		AND HUMAN SERVICES		F <sup>i</sup>	ORM APPROVED 8 NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		3) DATE SURVEY COMPLETED
		315226	B. WING		C 07/08/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HUNTER	DON CARE CENTER			1 LEISURE COURT FLEMINGTON, NJ 08822	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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 APPROPRIAT DEFICIENCY)	
F 000	INITIAL COMMENT	ſS	F 00	0	
	Complaint#: NJ14	5681, NJ146311			
	Census: 158				
	Sample Size: 4				
F 658 SS=E	COMPLIANCE WIT 42 CFR PART 483, TERM CARE FACI COMPLAINT VISIT Services Provided I CFR(s): 483.21(b)( §483.21(b)(3) Com The services provid as outlined by the c must- (i) Meet professiona	Meet Professional Standards 3)(i) prehensive Care Plans led or arranged by the facility, comprehensive care plan, al standards of quality. NT is not met as evidenced	F 65	8 Corrective action for residents affected	9/30/21
	Based on interview review of other perf 7/7/2021 and 7/8/20 the facility failed to medical records the adhere to the accep practice for not follo care plan interventi their own policies ti	s, medical record reviews and inent facility documents on 021, it was determined that consistently document in the e status of the residents and otable standards of nursing owing physician's orders and ons, as well as failed to follow tled "Nursing Philosophy and mentation" and Admission and		Corrective action for residents affected by deficient practice: Resident #1: The nurses were made aware of the deficient practice and re-educated by Director of Nursing on the necessity of documenting an accurate recording of administration of enteral orders on the Enteral tab in EMR. MD reviewed medical records and the were no new orders. Resident #2: The nurses were made aware of the deficient practice and re-educated by	the of f e ere
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

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

07/29/2021

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
		315226	B. WING			C 07/08/20		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
HUNTER	DON CARE CENTER				LEISURE COURT LEMINGTON, NJ 08822			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658	residents (Resident Resident #3). This evidenced by the for Review of the Elect (EMRs) were as fol 1. According to the <u>Resident #1</u> was ac	(BCP)" for 3 of 4 sampled t #1, Resident#2, and deficient practice was ollowing: tronic Medical Records	Fθ	\$58	Director of Nursing on the necessit documenting an accurate recording administration of enteral orders on Enteral tab in EMR. MD reviewed medical records and were no new orders. Resident #3: The nurses were made aware of th deficient practice and re-educated Director of Nursing on the necessit documenting an accurate recording administration of enteral orders on Enteral tab in EMR. MD reviewed medical records and were no new orders.	g of the there e by the y of g of the		
	According to the Minimal Data Set (MDS), an assessment tool dated (MOS), Resident #1 had a Brief Interview for Mental Status (BIMS) score of Motor (Interview for Mental Status (BIMS) associated (Interview for Mental Status (BIMS) associated (Interview for Mental Status (BIMS) associated (Interview for Mental Status (BIMS) Activities of Daily Living (ADLs) and received nutrition through tube feeding. Review of Resident #1's Care Plan revealed the following: Under "Focus": Resident is at risk for aspiration due to NAC 8435-271 and Exec Order 20, 4. b. 1 Intake and relies on Matched 20, 4. b. 1 Intake and relies on Check residuals as ordered. Check tube placement before feeding and medication administration Review of Resident #1's "Order Summary Report				Identification of other residents who be affected by the deficient practice The documentation of all residents enteral tube orders were audited to evaluate and assure compliance w accurate and complete documenta administration. No other residents affected by the deficient practice. Measures or systemic changes to a that the deficiencies will not recur: -Licensed nurses were re-educated the Director of Nursing (or designed documenting in the EMR the status residents, with enteral feedings and following physician orders. -Director of nursing (or designee) w audit all residents with enteral orde twice weekly X 4 weeks, then week weeks, and monthly for 3 months to	e: with ith tion of were ensure d by e)on s of the d vill ers kly X 4		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: BGPR11

Facility ID: NJ61007

If continuation sheet Page 2 of 10

NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.

