

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

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315312		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/22/2024	
NAME OF PROVIDER OR SUPPLIER HAMPTON RIDGE HEALTHCARE AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755			
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F 000	INITIAL COMMENTS Complaint #:154169, 161945, 170013, 172361, 172537, 1769295 Survey Date: 10/15/2024-10/22/2024 Census: 185 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized			F 656			11/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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11/10/2024

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 656	<p>Continued From page 1</p> <p>rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined that the facility failed to develop and implement a care plan that meets the medical needs identified on the comprehensive assessment care for 1 on 35 residents reviewed for comprehensive care plans, Resident #5.</p> <p>This deficient practice was evidenced by the following:</p> <p>A review of Resident #5's admissions record revealed that, Resident #5 was admitted with but not limited to NJ ex order 26.4b1</p>	F 656	<p>F656 SS=D Development/Implement Comprehensive Care Plan</p> <p>I. Corrective action(s) accomplished for resident(s) affected:</p> <ul style="list-style-type: none"> The facility failed to develop and implement a comprehensive, person-centered care plan which included documentation of the care plan focus area or interventions for the NJ ex order 26.4b1 for the resident #5. The care plan for this resident was updated on NJ ex order 26.4b1, including the documentation of the care plan focus area and interventions 		

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F 656	<p>Continued From page 2</p> <p>NJ ex order 26.4b1</p> <p>A review of the Resident #5's comprehensive Minimum Data Set (MDS), dated NJ ex order 26.4b1 revealed under section H that the resident NJ ex order 26.4b1</p> <p>A review of the current Care Plan (CP) for Resident #5 did not include documentation of a CP focus area or interventions for the care of NJ Exec Order 26.4b1.</p> <p>During an interview on 10/21/2024 at 10:15 AM with the surveyor the Licensed Practical Nurse (LPN)# 1 was asked what should be on the CP for a resident with an NJ ex order 26.4b1. At this time LPN #1 responded, "NJ ex order 26.4b1". When asked if there should be a focus on the NJ ex order 26.4b1 on the resident's baseline CP, LPN #3 replied. "Yes, NJ ex order 26.4b1".</p> <p>During an interview on 10/21/2024 at 01:22 PM with the surveyor asked the US FOIA (B) (6) if there should be a focus area on the NJ ex order 26.4b1 on the resident's CP. The US FOIA (B) responded, "yes of course".</p> <p>A review of a facility provided policy with a review date of 3/2024 and titled "Comprehensive Person-Centered Care Plan" revealed under section "Policy Statement" that, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."</p>	F 656	<p>for the NJ ex order 26.4b1.</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <ul style="list-style-type: none"> The deficient practice has the potential to affect all residents with indwelling catheters in the facility. All care plans for the residents that utilize indwelling urinary catheters were reviewed and updated as appropriate. <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> The nurse educator in-serviced nursing managers and licensed nursing staff on the importance to create comprehensive plan of care, including care plan focus area or interventions for the care of indwelling catheters as appropriate. Nursing staff were in-serviced on the importance of following resident's person-centered care plan including the care of the indwelling catheters. Care plans for the residents that utilize indwelling urinary catheters were reviewed and updated as appropriate. All C NA Care Tasks and C NA assignments for the residents that utilize indwelling urinary catheters were reviewed and updated as appropriate. <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> The unit manager/designee will conduct audits of C NA Care Tasks and C NA assignments for all residents that have person-centered care plans involving 		

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F 656	Continued From page 3 NJAC 8:39-27.1(a)	F 656	indwelling urinary catheters daily x7, then weekly x4, then monthly x3 month, then quarterly to make sure they are in compliance. <ul style="list-style-type: none"> The unit manager, IP nurse or designee will conduct audits for the person-centered care plans for the residents that utilize indwelling urinary catheters daily x7, then weekly x4, then monthly x3 month, then quarterly to make sure they are in compliance. The DON /designee will review above-mentioned audit data with QAPI committee for additional recommendations and follow up and report at the quarterly QAPI meeting for two quarters then reevaluate for continued monitoring if the facility can reach 100 % compliance and will discuss with QA team if there is a need for additional monitoring. 		

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S 000	<p>Initial Comments</p> <p>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.</p> <p>Census: 185 Sample Size: 35 + 3 closed</p> <p>TYPE OF SURVEY: Recertification and Complaint</p> <p>The facility was not in compliance with the standards in the New Jersey Administrative code, 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.</p>	S 000			
S 560	<p>8:39-5.1(a) Mandatory Access to Care</p> <p>The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.</p>	S 560			11/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 560	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint: # 154169, 172537</p> <p>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:</p> <p>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 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:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>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</p> <p>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.</p> <p>1. For the 2 weeks of Complaint staffing from</p>	S 560	<p>S560 Mandatory Access to care</p> <p>I. Corrective action(s) accomplished for resident(s) affected:</p> <ul style="list-style-type: none"> A review of resident care records for the time periods in question were conducted. No complaints or grievances related to resident care on the day or overnight shifts were discovered. This indicates that no residents were adversely affected by the deficient practice <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <ul style="list-style-type: none"> The deficient practice has the potential to affect all residents residing in the facility. <p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> Daily bonuses are offered for double shifts, extra shifts, weekend shifts and staff recognition as needed. Referral and sign on bonuses are offered for full time and part time employees. Full time and part time C NAs are being offered union benefits. The call out policy has been reviewed and the staff has been re-educated. The vacation policy has been reviewed and the staff has been re-educated. Advertisements signs are placed in front of the building. The facility is recruiting on multiple 	

