STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315199	A. BUILDING _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	**919 GREEN GROVE ROAD NEPTUNE, NJ 07753**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ00176173 Survey Date: 08/27/2024 Census: 85 Sample: 18 + 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 1 of 20 residents reviewed (Residents #12). This deficient practice was evidenced by the following: On 08/21/2024 at 9:44 AM, the surveyor observed Resident #12 in the bed.	F 641	1. MDS coordinator did a modified MDS for resident #12 immediately after being notified by surveyor on 08/26/24 in regard to [redacted] order. 2.All residents with oxygen use can be affected by this practice 3 [redacted] and [redacted]	10/1/24

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

Electronically Signed | 09/12/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315199	A. BUILDING _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	919 GREEN GROVE ROAD NEPTUNE, NJ 07753

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F 641	Continued From page 1 The surveyor reviewed the Admission Record for Resident #12 which reflected that the resident was admitted with diagnoses that included [redacted]. The surveyor reviewed the Physician's orders for Resident # 12. There was an order dated [redacted] for [redacted] via [redacted] every shift. The [redacted] Medication Administration Record had documentation that the [redacted] was in use. The surveyor reviewed Resident #12's Quarterly MDS, an assessment tool utilized to facilitate the management of care, dated [redacted]. The MDS indicated no for [redacted] for Resident #12. When interviewed on 08/26/24 at 11:36 AM, the [redacted] stated that Resident #12 utilized [redacted] He stated that the [redacted] MDS was coded incorrectly.	F 641	were in-serviced by the DON/administrator on 9/3/24 to have proper coding for oxygen therapy. MDS coordinator will review all residents with oxygen therapy for proper coding. 4. DON/Designee will monitor 5 recently completed MDS for oxygen therapy coding per month for 3 months. All findings to be brought to QA committee.	
F 644 SS=D	NJAC 8:39-11.2 Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		10/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315199	A. BUILDING _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 644	Continued From page 2 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASRR) assessment after a resident was newly diagnosed with a [redacted]. This deficient practice was identified in 1 of 1 resident reviewed for Preadmission Screening and Resident Review PASRR (Resident #55) and was evidenced by the following: Resident #55 was a resident of the facility. The surveyor reviewed the [redacted] PASRR (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) for Resident #55 dated [redacted] which was [redacted] meaning the resident did NJ Ex Order 26.4(b)(1) diagnoses that could lead to [redacted]. The surveyor reviewed the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted]. The MDS reflected that Resident #55 had NJ Ex Order 26.4(b)(1) and did not have diagnosis of [redacted] ([redacted]). The surveyor reviewed the quarterly MDS dated [redacted] The MDS	F 644	1. A new PASRR was done for resident #55 on 08/22/2024. 2.All residents with psychotropic medication can be affected by this practice. 3.Nursing staff, [redacted], social services were in-serviced on 9/3/24 by the Don/ Administrator that all consults by psychiatrist will be given to director of social services. 4.DON/Designee will monitor 3 charts weekly for 4 weeks and monthly for 3 months. All findings will be brought to QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 644	Continued From page 3 reflected Resident #55 had NJ Ex Order 26.4(b)(1) and had diagnosis which included NJ Ex Order 26.4(b)(1) The surveyor reviewed the NJ Ex Order 26.4(b)(1) consult for Resident #55 dated NJ Ex Order 26.4(b)(1). The consult included diagnoses of NJ Ex Order 26.4(b)(and NJ Ex Order . The surveyor reviewed the NJ Ex Order 26.4(b)(1) consult for Resident #55 dated NJ Ex Order 26.4(b)(1). The consult included a new diagnosis of NJ Ex Order 26.4(b)(1) During an interview with the surveyor on 08/22/2024 at 11:12 AM, the U.S. FOIA (b) (6) stated that when a resident was diagnosed with a NJ Ex Order 26.4(b)(1), a new PASRR should be completed. She stated that when Resident #55 was newly diagnosed with NJ Ex Order 26.4(b)(1) a new NJ Ex Order PASRR should have been completed but was not. The surveyor reviewed the facility policy titled, "PASRR Completion", with an issue date of 10/10. The policy reflected that PASRR screening will be completed in compliance with state and federal regulations. NJAC 8:39-27.1 (a)	F 644		

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	061335	A. BUILDING: _____ B. WING _____	C 08/27/2024

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (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 pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: 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	S 560	1.All residents can be affected by this deficient practice however no care issues were identified on the shifts that were deficient. The staffing coordinator was In-serviced on 9/3/2024 by the Administrator on tag S560to ensure that staffing requirements are met. 2. All residents can be affected by this practice. 3.Sign on and referral bonuses are in place along with weekend and overtime bonuses to ensure the facility is adequately staffed. The facility advertises on job sites and other venues to recruit	10/1/24

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

Electronically Signed | 09/12/24

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 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing prior to survey from 08/04/2024 to 08/17/2024 the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: The facility was deficient in CNAs for resident care on 11 of 14 day shifts as follows: -08/04/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/05/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/07/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/08/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/09/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/10/24 had 10 CNAs for 85 residents on the	S 560	more staff. The facility has recently added another staffing agency as well. 4. For the next month the Administrator/designee will review the projected staffing hours to ensure staffing requirements are met. Findings will be submitted for 3 months to the monthly QAPI committee for any concerns or interventions.	

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 day shift, required at least 11 CNAs. -08/11/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/12/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -08/13/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -08/14/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -08/17/24 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs. During an interview on 08/26/24 at12:31 PM, the Director of Nursing stated that the facility was utilizing CNA's according to regulations. The surveyor reviewed the facility provided policy titled, "Staffing", with a reviewed date of 1/2023. The policy reflected that the facility provides sufficient numbers of staff with the skills and compentency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment and 2. Licensed nurses and nursing assisitans meeting the state and federal guidelines are available 24 hours a day to provide direct resident care services.	S 560		
S2110	8:39-31.1(a) Mandatory Physical Environment (a) No construction, renovation or addition shall be undertaken without first obtaining approval from the Department, Long-Term Care Licensing and Certification Program and/or the Department of Community Affairs, Health Care Plan Review Unit	S2110		10/10/24

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S2110	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview and renovation of facility documents on 8/22/24 in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide updated approvals from the Department of Health, Certificate of Need and Licensing Program (CN&L), or the Department of Community Affairs (DCA) prior to conducting renovations. This deficient practice had the potential to affect all residents and was evidenced by the following: During a tour of the facility on 8/22/24 beginning at 10:10 AM, the surveyor observed that resident rooms #1 and #3 had plastic barriers on the outside of the resident room doors. The surveyor had the MD open the doors to observe the condition of the rooms. The resident room bathrooms were completely gutted, including concrete floors removed down to the dirt with large holes down to the main sewer pipe. In an interview at the time, the MD stated that the construction company obtained all necessary permits and indicated the main permit was posted	S2110	1.The Architect resubmitted an addendum to the scope of work which will include the major construction to resident rooms #1 and #3 to get updated approvals from the Department of Health, Certificate of Need and Licensing Program 2.This deficient practice has the potential to affect all residents. 3.Maintenance director/ construction manager was in serviced by the administrator on 9/3/24 and will monitor construction rooms to ensure the scope of work is correct according to the updated approvals from the Department of Health, Certificate of Need and Licensing Program. Maintenance Director/designee will audit monthly to ensure compliance with scope of work. Audit findings will be brought to the QA Committee quarterly.	