PRINTED: 02/06/2023 FORM APPROVED

		AND HUMAN SERVICES				FORM	02/06/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		315226	B. WING		C 07/08/2021		
NAME OF I	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	DON CARE CENTER				LEISURE COURT		
HOITEN				F	LEMINGTON, NJ 08822		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 658	Continued From parevealed the followin Every Shift NJAC 8:4 Every Shift flush tur NJAC 8:43E-2.1 and NJAC 8:43E-2.1 and NJAC 8:43E-2.1 and NJAC 8:43E-2.1 and Review of Resident Record (EAR) date revealed the above	ge 2         ing Matchedity 1 and Exec Order 26, 4. b. 1.         3E-2.1 and Exec Order 26, 4. b. 1.         be with Matchedity 1 and Exec Order 26, 4. b. 1.         and Exec Order 26, 4. b. 1.         I Exec Order 26, 4. b. 1.         and Exec Order 26, 4. b. 1.	F 6	558		ess of ill enteral n 3 on of plete. lity	
	t	8E-2.1 and Exec Order 26, 4. b. 1.					

Facility ID: NJ61007

If continuation sheet Page 3 of 10

		AND HUMAN SERVICES				FORM	02/06/2023 APPROVED
				וחוד			0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
			AL BOILD			(	C
		315226	B. WING				08/2021
NAME OF F	PROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HUNTER	DON CARE CENTER						
				F	LEMINGTON, NJ 08822		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
					DEFICIENCY		
F 658	Continued From no		<b>–</b>				
F 030	-	and Exec Order 26, 4. b. 1.	FC	658			
	NJAG 0.40L-2.1 8						
	N IAC 8:43E-2 1 and	d Exec Order 26, 4. b. 1.					
		a Exec order 20, 4. b. 1.					
	admitted to the faci	MR, Resident #2 was lity on Materials, with					
		cluded but were not limited to					
	NJAC 8:43E-2.1 and I	Exec Order 26, 4. b. 1.					
	According to the MI	DS, dated WAC Br43E-2.1 and 1,					
	Resident #2 had a	BIMS score of NACE ASE,					
	indicating the reside						
		that Resident #2 needed ce with ADLs and received					
	nutrition through tul						
	-	-					
		t #2's Care Plan indicated the					
		ocus": Resident is receiving nd Exec Order 26, 4. b. 1.					
		. Under "Interventions":					
	Administer feeding	as ordered Check residuals					

Facility ID: NJ61007

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		AND HUMAN SERVICES			FORM	02/06/2023 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	СОМ	E SURVEY PLETED C
		315226	B. WING			08/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	DON CARE CENTER			1 LEISURE COURT FLEMINGTON, NJ 08822		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 658	Check tube placem medications are ad Review of Residem NAR MARKED INFORMATION NAR MARKED INFORMATION NAR MARKED INFORMATION NJAC 8:43E-2.1 a NJAC 8:43E-2.1 a NJAC 8:43E-2.1 a Review of Residem NJAC 8:43E-2.1 a being administered	ster flushed as ordered. hent before feeding, and ministered t #2's OSR dated revealed the following <b>IDEXEC Order 26, 4. b. 1.</b> <b>IDEXEC Order 26, 4. b. 1.</b>	F 65			

Event ID: BGPR11

Facility ID: NJ61007

If continuation sheet Page 5 of 10

		AND HUMAN SERVICES					FORM	02/06/2023 APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIF	PLE CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	G			PLETED C
		315226	B. WING	;				08/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HUNTER	NON CARE CENTER				1 LEISURE COURT FLEMINGTON, NJ 08822			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD	BE	(X5) COMPLETION DATE
F 658	3. According to the admitted to the faci diagnoses which in NJAC 8:43E-2.1 a	6.44, b. 1. 3E-2.1 and Exec Order 26, 4. b. 1. 43E-2.1 and Exec Order 26, 4. b. 1.	F	658				
	According to the M	DS, dated Resident						

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Facility ID: NJ61007

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STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION       (M1) PROVIDERSUPPLIERCIAN JEENTHFICATION NUMBER:       (M2) MULTIPLE CONSTRUCTION A. BULINING			AND HUMAN SERVICES			FORM	: 02/06/2023 APPROVED . 0938-0391
MALE OF PROVIDER OR SUPPLIER     315226     B. WING     07/08/2021       HUNTERDON CARE CENTER     ILEISURE COURT FLEMINGTON, NJ 0822     Descent of construction of const						CON	IPLETED
HUNTERDON CARE CENTER     1 LEBURE COURT FLEMINGTON, NJ 08822       PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY     COMPANY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE TO THE APPROPRIATE			315226	B. WING _			
HUMERDON CARE CENTER       FLEMINGTON, NJ 08822         (X4) JD PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRÉCEDED BY FULL REGULATIORY OR LSC IDENTIFYING INFORMATION)       D PRÉFIX TAG       PROVIDERS ALL OF CORRECTION (EACH DEFICIENCY)       D PRÉFIX TAG       PROVIDERS ALL OF CORRECTION (EACH DEFICIENCY)       D PRÉFIX TAG       PROVIDERS ALL OF CORRECTION (EACH DEFICIENCY)       D PRÉFIX TAG       PREFIX (EACH DEFICIENCY)       D PRÉFIX TAG       PROVIDERS ALL OF CORRECTION (EACH DEFICIENCY)       D PRÉFIX (EACH DEFICIENCY) <td>NAME OF I</td> <td>PROVIDER OR SUPPLIER</td> <td></td> <td></td> <td></td> <td>E</td> <td></td>	NAME OF I	PROVIDER OR SUPPLIER				E	
Prečetki TAG       (EACH ORENCETIVE ACTION SHOULD BE REGULATORY OR LSC DENTIFYING INFORMATION)       PREFIX TAG       CEACH ORRECTIVE ACTION SHOULD BE CROSS-REPERENCE TO THE APPROPRIATE       COMMENTIFYING INFORMATION)         F 658       Continued From page 6 #3 had a BIMS score of the indicating the resident was cognitively indicating the resident was cognitively indicating the resident was cognitively indicating the revealed that Resident #3 needed extensive assistance with ADLs and received nutrition through tube feeding.       F 658         Review of Resident #3 cOSR dated Review of Resident #3 cOSR dated Review of Resident #3 cOTOP 26, 4, b, 1; Review of Resident #3 s EAR dated Review of Review of Review of Review of Review of Review of	HUNTER	DON CARE CENTER					
#3 had a BIMS score of finite indicating the resident was cognitively intact. The MDS also showed that Resident #3 needed extensive assistance with ADLs and received nutrition through tube feeding.         Review of Resident #3's OSR dated indication in the feeding.         With ADL and received nutrition through tube feeding.         Review of Resident #3's OSR dated indication in the feeding.         With ADL and received nutrition through tube feeding.         Review of Resident #3's OSR dated indication in the feeding.         With ADL 8:43E-2.1 and Exec Order 26, 4. b. 1         With 8:43E-2.1 and Exec Order 26, 4. b. 1         With 8:43E-2.1 and Exec Order 26, 4. b. 1         Review of Resident #3's EAR dated in the feeding revealed the above following physician's orders were not documented as being administered as follows:	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETION DATE
NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.	F 658	#3 had a BIMS sco resident was cognit showed that Reside assistance with AD through tube feedin Review of Resident NJAC 8:43E-2.1 and NJAC 8:43E-2.1 and NJAC 8:43E-2.1 and NJAC 8:43E-2.1 and Review of Resident NJAC 8:43E-2.1 and being administered	t #3's OSR dated <b>Exec Order 26, 4. b. 1.</b> <b>Exec Order 26, 4. b. 1.</b> <b>Exec Order 26, 4. b. 1.</b>	F 65	,		

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Facility ID: NJ61007

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		AND HUMAN SERVICES					FORM	02/06/2023 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		315226	B. WING			C 07/08/2021			
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE LEISURE COURT	, ZIP CODE			
	-			F	LEMINGTON, NJ 08822				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD O THE APPROPF	BE	(X5) COMPLETION DATE	
F 658	Continued From pa	ige 7	F 6	58					
	NJAC 8:43E-2.1 an	nd Exec Order 26, 4. b. 1.							
	NJAC 8:43E-2.1 a	and Exec Order 26, 4. b. 1.							
		d Exec Order 26, 4. b. 1.							
	NJAC 0.43L-2.1 and								
	NJAC 8:43E-2.1 an	NAC 8438-2 nd Exec Order 26, 4. b. 1.							
	Unit Manager (UM) document the treat the physician's orde	on 7/8/2021 at 8:31 a.m., the stated, "the blanks on the ord mean the nurse did not ment; the nurse should look at er, do the treatment such as							
	Medication Adminis Treatment Administ	eding, then document on the stration Record (MAR), tration Record (TAR) or ecord (TAR) or							
	the Director of Nurs	/ on 7/8/2021 at 10:22 a.m., sing stated, "the blanks on the from nurses not							
		ty's policy titled Nursing jective" dated 10/26/1999,							

If continuation sheet Page 8 of 10

		AND HUMAN SERVICES				FORM	: 02/06/2023 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	`́сом	E SURVEY IPLETED
		315226	B. WING	' <u> </u>			08/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	DON CARE CENTER				1 LEISURE COURT FLEMINGTON, NJ 08822		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 658	indicated the follow of the nursing depa maintain the reside emotional, and soci residents stay in the The Nursing Depar resident receives tr in accordance with care Document a which will be availa resident. Review of the facilit "Documentation" ur following: Under "P professional trackin care. Good clinical into the medical rec clinical documentat information in a way understand the pro- enhance continuity shifts and among a must be monitored. Under Guiltiness fo Skilled Nursing Pro- indicated the follow The licensed nurse on a daily basis: 2. of bed elevated. 4. Frequency of flus flush. 7. Intake and output interventions. 8. Oral intake (if ap appetite, swallowing	ing: Under "Goals": The goal irtment is to attain and nt's highest level of physical, ial well being during the e facility. tment will: Ensure that each eatment, medications and diet physician's medical plan of all care in accurate manner, ble upon request of the ty's policy titled hdated, indicated the olicy": Documentation is a ng tool to enhance continuity of practice dictates what goes cord. The key goals of sound ion are: to describe y that everyone can gress of the resident. To of care so that the staff on all Il disciplines will know what . To monitor outcomes of care. r Nursing Documentation , cedures-Tube Feeding ing: is to document the following, . Placement verification/head shes and the amount of the tt and parameters and plicable), note diet order,		658			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 02/06/2023 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	`́сом	E SURVEY IPLETED
		315226	B. WING				08/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTER	RDON CARE CENTER				LEISURE COURT LEMINGTON, NJ 08822		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 658	and Baseline Carep indicted the followin policy of this facility day of admission to and develop a base the first 48 hours of instructions for pers provided for each re complete and imple (BCP) within 48 hou which will promote communication am- safety, and safegua that are most like to admission"Under of initial admission nurse will complete develop a care plan of care will address resident including, I this plan of care will the BCP is develop of care may be inco- plan of care will inco-	plan (BCP) dated 11/2017, ng: Under "Policy": it is the y to initiate a care plan on the o address immediate needs, eline care plan (BCP) within f admission to ensure son centered care are resident. In addition, facility will ement a baseline care plan ours of a residents admission continuity of care and long staff, increase resident ard against adverse events o occur right after er Procedure": 1. On the date to the facility, the admitting e an initial assessment and n. (i) This initial admitting plan is the immediate needs of the but not limited to: (a) safety. 2. Il be updated as needed until bed. The initial admitting plan orporated into the BCP. 3. This clude measurable objectives o address resident specific	F 6	58			

Facility ID: NJ61007

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## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVISI	Т
IDENTIFICATION NUMBER	A. Building				
315226 <sub>Y1</sub>	B. Wing	Y	(2	8/4/2021	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
HUNTERDON CARE CENTER		1 LEISURE COURT			
		FLEMINGTON, NJ 08822			

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			ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix F0658		Correction	ID Prefix		Correction	ID Prefix		Correction
483.21 Reg. #	(b)(3)(i)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		08/04/2021	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 _		'			
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	I	DATE	
REVIEWED BY CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 7/8/2021			K FOR ANY UNCOR				s 🗆 no	