STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061305	A. BUILDING: _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

(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 000	Initial Comments The facility was 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 deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that he facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 2 of 14-day shifts reviewed. Findings include: 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	S 560	Element 1. This facility is diligently trying to fill all open positions and staff at or above required staffing ratios by advertising open positions, and adding sign on bonuses for new hires. Staffing agencies are utilized to provide staff as needed to prevent further occurrence of the deficiency. Element 2. All residents may be affected by poor staffing levels. Element 3. Continue to advertise for staff, interview,	5/27/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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. A review of the facility provided Nursing Home Resident Care Staffing Reports from 4/17/22 to 4/24/22 revealed the following: The facility was deficient in total staffing for residents on 2 of 14-day shifts as follows: 04/18/22 had 18 CNAs for 145 residents on the day shift, required 19 CNAs. 04/20/22 had 18 CNAs for 145 residents on the day shift, required 19 CNAs. During an interview with the surveyor on 5/16/22 at 11:10 AM, the Licensed Nursing Home Administrator (LNHA) said he was familiar with the minimum staffing requirements. He further revealed that he does believe they are meeting the requirements. A review of an undated facility policy, titled	S 560	hire, and train as staff are hired. Advertisements are posted in both Eatontown and Neptune locations for this facility. Staffing agencies are also being utilized as needed. Element 4. Administrator will audit the staffing levels on a weekly basis for four weeks, then every other week for two months, and then monthly for four months; results will also be discussed during quarterly QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 "Staffing Protocol" revealed under #2 that, "Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan."	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 000	Initial Comments The facility was 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 deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that he facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 2 of 14-day shifts reviewed. Findings include: 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	S 560	Element 1. This facility is diligently trying to fill all open positions and staff at or above required staffing ratios by advertising open positions, and adding sign on bonuses for new hires. Staffing agencies are utilized to provide staff as needed to prevent further occurrence of the deficiency. Element 2. All residents may be affected by poor staffing levels. Element 3. Continue to advertise for staff, interview,	5/27/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/15/22

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S 560	Continued From page 1 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. A review of the facility provided Nursing Home Resident Care Staffing Reports from 4/17/22 to 4/24/22 revealed the following: The facility was deficient in total staffing for residents on 2 of 14-day shifts as follows: 04/18/22 had 18 CNAs for 145 residents on the day shift, required 19 CNAs. 04/20/22 had 18 CNAs for 145 residents on the day shift, required 19 CNAs. During an interview with the surveyor on 5/16/22 at 11:10 AM, the Licensed Nursing Home Administrator (LNHA) said he was familiar with the minimum staffing requirements. He further revealed that he does believe they are meeting the requirements. A review of an undated facility policy, titled	S 560	hire, and train as staff are hired. Advertisements are posted in both Eatontown and Neptune locations for this facility. Staffing agencies are also being utilized as needed. Element 4. Administrator will audit the staffing levels on a weekly basis for four weeks, then every other week for two months, and then monthly for four months; results will also be discussed during quarterly QAPI meetings.	

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S 560	Continued From page 2 "Staffing Protocol" revealed under #2 that, "Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan."	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061305 Y1	A. Building B. Wing Y2	7/15/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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 05/27/2022	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 5/26/2022	☐ 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
	315177	A. BUILDING **01** B. WING _____	**05/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	**139 GRANT AVE** **EATONTOWN, NJ 07724**

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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 05/25, 26/2022 and Gateway Care Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Gateway Care Center is a single story, Type V Protected building that was built in January 1959. The facility is divided into 8 smoke zones.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/25/22 and 5/26/22, in the presence of facility management, it was determined that the facility failed provide a battery backup emergency light above 1 of 1 emergency generator's transfer switch, independent of the building's electrical	K 291	Element 1. The deficiency was corrected by installing a backup battery emergency lighting above the emergency generator at the transfer switch. The lighting is independent of the buildings electrical	5/27/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 291	Continued From page 1 system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 5/25/2022 (day one of survey) during the survey entrance at 9:05 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. On 5/26/2022 (day two of survey) during the building tour with the facility's Corporate Facility's Maintenance (CFM) and MA, an inspection of the building was conducted. During the tour at 10:57 AM, an inspection inside the boiler room where the generator's transfer switch is located was performed. The surveyor observed no evidence of a battery back up emergency light inside the Boiler room for the generator's transfer switch. The surveyor asked the (CFM) and MA if there was a battery back up emergency light for the transfer switch. The MA told the surveyor, No. The findings were verified and confirmed by the CFM and MA during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/26/2022 at 1:20 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	system and emergency generator. Element 2. No residents are affected by this deficiency as it is in the boiler room and not in a patient living area. Element 3. A backup battery powered emergency lighting was installed at the transfer switch. Additionally, an audit of the backup battery powered emergency lighting will be conducted to ensure that the unit is working properly. Element 4. The lighting audit will be monitored once per month by the Maintenance Director and reported to the Administrator monthly for four months; results will also be discussed during quarterly QAPI meetings.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101	K 293		6/3/22