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S 560	<p>Continued From page 2</p> <p>04/10/2022 to 04/23/2022, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows:</p> <p>-04/10/22 had 14 CNAs for 172 residents on the day shift, required at least 21 CNAs. -04/11/22 had 16 CNAs for 172 residents on the day shift, required at least 21 CNAs. -04/12/22 had 16 CNAs for 171 residents on the day shift, required at least 21 CNAs. -04/14/22 had 17 CNAs for 170 residents on the day shift, required at least 21 CNAs. -04/15/22 had 18 CNAs for 170 residents on the day shift, required at least 21 CNAs. -04/16/22 had 15 CNAs for 170 residents on the day shift, required at least 21 CNAs.</p> <p>-04/17/22 had 13 CNAs for 170 residents on the day shift, required at least 21 CNAs. -04/18/22 had 16 CNAs for 168 residents on the day shift, required at least 21 CNAs. -04/19/22 had 17 CNAs for 168 residents on the day shift, required at least 21 CNAs. -04/20/22 had 16 CNAs for 168 residents on the day shift, required at least 21 CNAs. -04/21/22 had 15 CNAs for 168 residents on the day shift, required at least 21 CNAs. -04/22/24 had 17 CNAs for 167 residents on the day shift, required at least 21 CNAs. -04/23/24 had 15 CNAs for 167 residents on the day shift, required at least 21 CNAs.</p> <p>2. For the 2 weeks of Complaint staffing from 03/10/2024 to 03/23/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <p>-03/10/24 had 17 CNAs for 177 residents on the day shift, required at least 22 CNAs. -03/11/24 had 17 CNAs for 177 residents on the</p>	S 560	<p>employment search engines and multiple social media platforms.</p> <ul style="list-style-type: none"> Depending on the needs of the day the unit clerk, staffing coordinator, restorative aid and director of activities that all hold C NA license will be evaluated to assist with resident care. Depending on the needs of the day nursing management that include DON, Nursing Managers, Supervisors and ADON will be evaluated to assist with resident care. Competitive rates have been implemented for CNAs and licensed nursing staff. The facility has multiple contracts with staffing agencies to assist with staffing needs. The facility has implemented a multifaceted approach for recruitment and retention of employees such as job fairs, flexible scheduling, split shifts, partnership with schools, variety of employee retention related activities, campaign to rehire staff that had resigned, text message alert campaigns. The facility utilizes corporate recruiters to assist with advertising and recruitment needs. The facility offers paying for as well as tuition reimbursement for employees enrolled in NATCEP. The facility offers tuition reimbursement for employees seeking higher education in nursing. <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> The DON/Staffing coordinator and administrator will meet daily during the 	

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S 560	<p>Continued From page 3</p> <p>day shift, required at least 22 CNAs. -03/12/24 had 21 CNAs for 177 residents on the day shift, required at least 22 CNAs. -03/13/24 had 16 CNAs for 177 residents on the day shift, required at least 22 CNAs. -03/14/24 had 16 CNAs for 176 residents on the day shift, required at least 22 CNAs. -03/15/24 had 20 CNAs for 176 residents on the day shift, required at least 22 CNAs. -03/16/24 had 18 CNAs for 176 residents on the day shift, required at least 22 CNAs.</p> <p>-03/17/24 had 18 CNAs for 176 residents on the day shift, required at least 22 CNAs. -03/18/24 had 20 CNAs for 179 residents on the day shift, required at least 22 CNAs. -03/19/24 had 18 CNAs for 179 residents on the day shift, required at least 22 CNAs. -03/20/24 had 19 CNAs for 178 residents on the day shift, required at least 22 CNAs. -03/21/24 had 18 CNAs for 178 residents on the day shift, required at least 22 CNAs. -03/22/24 had 20 CNAs for 178 residents on the day shift, required at least 22 CNAs. -03/23/24 had 18 CNAs for 178 residents on the day shift, required at least 22 CNAs.</p> <p>3. For the 2 weeks of staffing prior to survey from 09/29/2024 to 10/12/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows:</p> <p>-09/29/24 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs. -09/30/24 had 20 CNAs for 176 residents on the day shift, required at least 22 CNAs. -09/30/24 had 12 total staff for 176 residents on the overnight shift, required at least 13 total staff. -10/01/24 had 19 CNAs for 176 residents on the</p>	S 560	<p>week to review recruitment effort, staffing for the next day and staffing for the upcoming week.</p> <ul style="list-style-type: none"> The DON/Designee will conduct weekly C.N.A. staffing schedule audits to identify trends. The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for 2 months and then quarterly. The DON/Staffing coordinator and/or administrator will audit and monitor the staffing patterns until 100% compliance with state requirements for staffing is achieved. The audit and monitoring of the staffing pattern to ensure compliance with the state staffing ratios to continue daily for 2 months and then one random day per week to check the staffing ratios to make sure we are in compliance with state required staffing ratios. The results of Resident Council meeting minutes as well as identified staffing trends and recruitment data will be reviewed by the administrator or designee at the quarterly QAPI meeting for the entire year. 	

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S 560	<p>Continued From page 4</p> <p>day shift, required at least 22 CNAs. -10/02/24 had 20 CNAs for 176 residents on the day shift, required at least 22 CNAs. -10/03/24 had 21 CNAs for 176 residents on the day shift, required at least 22 CNAs. -10/05/24 had 17 CNAs for 176 residents on the day shift, required at least 22 CNAs.</p> <p>-10/06/24 had 16 CNAs for 176 residents on the day shift, required at least 22 CNAs. -10/07/24 had 21 CNAs for 176 residents on the day shift, required at least 22 CNAs. -10/10/24 had 18 CNAs for 179 residents on the day shift, required at least 22 CNAs. -10/12/24 had 19 CNAs for 184 residents on the day shift, required at least 23 CNAs.</p> <p>During an interview on 10/21/2024 at 11:42 AM with the surveyor, the Director of Nursing (DON) was asked if she felt they were meeting the staff requirements. The DON replied, "some yes, some no, usually we are good in the middle of the week, Mondays and weekends can be challenging".</p> <p>A review of a facility provided policy, with a review date of 5/2024, titled "Staffing Policy" revealed under the section titled " Procedure" that, " Certified nursing assistants will be available on each shift to provide the needed care and service of each resident as outlined on the resident's comprehensive care plan and with the following ratios: One certified nurse's aide to every eight residents for day shift. One direct care staff member to every ten residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct care staff member shall be signed in to work as a certified nurses aide and shall perform certified nurse aide duties. One direct care staff</p>	S 560		

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S2120	<p>Continued From page 6</p> <p>Based on documentation review and interview on 10/17/24 in the presence of the Maintenance Director (MD), it was determined the facility failed to ensure the quarterly New Jersey Uniform Fire Safety Code inspections were performed and documented. The deficient practice had the potential to affect 185 residents and was evidenced by the following:</p> <p>A documentation review between 9:00 AM and 3:30 PM revealed there was no quarterly local fire inspection reports and/or certificates of compliance for the past 12 months.</p> <p>In an interview at 1:03 PM, the MD stated that the township fire inspector performed the quarterly fire inspections but would not release the reports or certificates of compliance until a permit for the replacement of the dry sprinkler systems is closed. The facility had no documentation to demonstrate the quarterly fire inspections were performed, weather or not deficiencies were identified or that they were in compliance with the New Jersey Uniform Fire Code.</p> <p>The facility's Administrator was informed of the concern at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM.</p>	S2120	<p>1. All residents have the potential to be effected by this deficient practice of not having the quarterly local fire inspection reports and or certificates of compliance for the last 12 months as explained to the surveyor we did have the inspections but they did not release the certificates until the permit to replace the dry sprinkler system is closed we since have closed the permit the Township came to inspect the dry system and they emailed us all the quarterly certificates of compliance.</p> <p>2. All other mandatory inspections were checked and made sure they were done with any certificate necessary.</p> <p>3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an Is an audit to make sure that the quarterly New Jersey uniform fire safety code inspection is performed and documented.</p> <p>4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . Until a threshold of 100% is achieved for two quarters</p>	
S2315	<p>8:39-31.6(i)(1-2) Mandatory Physical Environment</p> <p>(i) The administrator shall serve as, or appoint, a disaster planner for the facility.</p> <p>1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation</p>	S2315		11/30/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061535	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER HAMPTON RIDGE HEALTHCARE AND REHABI			STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755		
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S2315	<p>Continued From page 7</p> <p>plan, or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management.</p> <p>2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 10/22/24 in the presents of the Maintenance Director (MD) and Administrator it was determined the facility failed to meet with county and municipal emergency management coordinators at least once a year to review and update the written comprehensive evacuation plan, or if county or municipal officials were unavailable for this purpose the facility failed notify the State Office of Emergency Management. This deficient practice had the potential to affect 185 residents and was evidenced by the following:</p> <p>A documentation review of the facilities Emergency Preparedness (EP) plan revealed there was no county, municipal or state emergency management coordinators represented on the annual EP review signature sheet dated 7/31/24 or on the previous annual review on 4/04/23. There was no other documents indicating that the county, municipal</p>	S2315	<p>1. All residents have the potential to be effected by this deficient practice of not having the facilities emergency preparedness plan which includes the written comprehensive evacuation plan reviewed and signed off by the county, municipal or state office of Emergency Management. On November 6th I met with the local Municipal and county officials from the emergency management office. We reviewed the plan and I left it there for their more thorough review. They said I can pick it up on November 19th and if no changes are necessary they will sign off on the manual. I will update the Department of Health as soon as I get it back signed by both the municipal and county officials.</p> <p>2. NA</p> <p>3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an Is</p>		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061535	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2024
NAME OF PROVIDER OR SUPPLIER HAMPTON RIDGE HEALTHCARE AND REHABI		STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755		
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S2315	Continued From page 8 or state emergency management officials participated in reviewing and updating the facilities EP plan during the last annual review. In an interview at the time, the Administrator and MD confirmed the findings. No further documentation was provided. The Administrator and MD were informed of the findings at the Life Safety Code survey exit conference at 1:51 PM.	S2315	an audit to make sure that the facilities emergency preparedness manual and the facilities evacuation plan is reviewed at least yearly by the county and municipal Emergency Management officials and signed off. 4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . Until a threshold of 100% is achieved for two quarters	11/30/24
S2460	8:39-31.8(c)(8) Mandatory Physical Environment (c) All residents shall have, in their rooms: 8. Night lights; This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/18/2024 in the presence of the Maintenance Director (MD), it was determined the facility failed to ensure residents rooms night lights were maintained in operational condition. This deficient practice had the potential to affect 14 of 185 residents and was evidenced by the following: Observations during a facility tour between 10:20 AM and 2:40 PM, revealed 7 of 20 resident room	S2460	1. All residents have the potential to be effected by this deficient practice of not having operational Night Lights in the residence rooms . On nov 5th the maint director together with his other employee in his department replaced the non operational Night Lights in room NJ ex order 26.4b1 and room NJ ex order 26.4b1 . 2.. All other rooms in the facility where checked to make sure that the Night	

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S2460	Continued From page 9 night lights observed did not operate. The non-operational night lights were located in rooms: NJ ex order 26.4b1 , and NJ ex order In an interview at the time, the MD confirmed the observations. The facility's Administrator was informed of the deficient practice at the Life Safety Code survey exit conference on 10/22/2024 at 1:51 PM.	S2460	Lights were operational and if they were not they were replaced. 3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an audit to to check each room in the facility and make sure that the light lights are operational and if they're not operational to replace them. 4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . Until a threshold of 100% is achieved for two quarters		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315312	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/6/2024
NAME OF FACILITY HAMPTON RIDGE HEALTHCARE AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755	

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 F0656	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/22/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061535	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/6/2024
NAME OF FACILITY HAMPTON RIDGE HEALTHCARE AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755	

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/22/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061535	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/6/2024
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S2120	Correction	ID Prefix S2315	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-31.1(c)	Completed	Reg. # 8:39-31.6(i)(1-2)	Completed
LSC	11/30/2024	LSC	11/30/2024	LSC	11/30/2024
ID Prefix S2460	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-31.8(c)(8)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/22/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

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

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315312	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER HAMPTON RIDGE HEALTHCARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755		
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E 000	Initial Comments	E 000			
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/17/2024, 10/18/2024 and 10/22/2024 and Hampton Ridge Healthcare And Rehabilitation 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.</p> <p>The nursing home building construction was stated to be 1990's with no current major renovations or noted additions. It is a one story building Type V (111) protected construction and is fully sprinklered. The 100 KW exterior diesel generator does 80 % of the facility. The facility has piped in medical gas. The building is connected to the Children's Hospital and has a vacant daycare wing recently unoccupied.</p> <p>There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 13 smoke zones.</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/08/2024

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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K 000	Continued From page 1	K 000			
K 131 SS=F	<p>The facility has 204 certified beds. At the time of the survey, the census was 185.</p> <p>Multiple Occupancies CFR(s): NFPA 101</p> <p>Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following:</p> <ul style="list-style-type: none"> o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. <p>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/18/24 and 10/22/24 in the presence of the US FOIA (B) (6) [REDACTED], it was determined that the facility failed to provide two-hour fire resistance-rated elements and assemblies for 2 of 2 fire separation doors in accordance with NFPA 101: 2012 Edition, Section 19.1.3.3*and NFPA 80:</p>	K 131			11/30/24
			<p>1. All residents have the potential to be effected by this deficient practice of not having a automatic self-closing fire door that wasn't closing properly, when released the left door did not close to the frame . This door was in a hazardous area by the laundry room. On October 23rd the</p>		

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K 131	<p>Continued From page 2</p> <p>2010 Edition. The deficient practice had the potential to affect 185 residents and was evidenced by the following:</p> <p>An observation on 10/18/24 at approximately 1:00 PM, revealed the fire barrier separation door that separated the Children's Hospital from the LTC facility at the end of the South Wing, when checked for its required fire resistant rating, the label was scraped and the fire resistant rating could not be determined.</p> <p>In an interview at the time, the [US FOIA] confirmed the observation.</p> <p>An observation on 10/18/24 at approximately 2:25 PM, revealed the fire barrier separation door in the back of the emergency food storage area that separated the Children's Hospital from the LTC facility. The [US FOIA] did not have the key to open the door and provide access to the fire rating label for the door assembly.</p> <p>In an interview at the time, the [US FOIA] confirmed the observation and stated he would try and get the key to access the door fire rating label.</p> <p>In an interview on 10/22/24 at 1:02 PM, the [US FOIA] stated that neither the facility or the Children's Hospital had a key that opens the fire door in the food storage room.</p> <p>The [US FOIA (b) (6)] was informed of the concerns at the Life Safety Code exit conference on 10/22/24 at 1:51 PM.</p> <p>NJAC 8:39-31.1(c), 31.2(e)</p> <p>Discharge from Exits</p>	K 131	<p>maintenance director together with the corporate VP of building services did a routine maintenance procedure on this specific door and it was closing properly where the left door closed all the way to its frame</p> <p>2.. All the double doors that are held open by a magnetic hold device which is tied into the fire alarm system were checked to make sure that when released they are closing properly all the way to its frame</p> <p>3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an audit for all fire doors especially in hazardous areas to make sure that they are closing all the way to the frame.</p> <p>4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . Until a threshold of 100% is achieved for two quarters</p>		
K 271 SS=F		K 271			11/30/24

