STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING ______ B. WING ______	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE CHERRY HILL, NJ 08003**

(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 Complaint #: 168513,168823,169299, 169356, 169828, 170170, 176350, 179621 Survey Date: 12/2/24-12/6/24 Census: 203 Sample: 35 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		1/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 12/19/2024

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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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to keep all areas clean specifically the hallways by leaving linen bundled up outside the linen cart and in the soiled-utility rooms by leaving trash bags on the floor, stacked up, and untied. The deficient practice was identified on 2 of 4 units reviewed under the Environment Task. The deficient practice was evidenced by the following: On 12/03/2024 at 11:08 AM in the St. George hallway, the surveyor observed linen including towels and blankets unfolded and piled onto the outside handle of the linen cart. On the same date at 12:15 PM in the St. George Soiled Utility room, the surveyor observed linens	F 584	Plan of Correction F584 Level D Completion Date: 1/15/2025 Corrective Action: " Linen found outside of the linen cart was placed in soiled laundry. " Linens in the Soiled Utility Room were tied, taken off the floor and placed in the receptacle. " Soiled linen was removed from Soiled Utility Room. ID Other Residents: " Any resident within the facility Systemic Change:	

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F 584	Continued From page 2 overflowing and not bagged from the receptacle, two trash bags were placed on top of the trash receptacle also. On the same date at 12:19 PM in the St. Mary's soiled utility room, the surveyor observed linens in an untied trash bags left on the floor. On 12/04/2024 at 11:07 AM during an interview with the surveyor, the U.S. FOIA (b)(6) said soiled utility rooms should not be piled up. She confirmed that she makes sure nothing is on the floor. On 12/05/2024 at 1:10 PM during an interview with the U.S. FOIA (b)(6)) said soiled utility rooms are to checked twice during the day shift however, they did ask housekeeping to make additional checks. At that time, the U.S. FOIA (b)(6) confirmed trash bags should be in receptacles and not on the floor. § 8:39-19.7 (a), (b)	F 584	" In-service □ Proper Storage of Linens will be given to the Nursing Department and Laundry by Nurse Educator □ completed by 1/15/2025. " In-service □ Proper Disposal of Soiled Linens will be given to the Nursing Staff and Laundry by Nurse Educator □ completed by 1/15/2025. " Soiled linens will be collected by laundry service 3 x□s daily on the morning shift and 2 x□s daily on the evening shift. " Additional laundry disposal bins will be purchased to handle the amount of soiled linen that is created. Monitoring: " Audit - Clean and Soiled Linen will be completed on the following schedule: (4) weekly x□s 2 weeks then (4) monthly x□s 2 months then (4) quarterly x□ 1 quarter by Infection Preventionist. " Audit □ Soiled Utility Room Linen Disposal will be completed on the following schedule: (4) weekly x□s 2 weeks then (4) monthly x□s 2 months then (4) quarterly x□ 1 quarter by Infection Preventionist. " Results of the audits will be brought to QA/QAPI on a quarterly basis x□s 3 quarters.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		1/15/25

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F 610 — Continued From page 3

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Complaint: NJ170170; NJ169828

Based on interview, record review and document review it was determined that the facility failed to maintain documentation and ensure that a complete and thorough investigation was conducted for a resident that had [NJ Exec Order 26.4b1]
This deficient practice was identified for 1 of 2 Residents (Resident #347) reviewed for [NJ Ex Ord] and was evidenced by the following:

On 12/03/2024 at 11:40 AM, the surveyor requested all accidents and/or investigations from the facility for Resident #347 during the year of [NJ Ex Order 2] The facility provided [NJ Exec O] investigations for incidents that occurred on [NJ Exec Order 26.4b1]

Upon review of document titled, "Incident Audit Report" (IR) dated [NJ Ex Order 26.4(b)(1)] at 4:00 PM revealed under Nursing Description: "Called to room [NJ Exec O] by [U.S. FOIA (b)(6)]] and noted resident [NJ Exec Order 26.4b1] ". Identified

F 610

Plan of Correction

F610 Level D
Completion Date: 1/15/2025

Corrective Action:
" Resident #347 □ incident report dated [NJ Exec Order 26.4] was reviewed and reinvestigated by Nursing Administration. Statements were obtained by nursing staff involved in care of resident during incident.
" Post incident follow up was rewritten.

ID Other Residents:
" Any resident within the facility who has an incident that requires an investigation.

Systemic Change:
" In-service □ How to Complete a Thorough Investigation to the Nursing Department by Nursing Administration by

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F 610	Continued From page 4 under Resident Description revealed: "Resident said [they were] NJ Ex Order 26.4(b)(1) [their] bed to NJ Ex and NJ Exec Order 26.4b1". The IR contained a signed conclusion by the U.S. FOIA (b), and a handwritten signed statement from the identified U.S. FOIA (b) that identified the NJ Exec as unwitnessed. Upon review of IR dated NJ Ex Order 26.4(b)(1) at 10:30 PM, it revealed under Nursing Description: "Resident sitting NJ Ex Order 26.4(b)(1), and [their] wheelchair behind [them]". Identified under Resident Description revealed: "Resident said [they're] NJ Ex Order 26.4(b)(1) from bed to NJ Ex Order 26.4(b)(1) but NJ Ex Order 26.4(b)(1)". Identified under Description of Action Taken revealed: "Resident NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)". Attached to the IR was an undated and unsigned document dated NJ Exec Order 26.4b1 that included, "Resident found by U.S. FOIA (b) during rounds NJ Exec Order 26.4b1. Prior [to] the incident, resident was in [their] wheelchair which was behind [them]. Resident stated [they were] NJ Exec Order 26.4b1 No NJ Ex Order 26.4 noted upon assessment. NJ Exec Order 26.4b1. Resident NJ Ex Order 26.4(b)(1) and then NJ Exec Order 26.4b1. Resident was wearing U.S. FOIA (b)(6). Wheelchair cushion was inspected with no issues noted. Anti-roll back breaks applied to wheelchair". The IR did not include statements from the identified CNA, vital signs, and did not specify if the NJ Exec was witnessed or unwitnessed. The surveyor reviewed the IR dated NJ Ex Order 26.4(b)(1) at 1:15 PM that revealed under Nursing Description: "This writer summoned to resident room at [approximately 1:15 PM] by Certified Nursing	F 610	1/15/2025. " In-service What to Include in an Incident Report: to the Nursing Department by Nursing Administration by 1/15/2025. " Statements will be obtained for all unwitnessed incidents by those individuals who interacted with resident within the timeframe of the incident. Monitoring: " Audit - Incident Reports and Investigations will be completed on the following schedule: (4) weekly xs 2 weeks then (4) monthly xs 2 months then (4) quarterly x 1 quarter by Nursing Administration by 1/15/2025. " Results of the audits will be brought to QA/QAPI on a quarterly basis xs 3 quarters.	

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F 610	Continued From page 5	F 610		

Assistant (CNA) assigned who stated, [the resident NJ Exec Order 26.4b1". Identified under Description of Action taken indicated: "Resident NJ Ex Order 26.4(b)(1) with the NJ Ex Order 26.4(b)(1) staff member-unit manager in to evaluate. NJ Exec Order 26.4b1 checks initiated. NJ Ex Order 26.4(b)(1)] NJ Exec Order 26.4b1. Message with [doctor] ...". Attached to the IR was an undated and unsigned document dated NJ Exec Order 26.4b at NJ Exec Order 26.4 indicated, "Resident NJ Exec Order 26.4b1 Prior to the incident, resident was sitting in [their] wheelchair after eating the room meal. NJ Exec Order 26 and upon assessment, NJ Exe . Resident was assisted back to wheelchair and assessed by U.S. FOIA (b)(6). U.S. FOIA (b)(6) checks were [within normal limits]. Resident U.S. FOIA (b)(6). [Doctor] ordered labs which are pending. Post incident, resident NJ Exec Order 26.4b1 Call placed to [doctor] with order for NJ Exec Order 26.4b1 Results noted with NJ Ex Order 26.4(b)(1) Resident sent to [emergency department]. Admitted to facility with U.S. FOIA (b)(6)". The Incident Audit Report did not include statements from the identified unit manager or CNA, did not specify if the NJ Exec was witnessed or unwitnessed, and did not have documentation of vital signs.

The surveyor reviewed the medical record for Resident #347.

A review of the Admission Record face sheet (an admission summary) reflected that Resident #347 was admitted to the facility with diagnosis that included, NJ Exec Order 26.4b1 .

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F 610	Continued From page 6 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, reflected a brief interview for mental status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1 On 12/4/2024 at 12:16 PM, the surveyor interviewed CNA#1 who reported that following a resident NJ Exec O whether it is witnessed or unwitnessed, the U.S. FOIA (b complete a handwritten report of everything that they they did and saw during the incident. On 12/4/2024 at 12:21 PM, the surveyor interviewed Licensed Nurse Practitioner (LPN #1) who advised that following a resident NJ Exec O the U.S. FOIA work together complete a thorough NJ Exec investigation. LPN#1 confirmed that nursing is responsible for ensuring that statements are obtained from nursing as both a progress note and risk management assessment in the EMR (electronic medical record), and any witnesses (including the CNA) will be on paper. LPN #1 further explained that the nursing progress note should include the resident assessment, including the resident's vital signs, environmental concerns, resident presentation, where they were found in the room, etc. On 12/5/2024 at 9:18 AM, the surveyor interviewed Licensed Nurse Practitioner Unit Manager (UM/LPN #1) who advised that nursing works together to complete the NJ Exec O investigation. UM/LPN #1 confirmed that statements are obtained from everyone that witnessed or was involved in the fall. UM/LPN #1 advised the CNA would fill out a form since they do not have	F 610		

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F 610	Continued From page 7	F 610		

access or the EMR progress notes. The UM/LPN #1 advised that the nursing documentation should include vital sings, if the resident is prescribed any NJ Exec Order 26.4b1 . UM/LPN #1 confirmed that the U.S. FOIA (b)(6) would review the NJ Exec investigation to ensure completeness. UM/LPN #1 reviewed the IR completed for NJ Ex Order 26.4(b and NJ Ex Order 26.4(b and confirmed that were no statements obtained, no vital signs documented, and no name, title, or date of the investigation summary.

On 12/5/2024 at 11:12 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who reviewed the NJ Exec Order 26.4b1 IRs and confirmed that statements were not obtained and that she could not identify who completed the IR conclusion summary since it was not signed. The U.S. FOIA (b) also acknowledged that thorough nursing documentation was not completed since there were not vitals signs documented on the IR. When asked if the two IRs were thoroughly completed, the U.S. FOIA (b) stated no.

On 12/5/202 at 10:09 AM, the U.S. FOIA (b)(6)), in the presence of the U.S. FOIA (b)(6) acknowledged that the facility does not require handwritten statements or names of witnesses in their NJ Exec investigations but could not speak to the facility policy.

A review of the facility's policy titled, "Fall Prevention/ Management", with an effective date of 6/2017 and revised date of 3/2023, documented under Procedure: "An incident report will also be initiated for any unwitnessed or witnessed fall ..."

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F 610	Continued From page 8 A review of the facility's policy titled, "Accident and Incident Investigation", with an effective date of 10/2018 and revised date of 1/202, documented under Policy Interpretation and Implementation: "The following data, as applicable, shall be included on the Report of Incident/Accident Form: "E. The name(s) of witnesses and their accounts of the accident or incident; I. The condition of the injured person, including his/her vital signs; M. The signature and title of the person completing the report. NJAC 8:39-9.4(f)	F 610		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		1/15/25

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F 812	Continued From page 9 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 12/02/2024 from 9:35 until 10:00 AM, the surveyor, accompanied by the U.S. FOIA (b)(6) [redacted]) observed the following in the kitchen: 1. In the walk-in refrigerator, on an orange tiered cart, 15 bags of hot dog rolls with a received by date of 11/11/24. The U.S. FOIA stated he will get rid of them. 2. In the walk-in refrigerator on the second shelf, an opened plastic container of prepared cucumber salad with a received by date of 11/21/24. The U.S. FOIA stated he will get rid of the cucumbers. 3. In the walk-in freezer on top of an opened box, an opened clear plastic bag with pizza dough with no label and no date. The U.S. FO stated the pizza dough should have been labeled and dated. The U.S. FO threw the pizza dough in the trash. 4. In the prep area, a large container of food thickener and large container of flour were opened and exposed to air. The U.S. FO stated the containers should be covered. The U.S. FOIA closed the containers. On 12/04/2024 at 01:49 PM, the surveyor, accompanied by the Nurse Manager #1 observed an unlabeled, covered plate with fish, pork, and fries in the St. George unit pantry refrigerator.	F 812	Plan of Correction F812 Level F Completion Date: 1/15/2025 Corrective Action: " Items that were outdated (hotdog rolls and cucumber salad were discarded). " Pizza dough was discarded. " Open containers in work area were closed. " Personal resident food in pantry (blueberries) were discarded. ID Other Residents: " Residents who require nutrition from the Dietary Department or who have personal food brought into the facility. Systemic Change: " In-service Labeling, Dating and Discarding Food to the Dietary Department by the Dietary Director completed by 1/15/2025. " In-service Resident Food Brought into the Facility to Dietary and Nursing Department by the Dietary Director completed by 1/15/2025. " Daily rounds will be completed by the dietary staff in the kitchen and pantry to monitor for outdated items and dispose of them per policy. Monitoring: " Audit - Labeling and Dating of Items will be completed on the following schedule: (4) weekly xs 2 weeks then (4) monthly xs 2 months then (4)	

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F 812	Continued From page 10 The Nurse Manager #1 stated the plate should be labeled and dated and removed the plate from the refrigerator. On 12/04/24 at 02:00 PM, the surveyor, accompanied by the Nurse Manager #2 observed a plastic container of fresh blueberries dated 11/23/2024 in the Rose Garden pantry refrigerator. A few of the blueberries appeared to be dry. The nurse manager was not aware of the expiration date of fresh fruit. The Nurse Manager #2 removed the blueberries from the refrigerator. A review of the facility policy titled Food Storage, revised 2/2024, reflected that refrigerated and ready to eat food shall be held at a temperature of 40 degrees Fahrenheit or less for a maximum of 7 days and refrigerated bread increases shelf life to 14 days. A review of the facility policy titled Freezer with a revised date of 10/2022 reflected that items that require dates in freezers will be dated per industry standards and when items are open or not labeled in freezers items will be discarded. A review of the facility policy titled Foods Brought by Family/Visitors dated 01/02/2024 reflected that perishable foods must be stored in re-sealable containers with tightly fitted lids in the refrigerator/unit pantry. Containers will be labeled with the resident's name, the item and the use by date. A review of the facility policy titled Dietary Practices with a revised date of 02/2024 reflected that all foods are to be protected from other sources of contamination and after food preparation is completed, food items should be	F 812	quarterly x□ 1 quarter by the Dietary Director. " Audit □ Nursing Pantry Refrigerator will be completed on the following schedule: (4) weekly x□s 2 weeks then (4) monthly x□s 2 months then (4) quarterly x□ 1 quarter by Nursing Administration. " Results of the audits will be brought to QA/QAPI on a quarterly basis x□s 3 quarters.	

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F 812	Continued From page 11 stored and covered appropriately. NJAC 18:39-17.2(g)	F 812		
F 847 SS=F	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly	F 847		1/15/25

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	315060	A. BUILDING ______ B. WING ______	C 12/06/2024

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F 847	Continued From page 12 state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to explicitly contain any language to inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at the facility and failed to contain any language allowing the resident or anyone else to communicate with federal, state, or local officials. The deficient practice has the potential to affect all residents that signed the binding arbitration clause. The deficient practice was evidenced by the following: A review of the the facility admission packet included an Arbitration Agreement, titled, "Voluntary, Binding Arbitration". The arbitration agreement at no time contained any language that explicitly informs the resident or his or her representative of his or her right not to sign the	F 847	Plan of Correction F847 Level F Completion Date: 1/15/2025 Corrective Action: " Admissions Agreement changed to reflect appropriate language in regards to Voluntary Binding Arbitration. Admissions Agreement now will state □ THIS AGREEMENT IS OPTINAL FOR RESDIENTS AND FACILITY. ADMISSION TO THE FACILITY IS NOT CONDITIONAL UPON A RESDIENT□S WILLINGNESS TO ENTER INTO THIS AGREEMENT. " Appropriate officials and departments for the New Jersey Department of Health and Human Services Division of Aging and Long-Term Care Ombudsman contact information added to Admissions	

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F 847	Continued From page 13 agreement as a condition of admission to, or as a requirement to continue to receive care at the facility. Further review of the facility Arbitration Agreement located in the Admission Packet did not reveal any language that allowed the resident or anyone else to communicate with federal, state, or local officials and a representative of the Office of the State Long Term Care Ombudsman. On 12/02/2024 at 10:16 AM during the Entrance Conference, the U.S. FOIA (b)(6) informed the surveyor that the facility includes Arbitration Agreements in the facility Admission Agreement. The U.S. FOIA (b)(6) informed the surveyor that no residents have entered into binding arbitration or resolved disputes through binding arbitration on or after 09/16/2019. On 12/05/2024 at 12:30 PM during an interview with the U.S. FOIA (b)(6) the surveyor asked does the arbitration agreement state that neither the resident or his or her representative is required to sign the binding arbitration. The U.S. FOIA (b) (6) replied, "The document is titled voluntary." On 12/06/2024 at 9:29 AM during an interview with the U.S. FOIA (b)(6) the surveyor asked if the arbitration agreement explicitly says neither the resident nor his or her representative is required to sign this agreement as a condition of admission to, or as a requirement to continue to receive care at the facility. The U.S. FOIA (b)(6) replied, "I don't see it in this section."	F 847	Agreement. " Added information will be available to those individuals who have previously signed admissions agreements prior to the above changes being made. ID Other Residents: " Any resident or Responsible Party who sign an Admission Agreement. Systemic Change: " In-service □ Updated Admissions Agreement to the Admissions Department by the LNHA completed by 1/15/2025. Monitoring: " Audit - Admissions Agreement will be completed on the following schedule: (4) weekly x□s 2 weeks then (4) monthly x□s 2 months then (4) quarterly x□ 1 quarter by the Admissions Coordinator. " Results of the audits will be brought to QA/QAPI on a quarterly basis x□s 3 quarters.	

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F 847	Continued From page 14 On the same date at 10:01 AM during an interview with the [redacted], the surveyor asked does the binding arbitration agreement allow the resident or anyone else to communicate with federal state, or local officials such as federal and state surveyors, other federal or state health employees and representatives of the Office of the State Long Term Care Ombudsman. The [redacted] replied, "Not in the arbitration agreement but we have the Ombudsman notification form in the admission agreement. The surveyor then asked does the arbitration agreement explicitly state neither the resident nor his or her representative is required to sign this agreement as a condition of admission to, or as a requirement to continue to receive care at the facility. The [redacted] replied, "No, it does not state in there." N.J.A.C. § 8:39-4.1 (8)	F 847		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		1/15/25