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K 293	Continued From page 2 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 05/25/2022, it was determined that the facility failed to ensure that illuminated exit signs were in four (4) locations to clearly identify the exit access path. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 5/25/2022 (day one of survey) during the survey entrance at 9:05 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments.	K 293	Element 1. The deficiency was corrected by installing illuminated exit signs outside the North Wing enclosed center courtyards two exit access doors leading out of the enclosed central courtyard. Also, the two exit doors to the East/West central courtyard to clearly identify the exit access path. Element 2. All residents are affected by this deficiency. Element 3. An audit to ensure the illuminated signs are working properly was conducted. The illuminated signs will be audited by the Maintenance Director once per week for four weeks, then once every other week for four weeks, then once a month for four months. Element 4. The lighting operations are being monitored once per week for four weeks by the Maintenance Director or his Designee, then once every other week for	

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K 293	Continued From page 3 A review of the facility provided lay-out identified that there were two (2) enclosed center courtyards in the facility. Starting at 9:28 AM, in the presence of facility's Corporate Facility's Maintenance (CFM) and MA, a tour of the building was conducted. During the tour the surveyor observed the following: 1. At 10:44 AM, the North Wing outside enclosed center courtyard failed to have illuminated exit signs to clearly identify the exit access route. Two (2) illuminated exit signs, one illuminated exit sign above each of the two (2) exit access doors leading you out of the enclosed center courtyard. 2. At 11:41 AM, the West/ East Wing enclosed center courtyard failed to have illuminated exit signs to clearly identify the exit access route. Two (2) illuminated exit signs, one illuminated exit sign above each of the two (2) exit access doors leading you out of the enclosed center courtyard. The CFM and MA confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/26/2022 at 1:20 PM. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293	four weeks, and then once a month for four months by the Maintenance Director, and reported to the Administrator; results will also be discussed at quarterly QAPI meetings.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101	K 351		8/10/22

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K 351	Continued From page 4 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 5/25/22 and 5/26/2022, it was determined the facility failed to ensure that a supervised automatic fire sprinkler system provided complete coverage for all areas of the building in accordance with NFPA 13, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. This deficient practice was evidenced by the following: On 5/25/2022 (day one of survey) during the	K 351	Element 1. The deficiency will be corrected by installing approved automatic sprinkler heads outside the North Wing exit discharge door, in the enclosed central courtyard, and on the West Wing activity room overhang Element 2. All residents in those areas are potentially affected by this deficiency Element 3. To ensure the sprinkler heads are working properly they will be audited by the	

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K 351	Continued From page 5 survey entrance at 9:05 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the building. Starting at 9:28 AM, in the presence of facility's Corporate Facility's Maintenance (CFM) and MA a tour of the building was conducted. Along the tour the surveyor observed three (3) areas that failed to provide proper fire sprinkler protection in the following locations; 1. On 5/25/2022 at 9:52 AM, the surveyor observed outside the North Wing (near the Exam/ Treatment room) exit discharge door's ten (10) feet by ten (10) feet over hang had no evidence of fire sprinkler protection. At that time, the surveyor asked the MA do you see any sprinkler heads. The MA said no. 2. On 5/25/2022 at 10:41 AM, the surveyor observed in the North Wing enclosed center courtyard five (5) feet angle over hang with no evidence of fire sprinkler protection. 3. On 5/25/2022 at 12:17 PM, the surveyor observed outside the exit discharge door next to the West wing Activity room an "I" shaped overhang that had no evidence of fire sprinkler protection. At that time, the surveyor used a [name of the company] measuring tape and recorded the "L" shaped six (6) feet from the building and twenty five (25) feet in one direction and thirty two (32) feet the other direction. The CFM and MA confirmed the findings at the time of observations.	K 351	Maintenance Director Element 4. The sprinkler heads will be audited once per month for the next three months by the Maintenance Director and reported to the Administrator. Audits will also be reviewed in quarterly QAPI meetings	