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K 271	<p>Continued From page 3 CFR(s): NFPA 101</p> <p>Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/22/24 in the presence of the US FOIA (B) (6), it was determined that the facility failed to maintain a stable level walking surface at exit discharge for 2 of 11 exterior exits observed in accordance with NFPA 101:2012 Edition, Section 7.7 and 7.1.7. This deficient practice had the potential to affect 185 residents and was evidenced by the following:</p> <p>An observation at 11:25 AM, revealed that the exterior exit by room NU Exit exit discharge path to a public way posed trip hazards in the path of egress for evacuation. There were 4 separate holes across the 6 foot wide path of the following sizes: 57-inches by 5-inches, 43-inches by 6-inches, 45-inches by 5-inches, and 42-inches by 3-inches measured by a standard tape measure.</p> <p>An observation at 2:30 PM, revealed exterior exit door "E" by room NU Exit exit discharge path to a public way posed a trip hazard in the path of egress for evacuation. There was a 3/4-inch lip where the second concrete slab was raised above the edge of the first concrete slab measured with a standard tape measure.</p>	K 271	<p>1. All residents have the potential to be effected by this deficient practice of the concrete pad being lifted at the exterior exit by room NU Exit which had 4 separate holes that could cause a trip hazard , and by the exit door E the discharge path to the public way had a 2 inch lip not connected properly to the pad in front of it causing it not to be level and failing to provide a firm level walking surface. The director of maintenance on 10/30/2024 purchased concrete and filled the four separate holes and the pad by exit E to the proper level which created a safe firm level walking surface.</p> <p>2.. All of the concrete pad at all exits leading to public way and all sidewalks were checked to make sure they are level and safe .</p> <p>3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee does was an audit of all concrete pads by all exits and all sidewalks to make sure they are connected properly and level and have no holes.</p> <p>4.. The Maintenance director or designee</p>		

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NAME OF PROVIDER OR SUPPLIER HAMPTON RIDGE HEALTHCARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755		
(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 271	Continued From page 4 In an interview at the times of discovery, the US FOIA confirmed the observations. The US FOIA (b) (6) was informed of the concerns at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM.	K 271	will report all these findings to the QAPI team until a compliance of 100% is shown for two consecutive quarters.		
K 321 SS=F	NJAC 8:39-31.2 (e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		11/30/24	

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K 321	Continued From page 5 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/18/24 in the presence of the US FOIA (B) (6) [REDACTED], it was determined that the facility failed to ensure that hazardous areas were protected with self-closing doors in accordance with NFPA 101: 2012 Edition, Sections 19.3.2, 19.3.5.9 and 8.4. This deficient practice had the potential to affect all 185 residents and was evidenced by the following: An observation at 11:43 AM, revealed the double doors to the laundry room were held open by a magnetic hold open device tied into the fire alarm system. When released, the left door leaf did not close to the frame. The left door leaf was equipped with an astragal and designed to close before the right leaf. When tested the right leaf closed first and the left leaf astragal hit the closed right leaf preventing it from closing all the way into its frame. The test was repeated 2 additional times with the same results. In an interview at the time, the US FOIA (B) (6) confirmed the observation. The US FOIA (B) (6) was informed of the concerns at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM. NJAC 8:39-31.2 (e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 321	1. All residents have the potential to be effected by this deficient practice of not having a automatic self-closing fire door that wasn't closing properly, when released the left door did not close to the frame. This door was in a hazardous area by the laundry room. On October 23rd the maintenance director together with the corporate VP of building services did a routine maintenance procedure on this specific door and it was closing properly where the left door closed all the way to its frame 2.. All the double doors that are held open by a magnetic hold device which is tied into the fire alarm system were checked to make sure that when released they are closing properly all the way to its frame 3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an audit for all fire doors especially in hazardous areas to make sure that they are closing all the way to the frame. 4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly. Until a threshold of 100% is achieved for two quarters		
K 374 SS=F		K 374			11/30/24

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K 374	<p>Continued From page 6</p> <p>Subdivision of Building Spaces - Smoke Barrier Doors</p> <p>2012 EXISTING</p> <p>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interview on 10/18/24 in the presence of the US FOIA (B) (6) it was determined that the facility failed to ensure smoke barrier doors closed into their door frame when released from their hold open devices or closed leaving only the minimum clearance necessary for proper operation to resist the passage of smoke for 2 of 19 smoke barrier doors observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3, 19.3.7 to 19.3.7.9, 8.5.4, 8.5.4.1 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect 185 residents and was evidenced by the following:</p> <p>An observation at 11:34 AM, revealed the service hall smoke barrier double doors' left door leaf did not close all the way into its frame when released from the fully open position. The left leaf hit the edge of the right leaf and stopped from closing. The test was repeated 3 times with the same result.</p>	K 374	<p>1. All residents have the potential to be effected by this deficient practice of the smoke barrier double door in the service hall as the left leaf did not close all the way into its frame when released from the fully open position. The double smoke barrier door by the maintenance shop had 1/2 inch space between the doors meeting edges when they were closed . On October 23rd the maintenance director did routine maintenance on the double door and the service hall OK and now the left leaf closes all the way to its frame. On October 23rd the maintenance director ordered select 2 inch brush type astragal brushes for the double smoke barrier door by the maintenance shop the item was delivered November 4 , installed and now there is no gap between the doors.</p> <p>2. All other smoke barrier double doors were checked to make sure that they meet the doors close properly when</p>		

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K 374	Continued From page 7 An observation at 12:00 PM of the service corridor, revealed the double smoke barrier doors by the maintenance shop had a 1/2-inch space between the doors meeting edges and brush type astragals closing the space which had a 1/4-inch gap running vertically from the floor up between the astragal brushes meeting edges. In an interview at the time, the US FOIA (B) (6) confirmed the observations. The US FOIA (B) (6) was informed of the deficient practice at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM. NJAC 8:39-31.2 (e) NFPA 80 HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/18/24 in the presence of the US FOIA (B) (6) , it was determined the facility failed to ensure residents bathroom exhaust fans were maintained in operational condition in accordance with NFPA 101:2012 edition, Sections 19.5.2.1,	K 374	released from the magnetic hold and have no gaps between the doors when closed 3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an audit for all smoke barrier doors to make sure they close properly from the magnetic hold and that there are no gaps when they are closed. 4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . Until a threshold of 100% is achieved for two quarters		
K 521 SS=F		K 521		11/30/24	
			1. All residents have the potential to be effected by this deficient practice of non operational exhaust pads in resident bathrooms The US FOIA (B) (6) on 10/24/2024 purchased the roof exhaust fans which controls room NJ EXRC 01		

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K 521	Continued From page 8 9.2 and NFPA 90A. This deficient practice had the potential to affect 185 residents and was evidenced by: Observations during a facility tour on 10/18/24 between 10:20 AM and 2:40 PM revealed 4 of 12 resident room bathrooms observed did not have windows and the exhaust fans did not operate. The non-operational exhaust fans were located in rooms: NJ Exec Order 26.4b1 . All rooms in the area of rooms NJ Exec Order 26.4b1 served by the same roof top unit would also be affected. In an interview at the time, the US FOIA confirmed the observation. In the South Wing Unit the US FOIA stated that if the main exhaust fan for the section is down all the bathrooms served by that unit will not work. The US FOIA (B) (6) was informed of the deficient practice at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM. NJAC 8:39-31.2 (e) NFPA 90A	K 521	NJ Exec Order 26.4b1 . The roof fans were installed on 11/04/2024 2.. All other bathroom exhaust fans in the building were checked to make sure they are operational and all roof fans that control the bathroom exhaust fans were checked to make sure they are operational. 3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee does was an audit of all exhaust fans in the bathroom and rooftop exhaust fans to make sure they are working properly . 4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly until a compliance of 100% is met for two quarters		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		11/30/24	

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K 918	<p>Continued From page 9 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 10/17/24 and 10/18/24 in the presence of the US FOIA (B) (6), it was determined the facility failed to ensure the Emergency Power Supply (EPS) was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Section 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect 185 residents and was evidenced by:</p>	K 918	<p>1. All residents have the potential to be effected by this deficient practice of not having the emergency power generator recording the percentage of the EPS at the required 30% on the 90 minute annual load bank test. On November 1st 2024 a representative from the company that services our generator came down and showed us on the electric display screen on the generator the percentage comes up while we were on load we tested it and it was at 37% we did enclose a picture as well.</p>		

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K 918	<p>Continued From page 10</p> <p>A record review on 10/17/24 at 9:30 AM of the emergency power generator logs revealed the facility did not record the percentage of the EPS nameplate kW rating that the generator was exercised monthly to determine if the load met the 30% of the nameplate rating requirement or perform a 90 minute annual load bank test for the last 12 months.</p> <p>In an interview on 10/18/24 at 9:30 AM, the US FOIA confirmed the record review findings.</p> <p>The US FOIA (B) (6) was informed of the concerns at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM.</p> <p>NJAC 8:39-31.2 (e) NFPA 99, 110</p>	K 918	<p>2.. NA as this is the only generator that services the building</p> <p>3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an audit to document the reading of the full load test in making sure that 30% of the nameplate rating requirement during the load test is met.</p> <p>4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . Until a threshold of 100% is achieved for two quarters</p>		

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E 000	Initial Comments	E 000			
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/17/2024, 10/18/2024 and 10/22/2024 and Hampton Ridge Healthcare And Rehabilitation 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.</p> <p>The nursing home building construction was stated to be 1990's with no current major renovations or noted additions. It is a one story building Type V (111) protected construction and is fully sprinklered. The 100 KW exterior diesel generator does 80 % of the facility. The facility has piped in medical gas. The building is connected to the Children's Hospital and has a vacant daycare wing recently unoccupied.</p> <p>There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 13 smoke zones.</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/08/2024

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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K 000	Continued From page 1	K 000			
K 131 SS=F	<p>The facility has 204 certified beds. At the time of the survey, the census was 185.</p> <p>Multiple Occupancies CFR(s): NFPA 101</p> <p>Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following:</p> <ul style="list-style-type: none"> o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. <p>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/18/24 and 10/22/24 in the presence of the US FOIA (B) (6) [REDACTED], it was determined that the facility failed to provide two-hour fire resistance-rated elements and assemblies for 2 of 2 fire separation doors in accordance with NFPA 101: 2012 Edition, Section 19.1.3.3*and NFPA 80:</p>	K 131			11/30/24
			<p>1. All residents have the potential to be effected by this deficient practice of not having a automatic self-closing fire door that wasn't closing properly, when released the left door did not close to the frame . This door was in a hazardous area by the laundry room. On October 23rd the</p>		

