STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYCAMORE LIVING AT EAST HANOVER	ONE SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 07936

(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 Standard Survey: 10/24/22 Census: 65 Sample Size: 19 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		11/21/22

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

Electronically Signed | 11/01/2022

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F 690	Continued From page 1 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a [redacted] in a manner that would decrease the possibility of the resident developing [redacted]. This was found with Resident # 111, who was 1 of 1 residents reviewed for [redacted] care. The deficient practice was evidenced by the following: On 10/14/22 at 9:24 AM, the surveyor observed the resident in bed while wearing a [redacted] attached to their [redacted]. The Registered Nurse (RN) who was assigned to the resident confirmed that the resident was wearing a [redacted] attached to their [redacted] and that the resident always wore the [redacted] while in bed and she did not know why. The RN lifted the resident's blanket and showed the surveyor the [redacted] on the resident's [redacted]. The drainage bag had [redacted] in it and in the tube. The [redacted] was bent up at the [redacted]. On 10/14/22 at 9:55 AM, the surveyor spoke with	F 690	F690 □ Bowel/Bladder Incontinence, Catheter, UTI 1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. Resident #111 was observed with a [redacted] on the [redacted] above the [redacted] which failed to be maintained in a manner that would decrease the possibility of the resident developing an infection. Upon further investigation, it was determined that the resident preferred to use the [redacted] when awake in bed. The ADON reviewed the concern with the resident and the resident□s daughter, and the resident□s daughter was then able to convince the resident not to wear the [redacted] when in bed. Nurse then replaced the resident□s [redacted] with [redacted] b. After the deficient practice was identified, the RN and the CNA involved	

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F 690	Continued From page 2 the Certified Nursing Assistant (CNA) who was assigned to the resident and asked about the resident wearing the [redacted] bag attached to the [redacted] while in bed. The CNA said she was full time and had been taking care of the resident since the resident had been there. The CNA said when she came to work in the morning there would be a [redacted] She would remove it and put on the [redacted], in case the resident got up. The CNA said the resident usually didn't like to be up and the resident fought to go back to bed. She said the resident always had the [redacted] on in bed. The surveyor asked if the resident should have the [redacted] on in bed. The CNA said "yes, in case [the resident] gets up." The CNA said the 3-11 shift changed the [redacted] to a [redacted] when the resident was settled in for the night. On 10/14/22 at 11:00 AM, the surveyor reviewed the resident's medical record which revealed the following: An admission record which included the following diagnoses [redacted] An Admission Minimum Data Set with a Brief Interview of Mental Status score of [redacted] which indicated that the resident was [redacted] at the time. It was dated 9/9/22. A [redacted] consent form and a [redacted] consent form. Both immunizations were refused by the	F 690	were immediately educated regarding the need to maintain the urinary catheter in a manner that will decrease the possibility of the resident developing an infection. c. The involved RN and CNA were immediately educated on the need to document resident□s preferences, and then educated on the need to communicate to the resident and document the potential risks associated with such preference of wearing the [redacted] while in bed. --- 2. How the facility will identify other residents having the potential to be affected by the same practice? a. All residents who use indwelling catheters have the potential to be affected by this deficient practice. --- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a. Facility Educator / ADON conducted a facility wide audit to determine whether the practice was observed with any other residents. It was determined that only resident #111 was observed with this deficient practice. Observations and competencies were conducted with clinical staff to determine proficiency with the [redacted] care and	