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GATEWAY CARE CENTER	**139 GRANT AVE** **EATONTOWN, NJ 07724**

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K 351	Continued From page 6 The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/26/2022 at 1:20 PM. NFPA 13. NJAC 8:39 -31.1 (c). NJAC 8:23.	K 351		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING 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. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 5/25/22 and 5/26/2022, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 7 smoke barrier doors tested and was evidenced by the following: Reference 1: - 8.5.4.1, Doors in smoke barriers shall close the	K 374	Element 1. The deficiency was corrected by purchasing new smoke barrier doors that are resistant to fire for a minimum of twenty minutes next to the Beauty Salon leading into the North Wing Element 2. All residents, staff, and visitors are potentially affected by this deficiency	8/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315177	A. BUILDING **01** B. WING _____	**05/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	**139 GRANT AVE** **EATONTOWN, NJ 07724**

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K 374	Continued From page 7 opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 5/25/2022 (day one of survey) during the survey entrance at 9:05 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. Starting at 9:28 AM, in the presence of facility's Corporate Facility's Maintenance (CFM) and MA a tour of the building was conducted. Along the tour the surveyor observed and tested seven (7) sets of double smoke barrier doors in the corridors with the following results. During the tour at 9:42 AM, a manual testing of the facility's smoke barrier doors next to the Beauty salon was performed. When both doors were allowed to self close into their frame, this revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 1/8 of an inch between the meeting edges. One door was warped/ bent and left a 3/8 of an inch gap near the bottom between the edges. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The findings were verified and confirmed by the CFM and MA during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit	K 374	Element 3. To ensure the doors are properly working and maintained, they will be audited by the Maintenance Director Element 4. The smoke barrier doors are being monitored once per week for four weeks by the Maintenance Director or designee, and then once every other week for four weeks, and then once a month for four months by the Maintenance Director, and reported to the Administrator. Audits will also be discussed at quarterly QAPI meetings	

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	315177	A. BUILDING **01** B. WING _____	**05/26/2022**

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K 374	Continued From page 8 conference on 05/26/2022 at 1:20 PM. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 521 SS=D	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 observations and interview conducted on 05/25/22 and 5/26/2022, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 3 of 11 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 5/25/2022 (day one of survey) during the survey entrance at 9:05 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. Starting at 9:28 AM, in the presence of facility's Corporate Facility's Maintenance (CFM) and MA	K 521	Element 1. The deficiency was corrected by installing new motors for the ventilation units in the identified rooms of [redacted], [redacted], and [redacted]. Element 2. The residents in the affected rooms are potentially affected by this deficiency. Element 3. To ensure the ventilation units are working properly, they are being audited by the Maintenance Director. Element 4. The ventilation units are being audited once per week for four weeks by the Maintenance Director or Designee, then once every other week for four weeks, and then one a month for four months. Results will be reported to the	6/3/22

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	315177	A. BUILDING **01** B. WING _____	**05/26/2022**

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K 521	Continued From page 9 an inspection of 9 Resident rooms and 2 Unisex resident bathrooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 3 of 11 resident bathrooms in the following locations: On 5/26/2022 1. At 10:04 AM, inside Resident room [redacted] bathroom, the exhaust system did not function properly when tested. At that time, the surveyor informed the CFM and MA that the exhaust system did not function properly. 2. At 10:15 AM, inside Resident room [redacted] bathroom, the exhaust system did not function properly when tested. 3. At 11:07 AM, inside Resident room [redacted] bathroom, the exhaust system did not function properly when tested. All the bathrooms identified had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The CFM and MA confirmed the findings at the time of the observation. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/26/2022 at 1:20 PM.	K 521	Administrator, and will also be discussed during quarterly QAPI meetings.	

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	315177	A. BUILDING **01** B. WING _____	**05/26/2022**

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K 521	Continued From page 10 NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		

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
315177 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/14/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY CARE CENTER	139 GRANT AVE EATONTOWN, NJ 07724

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 K0291	05/27/2022	LSC K0293	06/03/2022	LSC K0351	08/10/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0374	08/10/2022	LSC K0521	06/03/2022	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/26/2022	☐ YES ☐ NO