STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING **01** B. WING _____	**11/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

(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 11/28/22 and 11/29/22 and Allaire Rehabilitation and Nursing Center 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 Occupancies. Allaire Rehabilitation and Nursing Center is a four-story, Type I Fire Resistant Protected building that was built in June 1986. The facility is divided into 9 smoke zones.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to maintain 2 of 46 illuminated exit signs in proper working condition to clearly identify the exit access path to reach an exit discharge door.	K 293	1. All residents are at risk by this deficient practice. 2. The exit signs were immediately fixed to ensure proper compliance with exit lighting requirements. The maintenance	1/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING **01** B. WING _____	**11/30/2022**

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K 293	Continued From page 1 This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 11/28/22 during the survey entrance at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building. Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. Along the two-day tour of the facility, the surveyor observed 2 of 46 illuminated exit signs not functioning properly in the following locations: 1) On 11/29/22 at 10:11 AM, the surveyor observed one illuminated exit sign above the corridor double smoke doors next to resident room #232 that was not illuminated.	K 293	director and his staff were re-educated on the procedures for checking emergency exit lighting. 3. DOM/Designee shall audit 5 exit signs weekly for the next 3 months and submit the weekly logs to the facility administrator by the end of the week. 4. The audit findings shall be submitted to the monthly QA committee meeting for 3 months to review and determine if further interventions are needed.	

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	315387	A. BUILDING **01** B. WING _____	**11/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

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K 293	Continued From page 2 2) On 11/29/22 at approximately 11:08 AM, the surveyor observed inside the level one "FC" stairwell, one illuminated exit sign above the exit discharge door was not illuminated. The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 321 SS=D	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		1/15/23

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K 321	Continued From page 3 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 11/28/22 during the survey entrance at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building. Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. Along the two-day tour of the facility, the surveyor observed the following:	K 321	1. A self-closure was immediately purchased and installed for the medical records room. Maintenance director and his staff were re-educated on the requirements for enclosures of hazardous areas. 2. All residents are at risk to be affected by the deficient practice. 3. DOM/Designee shall audit monthly x3 months all rooms which require self-closures to ensure proper standards are being met and submit findings to facility administrator. 4. Findings shall be submitted to the monthly QA committee meeting x3 months to review and determine if further interventions are needed.	

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K 321	Continued From page 4 1) On 11/29/22 at approximately 11:58 AM, an inspection on the lower level Medical Records room identified that the corridor door had no means to self-close the door into its frame. The surveyor observed inside the room eight (8) five-drawer filing cabinets and one (1) four-drawer filing cabinet filled with combustible medical records. The surveyor also observed multiple combustible medical records on top of the cabinets. The surveyor recorded the room to be 15 feet by 13 feet (195 square feet) which is larger than 50 square feet. The door failed to self-close into its frame as required by code. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
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	K 351		1/15/23

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K 351	Continued From page 5 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 interview on 11/28/22 and 11/29/22, it was determined that the facility failed to properly install sprinklers, as required by Centers for Medicare & Medicaid Services' 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 Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 11/28/22 during the survey entrance at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building.	K 351	1. The masking tape was immediately removed from the two sprinkler heads inside the maintenance shop closets. A fire sprinkler was installed to provide coverage on the top landing area of stairwell A-3. An escutcheon cap was installed inside the first-floor housekeeping closet. The ceiling tile was removed to locate the fire sprinkler inside the ground floor Dining Room's closet. The ceiling tile was removed to locate the fire sprinkler inside the ground floor utility/electrical closet. The maintenance director and his staff were re-educated on the requirements and procedures for installation and checking for coverage of sprinkler systems. 2. All residents are at risk by this deficient practice. 3. DOM/Designee shall audit monthly x3 months all sprinklers and areas that require fire sprinkler coverage and submit	

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K 351	Continued From page 6 Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. Along the two-day tour of the facility, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 11/28/22 - 1) At approximately 10:22 AM, the surveyor observed, inside the maintenance shop, two (2) closets had masking tape covering the fire sprinklers inside the closets. 2) At approximately 10:35 AM, the surveyor observed no evidence of fire sprinkler coverage on the top landing area of stairwell A-3. At this time the surveyor asked the DOM, "Do you have a sprinkler on this level." The DOM said, "No." On 11/29/22 - 3) At approximately 11:22 AM, the surveyor observed, inside the first floor housekeeping closet, one (1) sprinkler had no escheon cap. This left a 1/2 inch gap in the ceiling tile. With the opening in the ceiling, in the event of a fire, the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system. 4) At approximately 11:50 AM, the surveyor observed no evidence of a fire sprinkler inside the ground floor Green Dining Room's two feet deep by four feet eight inch wide closet. 5) At approximately 11:55 AM, the surveyor observed no evidence of a fire sprinkler inside the ground floor utility/electrical closet. The surveyor recorded the closet to be two feet deep by six feet wide.	K 351	the report to the facility administrator. 4. The audit findings shall be submitted to the monthly QA committee meeting x3 months to review and determine if further interventions are needed.	