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S2110	Continued From page 4 on the front of the facility. The MD provided a "functional review submission" dated June 30,2023 of the proposed project for the interior renovations from the New Jersey Department of Health. The scope of work consisted of interior renovations on the ground floor of the existing Long Term Care (LTC) facility. The proposed project indicated renovations to existing rooms #1 to #28 located in the right-wing of the facility, to replace the built-in closets with movable wardrobes. The functional review submission to the Department of Health did not indicate any of the observed major construction project demolition details to resident rooms #1 and #3 by the surveyor on 8/22/24. The MD did not provide any further documentation and/or a timeline of the renovations with a project narrative along with any updated approvals obtained from CN&L, DCA, and local authorities. The Administrator was informed of the findings at the Life Safety Code exit conference on 8/22/24.	S2110		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315199	A. Building B. Wing	10/11/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	919 GREEN GROVE ROAD NEPTUNE, NJ 07753

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 F0641 Reg. # 483.20(g) LSC	Correction Completed 10/01/2024	ID Prefix F0644 Reg. # 483.20(e)(1)(2) LSC	Correction Completed 10/01/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061335 Y1	A. Building B. Wing Y2	10/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	919 GREEN GROVE ROAD NEPTUNE, NJ 07753

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 10/01/2024	ID Prefix S2110 Reg. # 8:39-31.1(a) LSC	Correction Completed 10/10/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315199	A. BUILDING **01** B. WING _____	**08/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	**919 GREEN GROVE ROAD** **NEPTUNE, NJ 07753**

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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 8/21/24 and 8/22/24, 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 Occupancy The facility is a 1-story building that was built in 80's, It is composed of Type II unprotected construction, with a combination of steel and wood frame materials. The facility is divided into an East and West wing with a Center Core kitchen and dining room. The East wing has resident rooms: 29-56 The West wing has resident rooms : 1-28 The facility has 3 partial basements identified as: East Basement, West Basement, and PT Basement. The PT basement has an elevator. The facility is licensed for 121 certified beds and is currently occupying 85 *The facility is currently using a temporary 200 KW diesel generator that is on a trailer with wheels. The U.S. FOIA (b) (6) indicated the rental generator is in service for approximately 1-year at the facility. The facility is divided into 7- smoke zones.	K 000		
K 161	Building Construction Type and Height	K 161		10/7/24

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

Electronically Signed | 09/12/2024

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	315199	A. BUILDING **01** B. WING _____	**08/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	**919 GREEN GROVE ROAD** **NEPTUNE, NJ 07753**

(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 161 SS=E	Continued From page 1 CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located,	K 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315199	A. BUILDING **01** B. WING _____	**08/26/2024**

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K 161	Continued From page 2 location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 8/21/24 in the presence of the U.S. FOIA (b) (6) [redacted] it was determined that the facility failed to provide an acceptable construction type and wall-ceiling assembly in accordance with the requirements of NFPA 101: 2012 Edition, Section 19.1.6.1, Table 19.1.6.1. This deficient practice had the potential to affect 29 residents and was evidenced by the following: In an interview at 9:45 AM during the entrance conference, the U.S. FO[redacted] was unable to provide Life Safety Code floor plans for 3 of 3 partial basements. The main building floor plan indicated that the facility had 3 partial basements: West basement East basement PT basement The provided main floor plan did not indicate any partial basement (3 of 3) specific square footage, room size, room identification, hazardous storage areas etc. The provided floor plans had not accurately identified smoke barrier walls, fire walls, shafts, or hazardous areas for the life safety code survey. The U.S. FO[redacted] confirmed the above review and stated that the main one-story building was constructed in the 80's, but could not provide a Life Safety Code floor plan for 3 of 3 partial basements in the facility.	K 161	1.A new floor plan will be submitted by the Architect and will identify smoke barrier walls, fire walls, shafts, or hazardous areas for the life safety code survey. Floor plans will be sent when ready from the architect. 2.All residents can be affected by this practice. U.S. FOIA (b) (6) [redacted] was in-service by administrator on 9/3/24 will monitor basements monthly for compliance of this deficient practice. 4.. Maintenance director/designee will audit basements monthly to ensure it meets compliance. Audit findings will be brought to the QA Committee quarterly.	

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K 161	Continued From page 3 The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 8/22/24.	K 161		
K 211 SS=E	NJAC 8:39-31.2(e) Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/22/24 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that the integrity of the means of egress were continuously maintained free of all obstructions in the event of an emergency. This deficient practice was evidenced for 1 of 2 exterior wood decks and had the potential to affect 40 residents residing in the facility by the following: At 11:15 AM, the surveyor observed the treated wood deck exit/egress surface outside resident room 55 and 56 had warped floor boards that were not secured to its frame. The floor boards would cause a tripping hazard in the event of an exit/egress evacuation. The surface of the wood deck was observed to have a green coating on its surface and the middle post. One (1) of three (3) posts was observed to be loose and not attached to the concrete foundation properly. The posts	K 211	1The warped floor boards that were not secured was replaced. One (1) of three (3) posts was secured and is no longer loose. Photos to be submitted. 2.All residents can be affected by this practice. 3 US FOIA (b)(6) was re-educated by the administrator on 9/3/24/ on the exterior stairs to ensure staircase is in good condition. 4.Maintenance director/designee will audit outside steps to ensure they are in good condition .Audit findings will be brought to the QA Committee quarterly	10/7/24

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K 211	Continued From page 4 were approximately 6-foot from the foundation to the floor decking surface above. The [redacted] confirmed the findings above during the observations. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 8/22/24. N.J.A.C. 8:39-31.2(e)	K 211		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/15/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Section 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 4 of 6 areas, had the potential to affect 40 residents, and was evidenced by the following: 1. An observation at 9:57 AM, revealed in the occupied day room identified as #1 that 2-wall light switches shutoff all 12 ceiling light fixtures. 2. An observation at 10:18 AM, revealed in the	K 281	1.Maintenance Director/designee will make sure day room #1 lounge room #1coke room and activities room by the elevator will all be illuminated in accordance with NFPA 101. Photos to be submitted. 2. All residents can be affected by this practice. US FOIA (b)(6) [redacted] was in serviced by Administrator on 9/3/24 on illumination being continuously in operation	10/7/24

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K 281	Continued From page 5 occupied lounge room identified as #1 that 1-wall light switch shutoff all 8 ceiling light fixtures. 3. An observation at 10:24 AM, revealed in the unoccupied sitting room called the coke room that 1-wall light switch shutoff all 4 ceiling light fixtures. 4. An observation at 10:32 AM, revealed in the occupied activities room by the elevator that 1-wall light switch shutoff all 13 ceiling light fixtures. The areas were not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code survey exit conference on 8/22/24.	K 281	accordance with NFPA 101. 4.Maintenance Director/designee will do monthly audits to ensure that the building will be in compliance with Illumination of Means of Egress any findings will be brought to the QA committee.	
K 351 SS=E	NJAC 8:39-31.2(e) Sprinkler System - Installation CFR(s): NFPA 101 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	K 351		10/7/24

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K 351	Continued From page 6 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 record review and interview on 8/22/24 in the presence of the facility U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide automatic fire sprinkler protection to all areas in accordance with NFPA 13. This deficient practice had the potential to affect 21 residents and was evidenced by the following: At 12:15 PM, the surveyor observed that fire sprinklers were not installed under the attached exterior wooden deck outside the exit/egress wing of resident rooms 43 to 56. The deck measured approximately 7-foot by 7-foot was approximately 6-foot off the ground. The facility was storing items under the wooden deck. In an interview at the time, when U.S. FO [redacted] was asked if the wood was labeled or had any fire resistant ratings, the U.S. FO [redacted] stated he was unsure. The U.S. FOIA (b) (6) was informed of the findings at the life Safety Code exit on 8/22/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	1.Absolute protective completed the installation of automatic fire sprinkler under the attached exterior wooden deck. Photos to be submitted. 2.All residents can be affected by this practice. 3. U.S. FOIA (b) (6) was educated by administrator on 9/3/24 to provide automatic fire sprinkler protection to all areas in accordance with NFPA 13. 4.Maintenance Director/designee will audit other locations to ensure automatic fire sprinkler protection to all areas are in accordance with NFPA 13.All findings will be brought to the QA committee.	

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K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/22/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to A.) maintain all parts of the automatic fire sprinkler heads free from corrosion and loading in accordance with NFPA 25: 2011 Edition, Section 5.2.1.1.1 and B.) to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101: 2012 Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13: 2010 Edition, Section 6.2.7.1 and NFPA 25: 2011 Edition, Section 5.1, 5.2.2.1. These deficient practices were identified for 3 of 8 basement rooms observed, had the potential to affect all residents, and was evidenced by the	K 353	1. Absolute protective Completed the deficiency for, A-1) basement boiler room 2 of 2 sprinkler heads were green with a coating of oxidation and were missing escutcheon plates. A-2) West basement laundry room missing escutcheon plates. A-3) West basement laundry room that in the commercial dryer area, 1 of 2 sprinkler heads were missing escutcheon plates.	10/7/24

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K 353	Continued From page 8 following: A-1) At 11:47 AM, the surveyor and U.S. FO observed in the East basement boiler room that 2 of 2 sprinkler heads were green with a coating of oxidation and were missing escutcheon plates. A-2) At 11:51 AM, the surveyor and U.S. FO observed in the West basement laundry room commercial washing machine area, the 2 sprinkler heads were missing escutcheon plates. A-3) At 11:55 AM, the surveyor and U.S. FO observed in the West basement laundry room that in the commercial dryer area, 1 of 2 sprinkler heads were missing escutcheon plates. A-4) At 11:58 AM, the surveyor and U.S. FO observed in the sprinkler room (wet and dry system), that a thermostat wire was attached to the fire sprinkler pipe. The U.S. FO confirmed the findings during the observations. B-1) At 11:48 AM, the surveyor and U.S. FO observed in the East basement boiler room, that more than 5 drop ceiling tiles were not in place. B-2) At 11:52 AM, the surveyor and U.S. FO observed in the West basement laundry room (washing machine area), gaps around the fire sprinkler heads from oversized drop ceiling tile cuts and more than 2 drop ceiling tiles were not in place. B-3) At 11:57 AM, the surveyor and U.S. FO observed in the West basement laundry room (dryer area), gaps	K 353	A-4) Maintenance director immediately removed the thermostat wire was attached to the fire sprinkler pipe. Photos to be submitted 2.All residents can be affected by this practice. 3 US FOIA (b)(6) was in-service by administrator on 9/3/24 on the importance of making sure all sprinkler heads are in accordance with NFPA 101 Sprinkler System. 4.Maintenance director/designee will audit on his monthly rounds to ensure sprinkler systems are in compliance with NFPA 101.All findings will be brought to the QA committee.	

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K 353	Continued From page 9 around the fire sprinkler heads from oversized drop ceiling tile cuts and more than 3 drop ceiling tiles were not in place. The [redacted] confirmed the findings above during the observations. The [redacted] was informed of the findings at the Life Safety Code exit conference on 8/22/24. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363		10/7/24

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K 363	Continued From page 10 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/22/24 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101: 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 10 of 40 resident rooms observed, had the potential to affect 20 residents, and was evidenced by the following: Observations from 9:15 AM to 12:45 PM in the presence of the U.S. FOI[redacted] revealed the resident room doors did not operate properly as follows: #4 resident room door gets stuck into its frame #16 resident room door gets stuck into its frame #19 resident room door gets stuck into its frame #21 resident room door gets stuck into its frame #33 resident room door gets stuck into its frame #39 resident room door gets stuck into its frame	K 363	Maintenance Director fixed residents rooms #4 #16 #19 #21 #33 #39 #41 #45 #51 #55 Photos to be submitted. 2.All residents can be affected by this practice. 3 US FOIA (b)(6) [redacted] was educated by administrator on 9/3/24 on corridor doors to be in accordance with the requirements of NFPA 101.	