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F 690	Continued From page 3 resident's son over the phone and signed for accuracy by a Registered Nurse. They were dated 9/3/22. On 10/14/22 at 12:00 PM the surveyor spoke with the Assistant Director of Nursing/ Unit Manager/ Nurse Educator (ADON/UM/NE) about the resident wearing the [redacted] attached to their [redacted] while in bed. The ADON/UM/NE said the resident liked the [redacted] on. The surveyor asked if there was any documentation that the resident was educated on the risks of wearing a [redacted] in bed. She said she wasn't sure but she would check. The surveyor asked the ADON/UM/NE if the resident was alert and oriented and able to make decisions. The ADON/UM/NE said the resident was confused sometimes. The surveyor asked if the resident should be wearing a [redacted] in bed. She said "It is not recommended because the [redacted]." On 10/14/22 at 1:30 PM, the surveyor spoke with the Director of Nursing (DON) about the concern with the resident wearing the [redacted] bag attached to their [redacted] while in bed. The DON said the resident shouldn't but she knew that was the resident's preference. Asked if there was any documentation that the resident was educated on the risks of wearing a [redacted] in bed. The DON said she would find out. On 10/17/22 at 9:35 AM, the DON stated that the ADON/UM/NE spoke to the resident and the family and went over the pros and cons of wearing a [redacted] in bed. The daughter convinced the resident to not wear a [redacted] in	F 690	usage of [redacted]. b. Facility Educator / ADON initiated education and clinical competencies on 10/14/22 regarding [redacted] and usage of [redacted]. c. All new hire nursing staff will be required to receive education regarding [redacted] and usage of [redacted] during orientation. Such new hires will also be required to pass clinical competency before completion of orientation. d. Education and competencies to be conducted annually to ensure proper practice of procedures are being followed. e. Facility educator / ADON will conduct weekly audits for one month, and monthly audits for the remaining months of the quarter on all residents with indwelling catheters to ensure compliant practice regarding indwelling foley catheter care and usage of [redacted]. f. Any identified deficient areas will be immediately reported to the DON and administrator, and corrective actions will be implemented as deemed necessary. --- 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?	

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F 690	Continued From page 4 bed. The resident agreed. The DON further stated that the resident was discharged the day before on [redacted]. There was no documentation provided to verify that the resident was educated on the risk of wearing a [redacted] attached to [redacted] while in bed. On 10/17/22 at 9:00 AM, the surveyor reviewed the facility's policy and procedure titled "Urinary Leg Drainage Bags" with an effective date of 12/1/2021, and a revision date of 8/1/2022. Under "Steps in the Procedure" number 11 read; When leg bag is in use, resident must be in the upright position to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The surveyor also reviewed the facility's policy and procedure titled "Catheter Care, Urinary" with an effective date of 12/1/2020 and a revision date of 12/1/2021 and 4/2/2022. Under "Maintaining Unobstructed Urine Flow" number 3 read: The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. NJAC 8:39-19.4 (a) 4,5,6	F 690	a. Facility Educator / ADON will submit the findings of the documented audits at the next quarterly QAPI meeting. b. The QAPI committee will determine whether compliance has been sustained or if further action is required.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		11/21/22

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F 695	Continued From page 5 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a record for the use of [redacted]. This was found with 1 of 3 residents, Resident # 111 reviewed for [redacted] use. The deficient practice was evidenced by the following: On 10/5/22 at 11:32 AM, the surveyor observed Resident # 111 in bed awake, the resident [redacted] The resident was receiving [redacted] via a [redacted] On 10/6/22 at 10:29 AM, the surveyor observed the resident in bed receiving [redacted] through an [redacted] concentrator. The resident was in bed awake. The resident did not answer appropriately when spoken to. The resident looked away and avoided conversation. On 10/11/22 at 10:38 AM, the surveyor observed the resident in bed with [redacted] on via a [redacted] through an [redacted] set a [redacted]. On 10/12/22 at 9:42 AM, the resident was in bed asleep. The [redacted] was off. The [redacted] was attached to the [redacted]. The excess tubing was in the drawer of the bedside stand. The tubing was attached to a mask and was in a plastic bag in the drawer of the bedside stand.	F 695	F695 □ Respiratory / Tracheostomy Care and Suctioning 1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. Resident #111 was observed receiving supplementa[redacted] intermittently via [redacted]. MD orders in place to receive [redacted] (as needed) for [redacted]. Upon further investigation, it was determined that staff failed to maintain a record of the resident's use of supplemental oxygen in the ETAR. The involved nurses were immediately educated regarding lack of documentation on 10/14/22. --- 2. How the facility will identify other residents having the potential to be affected by the same practice? a. All residents who utilize supplemental oxygen have the potential to be affected by the deficient practice of lack of documentation related to the use of supplemental oxygen. --- 3. What measures will be put into place	