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K 351	Continued From page 7 The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. 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, interview and review of other facility documentation on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to failed a.) to inspect 1 of 32 portable fire extinguishers annually, and b.) perform a monthly examination for 1 of 31 portable fire extinguishers, as required by the 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. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 7.3 Maintenance. - 7.3.1.1 All Fire Extinguishers.	K 355	1. All residents are at risk to be affected by the deficient practice 2. A new fire extinguisher was immediately purchased for the facility vehicle and the fire extinguisher in the basement elevator mechanical room was replaced. The list of fire extinguisher locations was updated to include the fire extinguisher on the facility vehicle and the updated list shall be used as a reference during monthly checking of fire extinguishers. The Maintenance director and his staff were re-educated on the procedures for checking portable fire extinguishers.	1/15/23

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K 355	Continued From page 8 - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than one year at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. According to NFPA 10- 4-3.4, 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. During the building tour on 11/28/22 and 11/29/22, in the presence of the facility Corporate Compliance Officer (CCO) and Director of Maintenance (DOM), the surveyor observed and inspected thirty-two (32) portable fire extinguishers in various locations as follows: 1) On 11/28/22 at 9:45, the surveyor observed, inside the basement-level Elevator Mechanical room one (1) "ABC-Type" fire extinguisher that was last annually inspected January 2022. There was no evidence of a monthly visual examination being performed and document on the inspection tag attached to the extinguisher for June, July, August, September and October 2022. 2) On 11/29/22 at 9:26 AM, the surveyor observed, inside the facility transportation bus (license plate 02-7459), one (1) "ABC-Type" fire extinguisher that had been last annually inspected 2019. The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency	K 355	3. DOM/Designee shall audit 5 fire extinguishers monthly for next 3 months and submit findings to the facility administrator. 4. Audit findings shall be submitted to the monthly QA Committee meeting for 3 months to review and determine if further interventions are needed.	

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K 355	Continued From page 9 at the survey exit on 11/29/22.	K 355		
	NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).			
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary 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 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or	K 363		1/15/23

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K 363	Continued From page 10 frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 18 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. The evidence includes the following: On 11/28/22 during the survey entrance at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building. Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. Along the two-day tour of the facility, the surveyor observed the following: 1) On 11/28/22 at approximately 11:29 AM, the surveyor observed the Third Floor Soiled Linen room corridor door had a one (1) inch hole through the door with electrician's black electrical tape on one side of the door. In the event of a	K 363	1. The third-floor soiled linen room corridor door hole was covered and sealed with appropriate fire rated material. The first-floor soiled linen room corridor door hole was covered and sealed with appropriate fire-rated material. The maintenance director and his staff were re-educated on the requirement and procedures for checking smoke resistant passages. 2. All residents are at risk by this deficient practice. 3. DOM/Designee shall audit monthly x3 months all fire door assemblies for holes and submit the report to the facility administrator. 4. The audit findings shall be submitted to the monthly QA committee meeting x3 months to review and determine if further interventions are needed.	

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K 363	Continued From page 11 fire, the tape would melt and leave a one-inch hole through the door. 2) On 11/29/22 at approximately 11:30 AM, the surveyor observed the First Floor Soiled Linen room corridor door had a one (1) inch hole through the door with electrician's black electrical tape on one side of the door. In the event of a fire, the tape would melt and leave a one-inch hole through the door. The CCO and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 911 SS=D	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 on 11/28/22 and 11/29/22, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 14 electrical outlets located next to a water	K 911	1. The two duplex GFCI protected electrical outlets in the third-floor unit manager□s office were immediately replaced. The maintenance director and	1/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING **01** B. WING _____	**11/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

(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 911	Continued From page 12 source (within six feet) were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: During the survey entrance on 11/28/22 at approximately 9:10 AM, a request was made to the Corporate Compliance Officer (CCO) and Director of Maintenance (DOM), to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were four stories in the main building and an Annex building. Starting on 11/28/22 at approximately 9:42 AM and continued on 11/29/22, a tour of the building with the CCO and DOM was performed. During the two-day tour of the facility, the surveyor observed and tested fourteen (14) electrical outlets (within six feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: 1) On 11/28/22, the surveyor observed, inside the Third Floor Unit Manager's office, two (2) duplex electrical outlets: one duplex outlet was 22 inches (1'-10") to the left and one duplex outlet was 57 inches (4'-9") to the left of the sink. These two (2) duplex electrical outlets had labels that read "GFCI protected outlet". When the surveyor tested the two (2) duplex electrical outlet with a GFCI tester to de-energize, both duplex electrical outlets did not de-energize as required by code. The CCO and DOM confirmed the findings at the	K 911	his staff were re-educated on the requirements and procedures for GFCI testing and compliance. 2. All residents are at risk by this deficient practice. 3. The DOM/Designee shall audit monthly x3 months all electrical outlets that require GFCI testing and submit the report to the facility administrator. 4. The audit findings shall be submitted to the monthly QA committee meeting x3 months to review and determine if further interventions are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING **01** B. WING _____	**11/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

(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 911	Continued From page 13 times of observations. The Administrator was informed of the deficiency at the survey exit on 11/29/22. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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
315387 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD FREEHOLD, NJ 07728

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 K0293	01/30/2023	LSC K0321	01/30/2023	LSC K0351	01/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	01/30/2023	LSC K0363	01/30/2023	LSC K0911	01/30/2023
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	
11/30/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO