STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315110	A. BUILDING **01** B. WING _____	**01/06/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW REHABILITATION AND CARE CENTER	**130 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS LIFE SAFETY CODE 101:2012 This facility is in substantial compliance with the Minimum Life Safety Code requirements as survey using CMS-2786R. The facility must submit a Plan of Correction to address the following concerns that pose no greater risk to resident health or safety than the potential for causing minimal harm.	K 000		
K 241 SS=B	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation in the presence of the facility's Maintenance Director on 12/31/19, it was determined that the facility failed to provide two remote exits from the basement section of the building as evidenced by the following: During a tour of the facility's basement at 10:00	K 241	1)FSES Survey was completed for LakeView for tag 0241-NFFPA 101. 2)The FSES survey yielded a passing score. 3)Two smoke detectors were installed in the main dinning room to correct the issues referenced in the survey.	6/26/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/10/2020

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.

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K 241	Continued From page 1 AM, the surveyor observed that the only means of egress from the facility's basement was a stairway leading to an exterior exit door and the first floor. At that time the surveyor interviewed the facility's Maintenance Director who confirmed that the basement was provided with only one exit. Also, the Maintenance Director indicated that this condition has always existed. NJAC 8:39-31.2(e)	K 241	4)A smoke detector was installed in a patient room. 5)All hazardous area doors were secure with a self-closing mechanisms to correct the issues referenced in the survey.	