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F 880	Continued From page 15	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 16 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents it was determined that facility staff failed to use appropriate infection control practices, specifically by failing to wear NJ Ex Order 26.4 during high-contact activity in a resident's room who was under NJ Ex Order 26.4(b)(1). The deficient practice was identified for 1 of 3 residents (Resident # 190) reviewed for NJ Ex Order 26.4(b)(1) Care. The deficient practice was evidenced by the following: A review of Resident # 190's Order Summary located in the Electronic Medical Record (EMR) revealed an order for, 'NJ Ex Order 26.4(b)(1) every shift for NJ Ex Order 26.4(b)(1).'' The order continued, 'NJ Ex Order 26.4(b)(1) adherence during high contact resident activities. Must wear NJ Ex Order 26 & Gloves during: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) Linen changes, Providing NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b assistance, NJ Ex Order 26.4(b)(1) care, and NJ Ex Order 26. care. DON/DOFF and cleanse hands before and after care..." A review of Resident # 190's Care Plan located in	F 880	Plan of Correction F880 Level E Completion Date: 1/15/2025 Corrective Action: " 1:1 in-service provided to CNA #1 regarding appropriate PPE when providing care to a resident on Enhanced Barrier Precautions. ID Other Residents: " Any resident within the facility who requires care. Systemic Change: " In-service Enhanced Barrier Precautions and Proper PPE will be given facility to the Nursing Department by Infection Preventionist will be completed by 1/15/2025. " Personal Protective Equipment (PPE) will be made available in clean work rooms as well as in each resident room who is identified on Enhanced Barrier Precautions (EBP).	

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F 880	Continued From page 17 the EMR revealed an intervention to, "Maintain NJ Ex Order 26.4(b)(1) -Utilize PPE when performing high-contact resident care." The date initiated was NJ Ex Order 26.4(b)(1). On 12/04/2024 at 12:04 PM, the surveyor observed Certified Nurse Aide (CNA) # 1 in Resident # 190's room with the door open and curtain partially drawn. On the door of the room was an NJ Ex Order 26.4(b)(1) sign indicating that staff are to wear NJ Ex Order 26.4(when performing high-contact activities including but not limited to providing NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1) At that time, the surveyor was able to see a clean, NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(near the foot of the resident's bed. At that time, the surveyor observed CNA # 1 in the room providing care to Resident # 190 with gloves and a mask on. CNA # 1 was not wearing NJ Ex Order 26.4(. At that time, in the presence of the surveyor, the Unit Manager/Licensed Practical Nurse (UM/LPN) # 1 observed CNA # 1 in the room. UM/LPN # 1 confirmed CNA # 1 was performing NJ Exec Order 26.4b1 without wearing NJ Ex Order 26.4(. On 12/04/2024 at 11:07 AM during an interview with the surveyor, the NJ Exec Order 26.4b1 confirmed Resident # 190 is under NJ Ex Order 26.4(b)(1). Further, she confirmed that if the CNA is providing NJ Exec Order 26.4b1, they are expected to wear NJ Ex Order 26.4(. On 12/05/2024 at 1:10 PM during an interview with the surveyor, the U.S. FOIA (b)(6) confirmed staff should be wearing NJ Ex Order 26.4(and gloves when a resident is on NJ Ex Order 26.4(b)(1) and NJ Exec Order 26.4b1 is being provided. During the same interview, the U.S. FOIA (b) stated, "It's NJ Ex Order 26.4(b)(1), so it's	F 880	Monitoring: " Audit - PPE for Enhanced Barrier Precautions will be completed on the following schedule: (4) weekly x□s 2 weeks then (4) monthly x□s 2 months then (4) quarterly x□ 1 quarter by Infection Preventionist " Results of the audits will be brought to QA/QAPI on a quarterly basis x□s 3 quarters.	

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F 880	Continued From page 18 NJ Ex Order 26.4(b)(1) control. A review of the facility policy titled, "Enhanced Barrier Precautions" dated 3/2024 revealed under, "General Overview" that, "Enhanced Barrier Precautions (EBP) utilizes targeted gown and glove use during high-contact resident care activities to reduce the transmission of MDROs [Multiple-Drug Resistant Organisms]". Further, the policy revealed, "Examples of high-contact resident care activities requiring gown and gloves for EBP include but are not limited to: Dressing, Bathing/Showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting..." N.J.A.C. § 8:39-19.4 (a)	F 880		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #'s: NJ00168823, 169356, 176350, and 179621 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Findings include: A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	Plan of Correction S560 Completion Date: 1/15/2025 Corrective Action: " No residents were identified " Staffing levels were reviewed for all deficient dates listed " Additional staff were recruited to meet the minimum staffing standards moving forward ID Other Residents: " Potential to affect all residents	1/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/19/24

New Jersey Department of Health

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S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the Nurse Staffing Report (AAS-11) completed by the facility, the facility was deficient as follows: 1. For the week of Complaint staffing from 10/29/2023 to 11/04/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -10/29/23 had 13 CNAs for 200 residents on the day shift, required at least 25 CNAs. -10/30/23 had 20 CNAs for 199 residents on the day shift, required at least 25 CNAs. -11/03/23 had 21 CNAs for 198 residents on the day shift, required at least 25 CNAs. -11/04/23 had 21 CNAs for 198 residents on the day shift, required at least 25 CNAs.	S 560	residing within the facility Systemic Change: " Bonuses are offered for double shifts, extra shifts and weekends " Perfect attendance bonuses are offered on a weekly basis " In-service □ Lateness and Attendance Policy " Usage of Staffing Agencies to supplement staffing needs " Offering of Certified Nursing Assistant Courses within the facility " Referral Program promoted for staff " Sign on bonuses to assist with staff recruitment " Employee Appreciation parties " In-service □ State Mandated Staffing Levels: to the Nursing Department by Nursing Administration by 1/15/2025 " Additional shifts will be made available to meet staffing levels for Certified Nursing Assistants " Licensed staff will supplement Certified Nursing Assistant positions if the need arises that staffing levels go below the state required minimum Monitoring: " Nursing Administration will conduct weekly CNA staffing schedule audits " Nursing Administration will report findings to the Administrator " Results of the audits will be brought to QA/QAPI on a quarter basis x□s 3 quarters.	

New Jersey Department of Health

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S 560	Continued From page 2 2. For the 2 weeks of Complaint staffing from 04/28/2024 to 05/04/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -04/28/24 had 18 CNAs for 204 residents on the day shift, required at least 25 CNAs. -04/29/24 had 16 CNAs for 204 residents on the day shift, required at least 25 CNAs. -05/02/24 had 18 CNAs for 204 residents on the day shift, required at least 25 CNAs. -05/03/24 had 20 CNAs for 203 residents on the day shift, required at least 25 CNAs. -05/04/24 had 21 CNAs for 202 residents on the day shift, required at least 25 CNAs. -05/05/24 had 16 CNAs for 201 residents on the day shift, required at least 25 CNAs. -05/06/24 had 21 CNAs for 201 residents on the day shift, required at least 25 CNAs. -05/07/24 had 21 CNAs for 201 residents on the day shift, required at least 25 CNAs. -05/09/24 had 20 CNAs for 201 residents on the day shift, required at least 25 CNAs. -05/10/24 had 21 CNAs for 199 residents on the day shift, required at least 25 CNAs. -05/11/24 had 19 CNAs for 198 residents on the day shift, required at least 25 CNAs. 3. For the week of Complaint staffing from 08/11/2024 to 08/17/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -08/14/24 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs. -08/16/24 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs. -08/17/24 had 20 CNAs for 185 residents on the day shift, required at least 23 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30402	A. BUILDING: ______ B. WING ______	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION &	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(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) COMPLETE DATE
S 560	Continued From page 3 4. For the week of Complaint staffing from 11/10/24 to 11/16/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -11/10/24 had 21 CNAs for 202 residents on the day shift, required at least 25 CNAs. -11/11/24 had 18 CNAs for 200 residents on the day shift, required at least 25 CNAs. -11/12/24 had 23 CNAs for 200 residents on the day shift, required at least 25 CNAs. -11/13/24 had 21 CNAs for 195 residents on the day shift, required at least 24 CNAs. -11/14/24 had 22 CNAs for 195 residents on the day shift, required at least 24 CNAs. -11/15/24 had 20 CNAs for 195 residents on the day shift, required at least 24 CNAs. -11/16/24 had 22 CNAs for 195 residents on the day shift, required at least 24 CNAs. 5. For the 2 weeks of staffing prior to survey from 11/17/2024 to 11/30/2024, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -11/22/24 had 22 CNAs for 197 residents on the day shift, required at least 25 CNAs. -11/23/24 had 21 CNAs for 197 residents on the day shift, required at least 25 CNAs. -11/24/24 had 23 CNAs for 197 residents on the day shift, required at least 25 CNAs. -11/25/24 had 18 CNAs for 201 residents on the day shift, required at least 25 CNAs. -11/26/24 had 22 CNAs for 201 residents on the day shift, required at least 25 CNAs. -11/28/24 had 23 CNAs for 201 residents on the day shift, required at least 25 CNAs. -11/29/24 had 22 CNAs for 203 residents on the day shift, required at least 25 CNAs. -11/30/24 had 23 CNAs for 202 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30402	A. BUILDING: ___ B. WING ___	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION &	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(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) COMPLETE DATE
S 560	Continued From page 4	S 560		

day shift, required at least 25 CNAs.

During the interview with the surveyor on 12/05/2024 at 10:02 AM, the Staffing Coordinator (SC) stated that she was aware of the minimum staffing requirements for direct care staff. When asked by the sureyor if the facility meets those requirements, the SC stated that the facility meets those requirements.

During the interview with the surveyor on 12/05/2024 at 01:10 PM, the Director of Nursing (DON) stated that she was aware of the minimum staffing requirements for direct care staff. When asked by the surveyor if the facility meets those requirements, the DON stated that the facility meets those requirements.

A review of the facility policy titled "Staffing" with a revised date of 3/2020 revealed under "Policy Statement" that, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents." Further, the policy revealed under "Policy Interpretation and Implementation" that, "Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, acuity, and the facility resident population."