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F 695	Continued From page 6 The surveyor reviewed the resident's hybrid medical record which revealed the following: An admission record with the following diagnoses [redacted] A current Physician's Order Sheet with an order that read; [redacted] The order date was 10/4/22. An initial Minimum Data Set assessment dated 9/9/22 indicated the resident scored a [redacted] out of a possible [redacted] when the brief interview for mental status was done. This indicated that the resident was cognitively [redacted] at the time. An electronic Treatment Administration Record (ETAR) that had an order which read; '[redacted] The start date was 10/4/22. The [redacted] was never signed for to indicate that it had been used. On 10/13/22 at 11:55 AM, the resident was in bed awake watching television. The [redacted] was off. The [redacted] was attached to the [redacted]. The end of the [redacted] had a mask attached to it and the mask was in a plastic bag that was in the drawer of the bedside stand. On 10/13/22 at 12:03 PM, the surveyor spoke with the Registered Nurse (RN) who was assigned to the resident. The RN said the resident did not receive [redacted] continuously, just as needed. She said the resident's [redacted] level was [redacted] that morning but she gave the resident	F 695	or systemic changes made to ensure that the deficient practice will not recur? a. Facility Educator / ADON conducted a comprehensive facility wide audit to determine whether the practice was observed with any other residents who have orders for PRN oxygen use. It was determined only resident #111 was observed with this deficient practice. b. Facility Educator / ADON initiated education on 10/14/22 with all nurses regarding the need to maintain a record of the resident's use of supplemental oxygen in the ETAR (electronic treatment administration record). c. All new hired nursing staff will receive education regarding such documentation requirements during the electronic documentation portion of orientation. This topic will now be added to the orientation check list and will be reviewed prior to completion of orientation. d. Education to be conducted annually to ensure proper practice of procedures are being followed. e. Nursing Unit Manager/ADON will conduct weekly audits for one month and monthly for the remaining months of the quarter for all residents on their respective units who have orders for PRN usage of supplemental oxygen to ensure compliance with documentation requirements.	

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F 695	Continued From page 7 a breathing treatment and the [redacted] went up to [redacted]. She said if she did give the resident [redacted] she would sign for it on the electronic treatment administration record (ETAR) that she gave the [redacted]. On 10/14/22 at 12:00 PM, the surveyor asked the Unit Manager/Assistant Director of Nursing/Nurse Educator (UM/ADON/NE) if the nurse should sign the EMAR if the resident used [redacted]. The UM/ADON/NE said yes, the nurse should be documenting when the resident used the [redacted] On 10/14/22 at 1:30 PM. the surveyor asked the Director of Nursing (DON) if the nurse should be documenting when the resident used [redacted]. The DON said yes, the nurse should. The surveyor reviewed the facility's policy and procedure titled "Oxygen Administration" with an effective date of 12/1/2020 and revision dates of 12/1/2021, and 4/2/2022. Under documentation it read: After completing the oxygen set up or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The rate of oxygen flow, route, and rationale. 3. The frequency and duration of the treatment. 4. The reason for p.r.n. administration. 5. All assessment data obtained before, during, and after the procedure. 6. How the resident tolerated the procedure. 7. If the resident refused the procedure, the reason (s) why and the intervention taken. NJAC 8:39-27.1 (a)	F 695	f. Any identified deficient areas will be immediately reported to the DON and Administrator, and corrective actions will be implemented as deemed necessary. --- 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? a. DON / ADON will submit the findings of the documented audits of PRN usage of supplemental oxygen at the next quarterly QAPI meeting. b. The QAPI committee will determine whether compliance has been sustained or if further action is required.	

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F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to administer medication with an error rate of less than 5%. The surveyor observed two nurses administer medications to three residents with 26 opportunities for error. There were five errors involving 3 of 3 residents observed, which resulted in an error rate of 19.2% as evidenced by the following: 1. On 10/14/22 at 8:06 AM, the surveyor observed a Licensed Practical Nurse (LPN) administer medication to a resident. One of the medications that the resident received was [redacted]. 2. Next, the LPN administered [redacted] for the same resident. Both medications were administered with a cup of water. There was a cautionary on the electronic medication administration record (EMAR) next to the [redacted] that read; give with or immediately after a meal. There	F 759	F759 □ Free of Medication Error Rates 5 Percent or More 1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. The LPN was observed administering Metoprolol Succinate and Levocarnatine prior to or without a meal. After this deficient practice was identified, the LPN was immediately educated on the need to review any/all cautionaries on the EMAR prior to administering medication. b. The RN was observed crushing the enteric coated [redacted] and incorrectly measuring / preparing [redacted] l. After the deficient practice was identified, the RN immediately discarded the crushed medication. The RN then prepared a [redacted] that she administered correctly. The RN attempted to administer the [redacted] to two residents, but both residents refused when offered. The RN was immediately educated on how to prepare / measure medications and when to crush /	11/21/22