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K 363	Continued From page 11 #41 resident room door gets stuck into its frame #45 resident room door gets stuck into its frame #51 resident room door has a top gap approximately 1/4 to 1/2- inch #55 resident room door gets stuck into its frame At the time of observations, the surveyor interviewed the U.S. FOIA (b) (6) who confirmed the above findings. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 8/22/24. NJAC 8:39-31.1(c), 31.2(e)	K 363	4. Maintenance Director/designee will audit doors monthly to ensure compliance and will bring any issues to the QA committee.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/22/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure the guarding of live parts of electrical equipment and controls within unlocked panels in resident accessible areas in accordance with NFPA 101: 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99: 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70: 2011 Edition, Section 110.26, 110.27	K 911	1. Maintenance Director closed secured all open electrical wall panels in the resident exit/egress corridors throughout the facility. Photos to be submitted. 2. All residents can be affected by this	10/7/24

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K 911	Continued From page 12 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas for 6 of 6 open electrical panels observed. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following: Observations from approximately 9:45 AM. to 1:45 PM. in the presence of the U.S. FO and U.S. FOIA (b) (6) revealed open electrical wall panels in the resident exit/egress corridors throughout the facility. The observations were confirmed by the U.S. FO and U.S. FOIA (b) (6) during the tour of the facility. In an interview, the U.S. FO stated he was aware of the unlocked electrical panels and that he could no longer get parts for the original panel locks. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 8/22/24. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	practice. 3 U.S. FOIA (b) (6) was in serviced by administrator on 9/3/24 in regards keeping electrical panels not accessible in resident areas. 4.Maintenance Director/designee will audit monthly to make sure electrical panels are not accessible in resident areas. All findings will be brought to the QA Committee.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		10/7/24

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	315199	A. BUILDING **01** B. WING _____	**08/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	**919 GREEN GROVE ROAD** **NEPTUNE, NJ 07753**

(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 914	Continued From page 13 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 8/22/24 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99: 2012 Edition. This deficient practice was identified for of 34 resident rooms observed, had the potential to affect 45 residents, and was evidenced by the following: During record review, the surveyor reviewed documentation provided by the U.S. FO which included the facility's electrical inspection report, dated 10/9/23, from the facility's licensed vendor. The report did not indicated that the rooms with non-hospital grade electrical outlets were annually inspected for grounding, polarity, and blade tension. In an interview at the time of observations, the U.S. FO stated that he was not currently conducting	K 914	1.Maintenance Director tested all 34 resident rooms and the rest of resident rooms for grounding, polarity, and blade tension in accordance with NFPA 99. 2.All residents can be affected by this practice. 3 U.S. FOIA (b) (6) was in-serviced by the administrator on 9/3/24 to functionally test electrical receptacles in residents rooms annually for grounding polarity, and blade tension. 4..Maintenance Director/ designee will monitor monthly resident rooms that need to be tested for grounding polarity, and blade tension in accordance with NFPA 99.All findings will be brought to the QA committee.	

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	315199	A. BUILDING **01** B. WING _____	**08/26/2024**

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IMPERIAL CARE CENTER	**919 GREEN GROVE ROAD** **NEPTUNE, NJ 07753**

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K 914	Continued From page 14 the required non-hospital grade outlet testing, but would have the non-hospital grade outlets tested for grounding, polarity, and blade tension as soon as possible. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 8/22/24. NJAC 8:39-31.2(e) NFPA 99	K 914		
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 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	K 918		10/7/24

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K 918	Continued From page 15 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 observation and interview on 8/21/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to install a permanent emergency generator and provide electrical wiring in accordance with National Electrical Code 70 (NEC-70). The deficient practice was observed for 1 of 1 temporary generators, had the potential to affect all residents, and was evidenced by the following: The surveyor observed the temporary rental unit 200 KW generator at 9:22 AM. The mobile generator was installed on a 4-wheel trailer that was observed to have wooden wheel chocks in place. There were exposed wires (approximately 8 heavy unprotected wires) on the blacktop surface and attached to the old (out of service generator) unit transfer case. The electrical cables were not protected in metal conduit. In addition, the wires installed from the temporary generator into the open transfer switch of the out of service unit were observed to be dirty and unorganized on the blacktop surface. The surveyor interviewed the U.S. FO[redacted] at the time of	K 918	1.Powerhouse generator installed a remote emergency stop and an alarm annunciator panel. The electrical cables were put in a protective conduit. Wheel locks/boots were installed on the wheels of the Generator. Photos to be submitted. 2.All residents can be affected by this practice. 3 U.S. FOIA (b) (6) was in serviced by the administrator on 9/3/24 on making sure the generator was in accordance with National Electrical Code 70. 4.Maintenance Director/designee will round monthly to make sure Generator is in compliance. Findings will be brought to QA Committee.	