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K 131	<p>Continued From page 2</p> <p>2010 Edition. The deficient practice had the potential to affect 185 residents and was evidenced by the following:</p> <p>An observation on 10/18/24 at approximately 1:00 PM, revealed the fire barrier separation door that separated the Children's Hospital from the LTC facility at the end of the South Wing, when checked for its required fire resistant rating, the label was scraped and the fire resistant rating could not be determined.</p> <p>In an interview at the time, the [US FOIA] confirmed the observation.</p> <p>An observation on 10/18/24 at approximately 2:25 PM, revealed the fire barrier separation door in the back of the emergency food storage area that separated the Children's Hospital from the LTC facility. The [US FOIA] did not have the key to open the door and provide access to the fire rating label for the door assembly.</p> <p>In an interview at the time, the [US FOIA] confirmed the observation and stated he would try and get the key to access the door fire rating label.</p> <p>In an interview on 10/22/24 at 1:02 PM, the [US FOIA] stated that neither the facility or the Children's Hospital had a key that opens the fire door in the food storage room.</p> <p>The [US FOIA (B) (6)] was informed of the concerns at the Life Safety Code exit conference on 10/22/24 at 1:51 PM.</p> <p>NJAC 8:39-31.1(c), 31.2(e)</p> <p>Discharge from Exits</p>	K 131	<p>maintenance director together with the corporate VP of building services did a routine maintenance procedure on this specific door and it was closing properly where the left door closed all the way to its frame</p> <p>2.. All the double doors that are held open by a magnetic hold device which is tied into the fire alarm system were checked to make sure that when released they are closing properly all the way to its frame</p> <p>3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an audit for all fire doors especially in hazardous areas to make sure that they are closing all the way to the frame.</p> <p>4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . Until a threshold of 100% is achieved for two quarters</p>		
K 271 SS=F		K 271			11/30/24

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K 271	<p>Continued From page 3 CFR(s): NFPA 101</p> <p>Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/22/24 in the presence of the US FOIA (b) (6), it was determined that the facility failed to maintain a stable level walking surface at exit discharge for 2 of 11 exterior exits observed in accordance with NFPA 101:2012 Edition, Section 7.7 and 7.1.7. This deficient practice had the potential to affect 185 residents and was evidenced by the following:</p> <p>An observation at 11:25 AM, revealed that the exterior exit by room 1U Ex 01 exit discharge path to a public way posed trip hazards in the path of egress for evacuation. There were 4 separate holes across the 6 foot wide path of the following sizes: 57-inches by 5-inches, 43-inches by 6-inches, 45-inches by 5-inches, and 42-inches by 3-inches measured by a standard tape measure.</p> <p>An observation at 2:30 PM, revealed exterior exit door "E" by room 1U Ex 01 exit discharge path to a public way posed a trip hazard in the path of egress for evacuation. There was a 3/4-inch lip where the second concrete slab was raised above the edge of the first concrete slab measured with a standard tape measure.</p>	K 271	<p>1. All residents have the potential to be effected by this deficient practice of the concrete pad being lifted at the exterior exit by room 1U Ex 01 which had 4 separate holes that could cause a trip hazard , and by the exit door E the discharge path to the public way had a 2 inch lip not connected properly to the pad in front of it causing it not to be level and failing to provide a firm level walking surface. The director of maintenance on 10/30/2024 purchased concrete and filled the four separate holes and the pad by exit E to the proper level which created a safe firm level walking surface.</p> <p>2.. All of the concrete pad at all exits leading to public way and all sidewalks were checked to make sure they are level and safe .</p> <p>3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee does was an audit of all concrete pads by all exits and all sidewalks to make sure they are connected properly and level and have no holes.</p> <p>4.. The Maintenance director or designee</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315312	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER HAMPTON RIDGE HEALTHCARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755		
(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 271	Continued From page 4 In an interview at the times of discovery, the US FOIA confirmed the observations. The US FOIA (B) (6) was informed of the concerns at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM.	K 271	will report all these findings to the QAPI team until a compliance of 100% is shown for two consecutive quarters.		
K 321 SS=F	NJAC 8:39-31.2 (e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		11/30/24	

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K 321	Continued From page 5 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/18/24 in the presence of the US FOIA (b) (6) [REDACTED] it was determined that the facility failed to ensure that hazardous areas were protected with self-closing doors in accordance with NFPA 101: 2012 Edition, Sections 19.3.2, 19.3.5.9 and 8.4. This deficient practice had the potential to affect all 185 residents and was evidenced by the following: An observation at 11:43 AM, revealed the double doors to the laundry room were held open by a magnetic hold open device tied into the fire alarm system. When released, the left door leaf did not close to the frame. The left door leaf was equipped with an astragal and designed to close before the right leaf. When tested the right leaf closed first and the left leaf astragal hit the closed right leaf preventing it from closing all the way into its frame. The test was repeated 2 additional times with the same results. In an interview at the time, the US FOIA confirmed the observation. The US FOIA (b) (6) was informed of the concerns at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM. NJAC 8:39-31.2 (e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 321	1. All residents have the potential to be effected by this deficient practice of not having a automatic self-closing fire door that wasn't closing properly, when released the left door did not close to the frame. This door was in a hazardous area by the laundry room. On October 23rd the maintenance director together with the corporate VP of building services did a routine maintenance procedure on this specific door and it was closing properly where the left door closed all the way to its frame 2.. All the double doors that are held open by a magnetic hold device which is tied into the fire alarm system were checked to make sure that when released they are closing properly all the way to its frame 3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an audit for all fire doors especially in hazardous areas to make sure that they are closing all the way to the frame. 4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly. Until a threshold of 100% is achieved for two quarters		
K 374 SS=F		K 374		11/30/24	