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F 759	Continued From page 9 was a cautionary on the pharmacy label of the [redacted] as well as the EMAR that read; give with or immediately after a meal. The surveyor asked the resident if they had eaten breakfast yet. The resident said no, they hadn't had anything to eat. On 10/14/22 at 8:35 AM, the surveyor asked the LPN if she noticed the cautionaries for the [redacted] and the [redacted] The LPN confirmed that the resident had not eaten breakfast. The LPN said she did not realize that the medication should have been given with a meal but she would get the resident some food. She said breakfast usually arrived at 8:30 AM and the medication the resident received was scheduled to be given at 9:00 AM. 3. On 10/14/22 at 8:58 AM, the surveyor observed a Registered Nurse (RN)administer medication to a resident. As she was preparing the medication she crushed two pills. One of the pills crushed was an [redacted]. After the RN crushed the pill, and proceeded to prepare the next medication the surveyor asked the RN if she should crush an enteric coated pill. The RN said "No, I will discard this." She then prepared a [redacted] that she administered. 4. Next, the RN prepared [redacted] for the same resident. The medication was a powder that had to be mixed with a liquid beverage. The cap for the medication was the	F 759	not crush medications. --- 2. How the facility will identify other residents having the potential to be affected by the same practice? a. All residents have the potential to be affected by the deficient practice. --- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a. Facility Educator / ADON initiated education with all nurses on 10/14/22 regarding reviewing any/all cautionaries prior to medication administration, preparing / measuring medications properly, and knowing when to crush / not crush medications. b. DON / ADONs and Pharmacy Consultant will conduct medication pass observation with all nurses on an annual basis and med pas in-servicing quarterly. c. All new hire LPNs and RNs will receive medication pass training and observation during orientation and must demonstrate 5% or better med error competency prior to completion of orientation process. d. Any identified deficient areas will be immediately reported to the DON, and corrective actions will be implemented as deemed necessary. ---	

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F 759	Continued From page 10 measuring device. The inside of the cap had an arrow pointing to the line where the medication should have been filled to. According to the manufacturers instructions, the medication should cover the entire white interior of the cap. The RN filled the cap to cover half of the white interior. The surveyor asked the RN if that was the whole dose. The RN said yes, she was told on orientation at the facility that's how much she should give. The RN attempted to administer the [redacted] to the resident but the resident refused the medication. 5. The RN then went on to prepare medication for the next resident. One of the medications the resident was to receive was [redacted]. The RN poured more of the powder into the cap than she poured for the previous resident but not the full dose. The RN attempted to administer the medication to the resident but the resident refused the medication. On 10/14/22 at 12:00 PM, the surveyor spoke with the Assistant Director of Nursing/Unit Manager/Nurse Educator (ADON/UM/NE). The surveyor asked her about the way the nurse measured the [redacted]. The ADON/UM/NE took out the measuring cap for the [redacted]. She showed the surveyor on the measuring cap that the medicine should be measured to the top of the white interior of the cap, she stated "See the arrow?". The surveyor asked her if the nurses were told on orientation to only fill the cap to half of the white interior of the cap. The ADON/UM/NE said no. On 10/14/22 at 12:45 PM, the survey team spoke with the Director of Nursing (DON), the	F 759	--- 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? a. DON / ADON will submit the documented medication pass observations at the QAPI meetings on a quarterly basis. b. The QAPI committee will determine whether compliance has been sustained or if further action is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYCAMORE LIVING AT EAST HANOVER	ONE SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 07936

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F 759	Continued From page 11 Administrator, and the Chief Operating Officer about the concerns with the medication pass observation. The DON said she would provide education to the RN and the LPN. On 10/17/22 at 10:00 AM, the surveyor reviewed the facility's policy and procedure titled "Administering Medication" with an effective date of 12/1/19 and revision dates of 12/31/21 and 4/2/22. The policy and procedure did not address cautionaries, or crushing enteric coated pills. Number 7 under "Policy Interpretation and Implementation" read; "The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication." NJAC 8:39-29.2 (d)	F 759		
F 761 SS=D	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 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.	F 761		11/21/22

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F 761	Continued From page 12 §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, and record review it was determined that the facility failed to: (a) properly label, store, and date medications in 1 of 5 medication carts and 1 of 2 medication refrigerators inspected; (b) properly discard an expired medication in 1 of 2 medication refrigerators inspected. The deficient practice was evidenced by the following: 1. On 10/6/22 at 10:22 AM, the surveyor inspected the medication cart on the [redacted] unit in the presence of the Licensed Practical Nurse (LPN) assigned to the cart. There was a Latanoprost 0.005% eye drops for a resident open and undated. The LPN # 1 stated she was unsure of when the eye drops were opened or if it was used. The pharmacy label read "refrigerate before opening". There was a Novolin R flexpen for a resident observed with a written open date of 9/1 on the plastic bag it was stored in and written on the flexpen itself. The pharmacy label on the flexpen appeared to have a written date of 9/11. The LPN # 1 stated the date opened was 9/11 and not 9/1.	F 761	F761 □ Label / Store Drugs and Biologicals 1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. The 3 south medication cart was observed with an opened and undated Latanoprost eye drop bottle that required refrigeration prior to opening. The 3 south medication cart was also observed having a Novolin-R Flexpen that was beyond 28 days from opening date. The 3 floor medication refrigerator was observed having a Firvanq bottle that was beyond the 14 days use by date. Upon identification of these deficient practices, LPN #1 disposed of all three medications. b. The 3 north medication refrigerator was observed having an opened and undated PPD, as well as an opened and undated Humalog Insulin Vial, which is not to be refrigerated once opened. Upon	

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F 761	Continued From page 13 On 10/6/22 at 10:42 AM, the surveyor inspected the medication refrigerator by the nurses' station on the [redacted]. There was a liquid bottle of Firvanq 50 mg/ml for a resident with a written expiration date from opening of the medication of 10/5/22. The Firvanq bottle label read to "use medication within 14 days". The surveyor asked the LPN # 1 about the medication. The LPN # 1 stated she re-ordered the medication to be delivered today. The LPN #1 removed the Firvanq bottle from the refrigerator to dispose. On 10/6/22 at 12:25 PM, the surveyor informed the Director of Nursing (DON), Administrator, and Chief Operating Officer about the concerns found during the medication storage inspection. On 10/11/22 at 12:57 PM, the DON stated the Novolin R flexpen had a written open date of 9/1 and it was not 9/11. The DON acknowledged the Novolin R flexpen was good for 28 days after opening and the Novolin R flexpen was expired and disposed. The DON further stated the Firvanq bottle was disposed by the LPN # 1 and the Latansprost eye drops was disposed as it could not be determined if it was open or if the eye drops were used. 2. On 10/6/22 at 10:30 AM, the surveyor inspected the [redacted] medication refrigerator with LPN # 2. Inside of the medication refrigerator there was an open Purified Protein Derivative (PPD), tuberculin skin test. The vial was not dated. The box had a date written on it of 9/20/22. According to the manufacturer's specifications, once opened the vial should be	F 761	identification of this deficient practice, LPN #2 disposed of both medications. c. LPN #1 and LPN #2 were immediately educated on proper labeling and storing of drugs and biologicals. d. There was no direct harm to any patient as a result of the deficient practice. --- 2. How the facility will identify other residents having the potential to be affected by the same practice? a. All residents have the potential to be affected by improper labeling and storage of drugs and biologicals. --- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a. Facility Educator/ ADON initiated education to all nurses on 10/06/22 regarding proper labeling and storage of Drugs and Biologicals. b. Night nurse / Supervisor will complete and document nightly inspections of all medication carts to ensure all medication is labeled and stored properly. c. Unit Managers/Supervisors will check	

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F 761	Continued From page 14 discarded after 30 days. There was also a Humalog Insulin Vial that was open and undated. The surveyor asked LPN #2 why the Humalog didn't have an open date written on it. LPN # 2 said she opened it that morning but didn't have a pen and then she got caught up with other things. According to the manufacturer's specifications, once opened the vial must be discarded after 28 days. On 10/6/22 at 12:30 PM, the survey team spoke with the DON and the Administrator about the issues found with the medication storage. The DON confirmed that the vials should have been dated when opened and that the nurses would be educated on dating medication vials when opened and not putting insulin in the refrigerator after it is opened. The surveyor reviewed the facility's policy and procedure titled, "Storage of Medications", with a revision date of May 30, 2022. Under Policy it read, "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier". Under Procedure it read "G. Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are removed from inventory, disposed of according to procedures for medication disposal if a current order exists." The surveyor reviewed the facility's policy and procedure, titled "Administering Medications", with a revision date of April 2, 2022. Under Policy Interpretation and Implementation, it read, "9. The expiration/beyond use date on the medication label must be checked prior to	F 761	daily all medications in the medication refrigerators during day and evening refrigerator temperature checks. d. DON / ADON□s will conduct audits of medication carts and refrigerators to ensure compliance of labeling, dating and storage. Audits will occur weekly x 1 month and monthly x 2 months. e. Any identified deficient areas will be immediately reported to the DON and corrective actions will be implemented as deemed necessary. --- 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? a. DON / ADON□s will submit the findings of the medication carts and refrigerator audits at the quarterly QAPI meetings. b. The committee will determine whether compliance has been sustained or if further action is required.	

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F 761	Continued From page 15 administering. When opening a multi-dose container, the date opened shall be recorded on the container ...12. Insulin pens will be clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the Nurse will verify that the correct pen is used for that resident and used within 28 days of opened date". NJAC 8:39-29.4(a)	F 761		

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
315529 Y1	A. Building B. Wing Y2	1/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SYCAMORE LIVING AT EAST HANOVER	ONE SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 07936

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 F0690	Correction	ID Prefix F0695	Correction	ID Prefix F0759	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	11/21/2022	LSC	11/21/2022	LSC	11/21/2022
ID Prefix F0761	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/21/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/21/2022	☐ YES ☐ NO

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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 10/18/22 and 10/19/22, 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 18 NEW Health Care Occupancies. The facility is a four story (4), Type II protected building, that was built in 4/30/20. The facility is divided into 4 smoke zones. The generator does 100 % of the building. The fuel for the generator in natural gas.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7. 18.1.6.4, 18.1.6.5 Construction Type 1 I (442), I (332), II (222) Not allowed non-sprinklered Any number of stories 2 II (111) Not allowed non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed	K 161		12/30/22

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

Electronically Signed | 11/01/2022

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 161	Continued From page 1 non-sprinklered 4 III (211) Maximum 1 story sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review on 10/19/22, in the presence of the facility's Maintenance Director and assistant Maintenance staff member, it was determined that the facility failed to provide an acceptable construction type and fire resistance rating of a building's structural elements in accordance with the requirements of NFPA 101, 2012 Edition, Section Table 19.1.6.1, 19.1.6.2 through 19.1.6.7. The deficient practice was evidenced in 2 of 4 rooms and could affect all residents. 1) At 10:58 AM, the surveyor observed on the lower level main electrical ATS panel room that the large girder was not fully enclosed in fire rated material. Areas where installers scraped off	K 161	K161 □ Building Construction Type and Height 1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. The Director of Maintenance contacted the Fire proofing vendor. Director of Maintenance has requested that they come to the facility and add the necessary fire proofing that is required for fire resistance in accordance with requirements of NFPA 101, 2012 Edition, Section Table 19.1.6.1, 19.1.6.2 through 19.1.6.7.	

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K 161	Continued From page 2 the fire rated material to hang pipe and wiring brackets now exposed the steel girder without fire protection. 2) At 11:10 AM, the surveyor observed on the lower level in the IT/MDF room that the ceiling was painted black and open to the above steel decking. The unprotected black steel girder was not enclosed in fire rated material. GIRDER: a large iron or steel beam or compound structure used for building framework of large buildings. A girder is a support beam used in construction. The findings were verified by the Maintenance Director. Plans identifying the UL assembly and fire resistance rating for the steel beams were not provided. The Maintenance Director indicated that he was unsure why the steel girder in the 4-story building was not fully enclosed in fire rated material. The Administrator was informed of the findings at the Life Safety Code exit conference on 10/19/22. NJAC 8:39-31.2(e)	K 161	b. The areas that will be addressed are the exposed large girder in the main electrical ATS panel room and steel decking in the ceiling of the IT/MDF room. c. The corrective action will be completed by 12/30/2022 d. It was determined that the root cause of this deficiency resulted from the exclusion of these two locations during the initial fireproofing of the building. --- 2. How the facility will identify other residents having the potential to be affected by the same practice. a. All residents have the potential to be affected by the deficient practice. This deficient practice would potentially result in hazardous exposure. --- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a. Fire proofing will be installed in the identified deficient areas in the main electrical ATS panel room and IT/MDF room on or before 12/30/2022 b. To address the deficient practice and to ensure the deficient practice will not recur, the maintenance director and/or his designee will inspect and document all areas of the facility with exposed beams	

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K 161	Continued From page 3	K 161	semiannually to ensure all fire proofing is adequate. c. A log will be created to reflect date, location, and indication of compliance for each facility area that was inspected. d. All maintenance department staff will be educated with regard to the appropriate fire rated material covering all steel girders in the building. e. Any identified deficient areas will be immediately reported to the administrator and corrective actions will be implemented as deemed necessary. --- 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? a. The Maintenance Director will submit the logged reports from the semiannual inspections of fire resistance at the next two quarterly QAPI meetings. b. The committee will determine whether compliance has been sustained.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary	K 363		11/2/22

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K 363	Continued From page 4 spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/19/22, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close, and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was identified in 37 of 50 resident room doors (single door with opening sidelight- active leaf door's) observed and was evidenced by the following: The following resident room doors, when closed	K 363	K363 □ Corridor □ Doors 1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. The Maintenance Director purchased weather stripping on 10/24/2022 and will install such stripping to all resident rooms in order to eliminate gaps per the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1, and 19.3.6.5. b. All resident rooms will have the vertical brush secured in its channel ensuring that the corridor doors are able to resist the passage of smoke by	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYCAMORE LIVING AT EAST HANOVER	**ONE SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 07936**

(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 363	Continued From page 5 left a gap at the top of the door's, approximately 1/2" to 1" inch, due to a malfunction in the door's vertical brush installation. The brush was not secured into its channel and was released to the lower section of the door to the floor, failing to ensure that corridor doors were able to resist the passage of smoke in the following resident rooms:  An interview was conducted with the Maintenance Director and Assistant Maintenance staff member, at the time of the observations and both confirmed the above findings. The Administrator was informed of the finding at the Life Safety Code exit conference on 10/19/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.	K 363	11/1/2022. --- 2. How the facility will identify other residents having the potential to be affected by the same practice. a. The residents occupying the 37 identified rooms have the potential to be affected by the gap at the top of the resident□s rooms corridor doors. --- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a. All maintenance department staff will be educated with regard to the appropriate placement of the vertical brush installation and security of all gaps in corridor doors. b. A log will be created to reflect an audit of all resident room doors, which is to include date of inspection, location, and indication of compliance with resistance to the passage of smoke. c. To address the deficient practice and to ensure the deficient practice will not recur, the maintenance director and/or his designee will inspect and document all resident room corridor doors on a quarterly basis for the next year and then annually thereafter. d. Any identified deficient areas will be immediately reported to the administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**10/21/2022**

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SYCAMORE LIVING AT EAST HANOVER	**ONE SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 07936**

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K 363	Continued From page 6	K 363	and corrective actions will be implemented as deemed necessary. --- 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? a. The Maintenance Director will submit the logged reports from the quarterly inspections of the resident room corridor doors at the QAPI meetings on a quarterly basis for one year. b. The committee will determine whether compliance has been sustained or if further action is required.	
K 364 SS=E	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3	K 364		11/30/22

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	315529	A. BUILDING **01** B. WING _____	**10/21/2022**

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K 364	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/19/22, in the presence of the Maintenance Director, it was determined that the facility failed to maintain doors to hazardous areas in a manner designed to resist the passage of smoke into exit corridors. This deficient practice was identified for 2 of 6 closet doors to (HVAC) units, and was evidenced by the following: At 12:22 PM, the surveyor observed the HVAC #1 and #2 closet's, located outside the 2 elevator banks on the lower level, that each door had an approximately 18' x 18' open vent transfer grille installed on each door. The door's were located on the same floor as the LTC physical therapy gym. An interview was conducted with the Maintenance Director at the time of the observation, where he confirmed that the open vent transfer grille was not to be used in corridor doors. The Administrator was informed of the finding at the Life Safety Code exit conference on 10/19/22. NFPA 101-2012 edition Life Safety Code 19.3.6.4 Transfer Grilles. 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors. NJAC 8:39-31.2(e)	K 364	K364 □ Corridor □ Openings 1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. The maintenance director purchased electronic dampers on 10/27/2022. The maintenance director will install such electronic dampers in HVAC #1 and #2 closets by 11/30/2022. The dampers will be tied in to the fire alarm system and will immediately close / shut down whenever the fire alarm system activates or carbon monoxide is detected in such room. In addition, these HVAC systems are designed to shut down immediately if they sense heat or smoke. These damper solutions will prevent any smoke or carbon monoxide to pass into the exit corridors. 2. How the facility will identify other residents having the potential to be affected by the same practice. a. All residents have the potential to be affected by smoke exposure in the exit corridors from the identified HVAC #1 and #2 closets. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	

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K 364	Continued From page 8	K 364	a. All maintenance department staff will be educated with regard to the design of corridor doors to resist the passage of smoke in exit corridors. b. A log will be created to reflect an audit of proper functioning of the ventilation system in HVAC #1 and #2 closets, which is to include date of inspection, location, and indication of compliance with resistance to the passage of smoke into exit corridors. c. To address the deficient practice and to ensure the deficient practice will not recur, the maintenance director and/or his designee will inspect and document the HVAC #1 and #2 closets on a quarterly basis for two quarters and then annually thereafter. d. Any identified deficient areas will be immediately reported to the administrator and corrective actions will be implemented as deemed necessary. 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? a. The Maintenance Director will submit the logged reports from the quarterly inspections of the HVAC #1 and #2 closet ventilation system at the QAPI meetings on a quarterly basis for two quarters and then annually thereafter.	

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K 364	Continued From page 9	K 364	b. The committee will determine whether compliance has been sustained or if further action is required.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 10/18/22 in the presence of the Maintenance Director and assistant Maintenance staff member, it was determined that the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. for 1 of 1 generator. This deficient practice could affect all residents and was evidenced by the following: Based on observation, interview, and review of facility documentation on 10/18/22, the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. for 1 of 1 generator. This deficient practice could affect all residents and was evidenced by the following: reviewed all the facility's generator documentation. The facility currently had a 1 megawatt natural gas generator and the facility	K 911	K911 □ Electrical Systems □ Other 1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. To address survey concerns related to the production of a reliability letter from the natural gas and generator providers. The administrator requested documentation from the gas supply and generator vendors. b. The following actions have been taken: i. The natural gas and generator provider were contacted and the request for a reliability letter was made. ii. Corporate leadership contacted the natural gas provider's legal department on October 24, 2022 and was awaiting a response. iii. During survey, the	1/4/23

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K 911	Continued From page 10 could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The finding was verified by the Maintenance Director at the time of the observation. On 10/19/22 at 2:30 PM, the Administrator was informed of the finding at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911	maintenance director provided a letter from the generator company indicating that in the event of an emergency, including generator failure, the company will provide backup generator and associated personnel needed to power the facility within 2-4 hours of such event. --- 2. How the facility will identify other residents having the potential to be affected by the same practice. a. All residents have the potential to be affected by an interruption of utility services. --- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? a. All administrative staff has been educated regarding the need for a reliability letter from the natural gas or generator provider to ensure knowledge of the requirement. b. The maintenance director will provide confirmation annually of reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. c. The generator company will continue to provide yearly inspections to ensure generator is functioning properly. d. Any identified deficient areas will be immediately reported to the administrator and corrective actions will be implemented as deemed necessary. e. Should the emergency generator	

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K 911	Continued From page 11	K 911	fail for any reason: Gas failure, mechanical failure, etc. the building is equipped with a 90 Min backup battery and inverter system that supports each neighborhood powering all emergency exit lights and every other hallway light. --- 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? a. The Maintenance Director will submit the inspection results and reliability letter at the next quarterly QAPI meeting to be reviewed by the committee. b. The committee will determine whether compliance has been sustained or if further action is required.	

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
315529 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	1/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SYCAMORE LIVING AT EAST HANOVER	ONE SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 07936

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 K0161	12/30/2022	LSC K0363	11/02/2022	LSC K0364	11/30/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	01/04/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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?
10/21/2022	☐ YES ☐ NO