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315060	A. Building B. Wing	1/21/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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 F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 01/15/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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
12/6/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315060 (Y1)	A. Building B. Wing (Y2)	1/21/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 01/15/2025	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 01/15/2025	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/15/2025
ID Prefix F0847 Reg. # 483.70(m)(1)(2)(i)(ii)(3)-(5) LSC	Correction Completed 01/15/2025	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/15/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
12/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
30402	A. Building B. Wing	1/21/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/15/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 12/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING 01 B. WING ______	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(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 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/3/24, 12/4/24 and 12/6/24, and St. Mary's Center for Rehabilitation and Healthcare 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. St. Mary's Center for Rehabilitation and Healthcare is a two story building with a partial basement. It is a Type II protected building that was built in the 80's. The facility is divided into 13 smoke zones. The interior diesel generator does 70 to 80% of the building. The facility has 215 licensed beds with a census of 203 at entrance.	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		1/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/19/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING 01 B. WING ______	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(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 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/4/24 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to provide 1 of 6 exit stairways free of storage in accordance with NFPA 101: 2012 Edition, Sections 19.2.2.3, 19.2.2.4 and 7.2. This deficient practice had the potential to affect 50 residents and was evidenced by the following: An observation at 10:22 AM with the U.S. FOIA (b)(6) revealed in the physical therapy stairway, that two (2) chairs were observed in the path of egress. One chair was observed on the middle landing and one was observed on the lower level of the exit/egress stairs to the public way. In an interview at the time of observations, the U.S. FOIA (b)(6) both stated and agreed that nothing should be stored in the stairway exits at any time. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 12/4/24 at 2:10 PM, NJAC 8:39-31.2(e)	K 225	Plan of Correction K0225 Level E Completion Date: 1/15/2025 Corrective Action: " 2 chairs removed from therapy stairwell. " Other stairwells were checked and no obstruction noted. ID Other Residents: " Any resident within the facility have the potential to be affected. Systemic Change: " In-service Stairwells Free of Obstruction to the Maintenance and Therapy Departments by the Maintenance Director completed on 12/20/24. Monitoring: " Audit - Obstruction in Stairwell will be completed on the following schedule: (4) quarterly x 3 quarter by the Maintenance Director. " Results of the audits will be brought to QA/QAPI on a quarterly basis xs 3 quarters.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection	K 347		1/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING 01 B. WING ______	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(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 347	Continued From page 2 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 12/4/24 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure a testing and maintenance of battery-operated smoke detectors in resident rooms in accordance with NFPA 101 Life Safety Code: 2012 Edition, Sections 19.3.6.1 and 19.3.4.5.2. This deficient practice was evidenced for 114 of 114 documented battery-operated smoke detectors, had the potential to affect all residents in the facility and was evidenced by the following: In an interview, the U.S. FOIA (b)(6) both stated that resident rooms had battery operated smoke detectors. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance and testing document for the testing of the detectors including the make, model, installation date and type of battery required to power the smoke detector. The U.S. FOIA provided a monthly resident room smoke detector log, but it did not provide any information other than a checkmark for each room every month. The U.S. FOIA provided a user's manual from the manufacturer indicating the device should be tested at least once a week. The U.S. FOIA (b)(6) was informed	K 347	Plan of Correction K0347 Level F Completion Date: 1/15/2025 Corrective Action: " 10 year maintenance free battery operated smoke detectors were tested in all resident rooms on 12/12/24 and operational as designed. ID Other Residents: " Any resident within the facility Systemic Change: " In-service Monitoring Smoke Detectors to the Maintenance Department by the Maintenance Director completed on 12/20/24. " Smoke Detectors will be tested monthly and a log maintained by the Maintenance Department. Monitoring: " Audit - Smoke Detectors will be completed on the following schedule: (10) quarterly x 3 quarter by the Maintenance Director/Designee. " Results of the audits will be brought to QA/QAPI on a quarterly basis xs 3 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING 01 B. WING ______	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(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 347	Continued From page 3 of the findings at the Life Safety Code exit conference on 12/6/24 as 2:10 PM. NJAC 8:39-31.2(e) NFPA 72	K 347		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 12/3/24 in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to conduct fire drills with varying activation types in accordance with NFPA 101: 2012 Edition, Sections 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 12 of 12 fire drills, had the potential to affect all residents in the facility and was evidenced by the following: A document review on 12/3/24 with the U.S. FOIA revealed the facility fire drill reports identified the method for the simulation of alarm transmission signals, but were not specific. Six of 12 drills were conducted on a Saturday and "Times" were not	K 712	Plan of Correction K0712 Level F Completion Date: 1/15/2025 Corrective Action: " Additional 12/24 Fire Drill will be performed during the day shift and not on a weekend. " Additional 12/24 Fire Drill will reflect type of signal. ID Other Residents: " All residents within the facility have the potential to be affected.	1/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING 01 B. WING ______	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(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 712	Continued From page 4 varied on the 1st shift as follows: Date:, type of alarm transmission signal: Pull, Smoke or Page, weekend drill for 1st shift times not varied. 11/22/24 no signal type noted 10:25 AM, 10/26/24 no signal type noted- Saturday 9/21/24 no signal type noted- Saturday 8/30/24 no signal type noted 11:30 AM, 7/27/24 no signal type noted- Saturday 6/22/24 no signal type noted- Saturday 5/17/24 no signal type noted 11:00 AM, 4/17/24 no signal type noted 3/16/24 no signal type noted- Saturday 2/24/24 no signal type noted- Saturday 11:00 AM, 1/15/24 no signal type noted 12/5/23 no signal type noted The findings were verified by the U.S. FOIA at the time of record review. The U.S. FOIA (b)(6) confirmed that the fire drills were not descriptive as to the type of device used to activate the fire alarm system, (pull, page and smoke) on the above dates, 6 of 12 drills were conducted on a Saturday and time were not varied on the 1st shift. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 12/4/24 at 2:10 PM. NJAC 8:39-31.2(e)	K 712	Systemic Change: " In-service Fire Drill Testing, Scheduling, Monitoring to the Maintenance Department by the Maintenance Director on 2/2/24. " Fire Drills will be performed during the evening and night shifts and not on the weekend to ensure fire drill training is completed on all shifts. " Supervision log will be utilized to ensure fire drills are completed timely, note signal type and vary for the appropriate shift and time. Monitoring: " Audit - Fire Drill will be completed on the following schedule: (3) quarterly x 3 quarters by the Maintenance Director/Designee. " Results of the audits will be brought to QA/QAPI on a quarterly basis xs 3 quarters.	
K 912 SS=E	Electrical Systems - Receptacles	K 912		1/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING 01 B. WING ______	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