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K 374	<p>Continued From page 6</p> <p>Subdivision of Building Spaces - Smoke Barrier Doors</p> <p>2012 EXISTING</p> <p>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interview on 10/18/24 in the presence of the US FOIA (B) (6) it was determined that the facility failed to ensure smoke barrier doors closed into their door frame when released from their hold open devices or closed leaving only the minimum clearance necessary for proper operation to resist the passage of smoke for 2 of 19 smoke barrier doors observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3, 19.3.7 to 19.3.7.9, 8.5.4, 8.5.4.1 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect 185 residents and was evidenced by the following:</p> <p>An observation at 11:34 AM, revealed the service hall smoke barrier double doors' left door leaf did not close all the way into its frame when released from the fully open position. The left leaf hit the edge of the right leaf and stopped from closing. The test was repeated 3 times with the same result.</p>	K 374	<p>1. All residents have the potential to be effected by this deficient practice of the smoke barrier double door in the service hall as the left leaf did not close all the way into its frame when released from the fully open position. The double smoke barrier door by the maintenance shop had 1/2 inch space between the doors meeting edges when they were closed . On October 23rd the maintenance director did routine maintenance on the double door and the service hall OK and now the left leaf closes all the way to its frame. On October 23rd the maintenance director ordered select 2 inch brush type astragal brushes for the double smoke barrier door by the maintenance shop the item was delivered November 4 , installed and now there is no gap between the doors.</p> <p>2. All other smoke barrier double doors were checked to make sure that they meet the doors close properly when</p>		

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NAME OF PROVIDER OR SUPPLIER HAMPTON RIDGE HEALTHCARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755		
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K 374	Continued From page 7 An observation at 12:00 PM of the service corridor, revealed the double smoke barrier doors by the maintenance shop had a 1/2-inch space between the doors meeting edges and brush type astragals closing the space which had a 1/4-inch gap running vertically from the floor up between the astragal brushes meeting edges. In an interview at the time, the US FOIA confirmed the observations. The US FOIA (b) (6) was informed of the deficient practice at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM. NJAC 8:39-31.2 (e) NFPA 80 K 521 HVAC SS=F CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/18/24 in the presence of the US FOIA (B) (6) US FOIA (b) (6) it was determined the facility failed to ensure residents bathroom exhaust fans were maintained in operational condition in accordance with NFPA 101:2012 edition, Sections 19.5.2.1,	K 374	released from the magnetic hold and have no gaps between the doors when closed 3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an audit for all smoke barrier doors to make sure they close properly from the magnetic hold and that there are no gaps when they are closed. 4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . Until a threshold of 100% is achieved for two quarters	11/30/24	
		K 521	1. All residents have the potential to be effected by this deficient practice of non operational exhaust pads in resident bathrooms The director of maintenance on 10/24/2024 purchased the roof exhaust fans which controls room NJ ex 001 ,		

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NAME OF PROVIDER OR SUPPLIER HAMPTON RIDGE HEALTHCARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755		
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K 521	Continued From page 8 9.2 and NFPA 90A. This deficient practice had the potential to affect 185 residents and was evidenced by: Observations during a facility tour on 10/18/24 between 10:20 AM and 2:40 PM revealed 4 of 12 resident room bathrooms observed did not have windows and the exhaust fans did not operate. The non-operational exhaust fans were located in rooms: NJ ex order 26.4b1 , and NJ ex order . All rooms in the area of rooms NJ ex order to NJ ex order served by the same roof top unit would also be affected. In an interview at the time, the US FOIA confirmed the observation. In the South Wing Unit the US FOIA stated that if the main exhaust fan for the section is down all the bathrooms served by that unit will not work. The US FOIA (b) (6) was informed of the deficient practice at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM. NJAC 8:39-31.2 (e) NFPA 90A	K 521	NJ ex order 26.4b1 and NJ ex order . The roof fans were installed on 11/04/2024 2.. All other bathroom exhaust fans in the building were checked to make sure they are operational and all roof fans that control the bathroom exhaust fans were checked to make sure they are operational. 3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee does was an audit of all exhaust fans in the bathroom and rooftop exhaust fans to make sure they are working properly . 4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly until a compliance of 100% is met for two quarters		
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		11/30/24	

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K 918	<p>Continued From page 9 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 10/17/24 and 10/18/24 in the presence of the US FOIA (B) (6), it was determined the facility failed to ensure the Emergency Power Supply (EPS) was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Section 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect 185 residents and was evidenced by:</p>	K 918	<p>1. All residents have the potential to be effected by this deficient practice of not having the emergency power generator recording the percentage of the EPS at the required 30% on the 90 minute annual load bank test. On November 1st 2024 a representative from the company that services our generator came down and showed us on the electric display screen on the generator the percentage comes up while we were on load we tested it and it was at 37% we did enclose a picture as well.</p>		

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K 918	<p>Continued From page 10</p> <p>A record review on 10/17/24 at 9:30 AM of the emergency power generator logs revealed the facility did not record the percentage of the EPS nameplate kW rating that the generator was exercised monthly to determine if the load met the 30% of the nameplate rating requirement or perform a 90 minute annual load bank test for the last 12 months.</p> <p>In an interview on 10/18/24 at 9:30 AM, the US FOIA confirmed the record review findings.</p> <p>The US FOIA (B) (6) was informed of the concerns at the Life Safety Code survey exit conference on 10/22/24 at 1:51 PM.</p> <p>NJAC 8:39-31.2 (e) NFPA 99, 110</p>	K 918	<p>2.. NA as this is the only generator that services the building</p> <p>3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee audits was an audit to document the reading of the full load test in making sure that 30% of the nameplate rating requirement during the load test is met.</p> <p>4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . Until a threshold of 100% is achieved for two quarters</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315312	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 12/6/2024
NAME OF FACILITY HAMPTON RIDGE HEALTHCARE AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD TOMS RIVER, NJ 08755

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0131	11/30/2024	LSC K0271	11/30/2024	LSC K0321	11/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	11/30/2024	LSC K0521	11/30/2024	LSC K0918	11/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/22/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			