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K 918	Continued From page 16 the observation, where he stated the facility generator has been out of service for approximately 1-year. It was also observed that the temporary mobile generator did not have a remote emergency stop and did not have an alarm annunciator panel to notify staff of the current operating conditions of the temporary generator. The annunciator panel at the nurse station was not hooked up to the temporary generator. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 8/22/24. NJAC 8:39 -31.2 (c) NFPA 99, 110	K 918		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment	K 921		10/7/24

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K 921	Continued From page 17 instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/21/24 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, and 10.5.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations from approximately 9:45 AM to 1:45 PM, revealed that all fixed and portable patient-care related equipment (PCREE) did not have a current inspection sticker throughout the facility. In an interview at the time, the U.S. FO stated he checked all PCREE equipment but could not provide a policy and procedures for testing of the equipment or evidence of annual testing and maintenance program for PCREE.	K 921	1.Maintenance Director/designee put a sticker on all fixed and portable patient-care related equipment (PCREE)that did not have a current inspection sticker throughout the facility. 2. All residents can be affected by this practice. 3. U.S. FOIA (b) (6) was in-service by the administrator on 9/3/24 to make sure all fixed and portable patient-care related equipment (PCREE) have a current inspection sticker throughout the facility and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99. 4. Maintenance Director/Designee will audit monthly to make sure fixed and portable patient-care related equipment (PCREE) have a current inspection	

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K 921	Continued From page 18 The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 8/22/24. NJAC 8:39-31.2(e) NFPA 99	K 921	sticker. All findings will be brought to the QA committee.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier.	K 923		10/7/24

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K 923	Continued From page 19 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/22/24 in the presence of the U.S. FOIA (b) (6) [redacted], the facility failed to provide storage of cylinders so empty cylinders are segregated from full cylinders, or appropriately labeled full and empty in accordance with NFPA 99: 2012 Edition, Sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. This deficient practice was evidenced for 1 of 2 oxygen storage rooms observed and was evidenced by the following: At 1:02 PM, the surveyor and U.S. FOIA (b) (6) [redacted] observed the oxygen storage room by resident room #16. The oxygen storage room contained 22 compressed Oxygen cylinders. It could not be determined what cylinders were full or empty as they were not segregated and not marked to identify which were full or empty. In an interview at the time, the U.S. FO[redacted] confirmed the observations. The U.S. FOIA (b) (6) was informed of the findings at the life safety code exit conference on 8/22/24. NJAC 8:39-31.2(e) NFPA 99	K 923	Maintenance Director put up signage that is appropriately labeled full and empty in accordance with NFPA 99. Photos to be submitted. 2.All residents can be affected by this practice. 3 U.S. FOIA (b) (6) [redacted] was in-serviced by the Administrator on 9/3/24 on having signage that is appropriately labeled full and empty in accordance with NFPA 99. 4.Maintenance Director/designee will do weekly rounds to make sure oxygen storage room signage is appropriately labeled full and empty in accordance with NFPA 99.All findings will be brought to the QA committee.	

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
315199 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	919 GREEN GROVE ROAD NEPTUNE, NJ 07753

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 K0161	10/07/2024	LSC K0211	10/07/2024	LSC K0281	10/07/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	10/07/2024	LSC K0353	10/07/2024	LSC K0363	10/07/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0911	10/07/2024	LSC K0914	10/07/2024	LSC K0918	10/07/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0921	10/07/2024	LSC K0923	10/07/2024	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?
8/26/2024	☐ YES ☐ NO