(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 912	Continued From page 5 CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 12/4/24 in the presence of the U.S. FOIA (b)(6) and U.S. FOIA), it was determined that the facility failed to ensure that 1 of 10 electrical outlets located next to a water source was equipped with a Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 and NFPA 99. This deficient practice had the potential to affect 10 residents and was evidenced by the following: Observations at 11:50 AM revealed in the Physical Therapy room, that a NJ Ex Order 26.4(b)(1) was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. The U.S. FOIA (b)(6) both confirmed the finding at the time of observation. The U.S. FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 12/4/24 at 2:10 PM.	K 912	Plan of Correction K0912 Level F Completion Date: 1/15/2025 Corrective Action: " Existing outlet was removed and replaced with GFCI outlet. " Facility wide inspection has been completed for GFCI outlets. ID Other Residents: " All residents within the facility have the potential to be affected. Systemic Change: " In-service □ Testing and Inspection of GFCI Outlets to the Maintenance Department by the Maintenance Director on 12/20/2024.. " Facility wide inspection of installed GFCI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING 01 B. WING ______	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(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 912	Continued From page 6 NJAC 8:39 -31.2 (e) NFPA 70, 99	K 912	Monitoring: " Audit - GFCI Outlet will be completed on the following schedule: (4) quarterly x□ 3 quarters by the Maintenance Director/Designee. " Results of the audits will be brought to QA/QAPI on a quarterly basis x□s 3 quarters.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/4/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that the facility's emergency generator annunciator was fully functional and in normal mode as per NFPA 99: 2012 Edition, Section 6.4.1.1.17 and 6.4.1.1.17.5. This deficient practice was identified for 1 of 1 generator annunciator panels, had the potential to affect all residents, and was evidenced by the following: An observation at 11:32 AM in the presence of the U.S. FOIA (b)(6) revealed on floor-1 at the nurse	K 916	Plan of Correction K0916 Level F Completion Date: 1/15/2025 Corrective Action: " The generator was inspected and found to be functioning as designed and a new annunciator control board ordered for Generator Annunciator Panel. ID Other Residents: " All residents within the facility have	1/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING ______	**12/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(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 916	Continued From page 7 station, that the generator annunciator panel test lamp button (when activated) did not work. The U.S. FOIA (b) had the maintenance staff activate the generator to see if the annunciator was working. When the generator was running, it produced a green light at the annunciator panel indicating it was running, but no other alarm condition lights would function at the time of observation. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 12/4/24 at 2:10 PM. NJAC 8:39-31.2(e) NFPA 99	K 916	the potential to be affected. Systemic Change: " In-service Annunciator Panel Monitoring and Resident Safety to the Maintenance Department by the Maintenance Director completed by 12/20/2024. Monitoring: " Audit - Annunciator Panel will be completed on the following schedule: every quarter x 3 quarters by the Maintenance Director/Designee. " Results of the audits will be brought to QA/QAPI on a quarterly basis xs 3 quarters.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315060	A. Building 01 - MAIN BUILDING 01 B. Wing	1/21/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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 Reg. # NFPA 101 LSC K0225	Correction Completed 01/15/2025	ID Prefix Reg. # NFPA 101 LSC K0347	Correction Completed 01/15/2025	ID Prefix Reg. # NFPA 101 LSC K0712	Correction Completed 01/15/2025
ID Prefix Reg. # NFPA 101 LSC K0912	Correction Completed 01/15/2025	ID Prefix Reg. # NFPA 101 LSC K0916	Correction Completed 01/15/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
12/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO