	ROSPECT A	VE		
040.15	CUMMA DV CTA			DROVIDER'S DI ANI OF CORRECTIO		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 560	Continued From pa	ge 3	S 560			
		mum staffing requirements on 7:00 AM - 3:00 PM shift.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	e facility's census was 71. shift, 71/10 = 7.1 (met) 4 shift, 71/12 = 5.92 (met) 4 shift, 71/7 = 10.14 (met)				
		compliance with the State of um staffing requirements on shifts.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	ne facility's census was 72. shift, 72/12 = 6.0 (met) 4 shift, 72/11 = 6.55 (met) 4 shift, 72/6 = 12 (met)				
		compliance with the State of um staffing requirements on e shifts.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	21 the facility's census was 72. shift, 72/15 = 4.8 (met) 4 shift, 72/13 = 5.54 (met) 4 shift, 72/6 = 12(met)				
	-	compliance with the State of um staffing requirements on shifts.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	ne facility's census was 74. shift, 74/13 = 5.69 (met) 1 shift, 74/12 = 6.16 (met) 1 shift, 74/8 = 9.25 (met)				
		compliance with the State of um staffing requirements on shifts				
	Friday, 7/2/21 the fa	acility's census was 76.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED		
		62203		B. WING		07/2	27/2021
	PROVIDER OR SUPPLIER	CENTER	497 MT P	DRESS, CITY, S ROSPECT A' , NJ 07104	STATE, ZIP CODE VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE CIDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S 560	Continued From part 7:00 AM - 3:00 PM 3:00 PM - 11:00 PM 11:00 PM - 7:00 AM The facility was in the facil	shift, 76/13 = 5. I shift, 76/13 = 5. I shift, 76/7 = 10 compliance with a shifts. I shift, 75/9 = 8.3 I shift, 75/9 = 8.3 I shift, 75/6 = 12 compliance with a shift, 75/6 = 12 compliance with a staffing requision of the season of the seas	2.5 (met) 2.86 (met) 3.86 (met) 3.86 (met) 3.86 (met) 3.82 (met) 3.84 (met) 3.87 (met)	S 560			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		62203	B. WING		07/2	7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
FOREST	HILL HEALTHCARE	CENTER	PROSPECT A K, NJ 07104	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 560	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM - 11:00 PM 11:00 PM - 7:00 AM The facility was in one New Jersey minimum 7/6/21 during all through Wednesday, 7/7/21 7:00 AM - 3:00 PM 3:00 PM - 11:00 PM - 7:00 AM The facility was in one New Jersey minimum 7/7/21 for all three some Thursday, 7/8/21 through 7:00 AM - 3:00 PM 3:00 PM - 11:00 PM 11:00 PM - 7:00 AM The facility was in one New Jersey minimum 7/8/21 for all three some New Jersey minimum 7/8/21 for all three some PM - 11:00 PM - 7:00 AM	e facility's census was 73. shift, 73/12 = 6.08 (met) M shift, 73/12 = 6.08 (met) M shift, 73/9 = 8.11 (met) compliance with the State of um staffing requirements on ree shifts. I the facility's census was 73. shift, 73/9 = 8.11 (met) M shift, 73/12 = 6.08 (met) M shift, 73/11 = 6.64 (met) compliance with the State of um staffing requirements on shifts. The facility's census was 75. shift, 75/9 = 8.34 (met) M shift, 75/11 = 6.82 (met) M shift, 75/11 = 6.82 (met) M shift, 75/11 = 6.82 (met) Compliance with the State of um staffing requirements on shifts.	S 560			
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	facility's census was 75. shift, 75/11 = 6.82 (met) M shift, 75/12 = 6.25 (met) M shift, 75/9= 8.33 (met)				
		compliance with the State of um staffing requirements on ree shifts.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	the facility's census was 74. shift, 74/8 = 9.25 (not met) M shift, 74/11 = 6.73 (met) M shift, 74/8 = 9.25 (met)				

	sey Department of I		I			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
	5. 55111E511611	BENTH IS WIGHT HOMBEN.	A. BUILDING:		JOIVII	,
			D WINC			
		62203	B. WING	·	07/2	7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FOREST	HILL HEALTHCARE	CENTER 497 MT PI	ROSPECT A	VE		
TORLOT	THEE HEALTHOAKE	NEWARK	NJ 07104			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROPERTY OF T		DATE
				DEFICIENCY)		
S 560	Continued From pa	age 6	S 560			
	, , , , , , , , , , , , , , , , , , ,	.900				
	The facility was not	in compliance with the State				
		mum staffing requirements on				
		7:00 AM - 3:00 PM shift.				
		ered the facility to conduct a				
		ey on 7/16/21. Review of the				
	facility's census and staffing for the fourth and					
	fifth floor from 7/16/21 through 7/27/21 revealed the following:					
		facility's census was 76.				
		shift , 9 CNA's. 76/9 =				
	8.44(met)	1 - h:ft 42 CNA - 76/42 - F 9F				
	(met)	<i>I</i> shift, 13 CNA's 76/13 =5.85				
	,	// shift, 3 CNA's 76/8 = 9.5				
	(met)	,				
		compliance with the State of				
	7/16/21 for all three	um staffing requirements on				
	1/10/21 101 all tilled	s stilles.				
	Saturday, 7/17/21 t	he facility's census was 74.				
	7:00 AM - 3:00 PM	shift, 74/9 = 8.22 (met)				
		// shift, 74/10 = 7.4 (met)				
	11:00 PM - 7:00 AN	/I shift, 74/7 = 10.57 (met)				
	The facility was in o	compliance with the State of				
		um staffing requirements on				
	7/17/21 for all three					
	THE FOR All tilles Stills.					
	Sunday, 7/18/21 the facility's census was 73.					
	7:00 AM - 3:00 PM shift, 73/9 = 8.11 (met)					
	3:00 PM - 11:00 PM shift, 73/10 = 7.3 (met) 11:00 PM - 7:00 AM shift, 73/8 = 9.13 (met)					
	11.00 FW - 1.00 AN	n silit, 13/0 – 9.13 (IIIet)				
	The facility was in o	compliance with the State of				
	New Jersey minimu	um staffing requirements on				
	7/18/21 for all three					

STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		62203	B. WING		07/2	7/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, §	STATE, ZIP CODE	1 0172	<u></u>
FOREST	HILL HEALTHCARE	CENTER	ROSPECT AV , NJ 07104	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 560	Continued From pa	nge 7	S 560			
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM 11:00 PM - 7:00 AM The facility was in c	the facility's census was 74. shift, 74/10 = 7.4 (met) A shift, 74/12 = 6.17 (met) A shift, 74/8 = 9.25 (met) compliance with the State of the staffing requirements on				
	7/19/21 during all th					
	Tuesday, 7/20/21 the facility's census was 74. 7:00 AM - 3:00 PM shift, 74/9 = 8.22 (met) 3:00 PM - 11:00 PM shift, 74/13 = 5.69 (met) 11:00 PM - 7:00 AM shift, 74/8 = 9.25 (met)					
		compliance with the State of um staffing requirements on e shifts.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	21 the facility's census was 73. shift, 73/9 = 8.11 (met) A shift, 73/13 = 5.62 (met) A shift, 73/8 = 9.13 (met)				
		t in compliance with the State imum staffing requirements on e shifts.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	the facility's census was 75. shift, 75/9 = 8.33 (met) A shift, 75/12 = 6.25 (met) A shift, 75/8 = 9.38 (met)				
		compliance with the State of um staffing requirements on e shifts.				
	7:00 AM - 3:00 PM	facility's census was 74. shift, 74/10 = 7.4 (met) A shift, 74/11 = 6.73 (met)				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		62203	B. WING		07/2	7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FOREST	HILL HEALTHCARE	CENTER	ROSPECT A' , NJ 07104	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 560	Continued From pa	nge 8	S 560			
	11:00 PM - 7:00 AN	M shift, 74/7 = 10.57 (met)				
		compliance with the State of um staffing requirements on hree shifts.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	he facility census was 73. shift, 73/8 = 9.13 (not met) A shift,73/11 = 6.64 (met) A shift, 73/8 = 9.13 (met)				
	The facility was not in compliance with the State of New Jersey minimum staffing requirements on 7/24/21 during the 7:00 AM - 3:00 PM shift.					
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	e facility census was 73. shift, 73/8 = 9.13 (not met) \$\mathcal{A}\$ shift, 73/10 = 7.3 (met) \$\mathcal{A}\$ shift, 73/8 = 9.13 (met)				
	of New Jersey mini	t in compliance with the State imum staffing requirements on 7:00 AM - 3:00 PM shift.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	ne facility census was 74. shift, 74/9 = 8.22 (met) M shift, 74/12 = 6.17 (met) M shift, 74/8 = 9.25 (met)				
		compliance with the State of um staffing requirements on e shifts.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM	he facility census was 73. shift, 73/9 = 8.11 (met) A shift, 73/11 = 6.64 (met) A shift, 73/8 = 9.13 (met)				
		compliance with the State of um staffing requirements on				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		62203	B. WING		07/2	7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FOREST	HILL HEALTHCARE	CENTER	ROSPECT A' , NJ 07104	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 560	the Administrator w New Jersey require the 7:00 AM - 3:00 ratio on the 3:00 PM CNA staffing ratio of shift. The Administration of the Administrator of staff, offering over reaching out to other The Administrator of staff, offering over reaching out to other the Administrator of staff, offering over reaching out to other the Administrator of staff, offering over reaching out to other the Administrator of the Administrator of the Administrator of the facilital Interpretation and Interpretation and Interpretation and Interpretation and Interpretation and Interpretation of the control of the	AM, the surveyor interviewed tho stated that the State of ed an 8:1 CNA staffing ratio on PM shift, a 10:1 CNA staffing M -11:00 PM shift, and a 14:1 on the 11:00 PM - 7:00 AM rator stated that the facility was ey could to maintain staffing sted of continuous recruitment ertime, bonus incentives, and er sister facilities to share staff. Stated we, "Have never staff and are always trying to the staff and are always trying to the staff and staff. The staff and shall be staff and shall be shall be shall be shall be increased to the shall be increased to the number when the ration is "The Policy added, "The vertime pay, bonus pay, and CNA staff members in order to a CNA staffing requirements." The Policy Interpretation and cumented the required CNA red by the State of New Jersey	S 560	DEFICIENCY)		
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STATE FORM: REVISIT REPORT

					SIAIEF	URIVI: RE	VISII REPURI					
PROVIDE				MULTIPLE CON	ISTRUCTION					DATE O	F REVIS	ΙΤ
identification 62203	CATION N	IOMBI	=R Y1	A. Building B. Wing					Y2	9/27/20	21	Y3
NAME OF	FACILIT	Υ		<u> </u>			STREET ADDRESS, C	CITY, STATE, ZIF	P CODE			
FOREST	THILL HE	EALTI	HCARE (CENTER			497 MT PROSPECT A	VE				
							NEWARK, NJ 07104					
corrective	e action v	was a	ccomplis	shed. Each defi	iciency should b	e fully ident	reviously reported that ified using either the r efix codes shown to th	regulation or L	SC provision	number	and the	oort
ITE	M			DATE	ITEM		DATE	ITEM		DATE		
Y4				Y5	Y4		Y5	Y4			Y5	
ID Prefix	S0560			Correction	ID Prefix		Correction	ID Prefix			Correct	ion
Reg. #	8:39-5.1(a)		Completed	Reg. #		Completed	Reg.#			Comple	eted
LSC				09/27/2021	LSC			LSC				
							 -					
ID Prefix				Correction	ID Prefix		Correction	ID Prefix			Correct	ion
				_	——————————————————————————————————————						Ooncol	1011
Reg. #				Completed	Reg. #		Completed	Reg.#			Comple	ted
LSC				_	LSC			LSC _				
ID Prefix				Correction	ID Prefix		Correction	ID Prefix			Correct	ion
Reg. #				Completed	Reg. #		Completed	Reg.#			Comple	ted
LSC				-	LSC			LSC				
ID Prefix				Correction	ID Prefix		Correction	ID Prefix			Correct	ion
Reg. #				Completed	Reg. #		Completed	Reg.#			Comple	eted
LSC				_	LSC			LSC				
ID Prefix				Correction	ID Prefix		Correction	ID Prefix			Correct	ion
Reg. #				Completed	Reg. #		Completed	Reg.#			Comple	eted
LSC					LSC			LSC				
				_								
REVIEWE STATE A			REVIEN	WED BY LS)	DATE	SIGNATU	JRE OF SURVEYOR	l		DATE		
REVIEWE CMS RO	ED BY		REVIEN (INITIA	WED BY LS)	DATE	TITLE				DATE		
FOLLOWUP TO SURVEY COMPLETED ON 7/27/2021			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES					s □ N	10			

Page 1 of 1

EVENT ID:

WOBX12