STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315299	A. BUILDING _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE 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
F 000	INITIAL COMMENTS Complaint #:168449, 178432, 171700, 178432 Survey Date: 10/25/24 Census: 87 Sample: 21 + 2 (closed Records) = 23 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 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint # NJ 168449 Based on observation, interview, record review, and review of facility provided documents it was determined that the facility failed to consistently provide appropriate and timely NJ Ex Order 26.4(b)(1) care for residents who were NJ Ex Order 26.4(b)(1) staff for Activities of Daily Living (ADLs) care. This deficient practice was identified for 2 of 3 residents (Resident #3 and #184) reviewed for ADL care and was evidenced by the following: 1. On 10/21/24 at 8:20 AM, the surveyor conduced an initial tour of the NJ Ex Order 26.4(b)(1) Unit and observed a NJ Ex Order 26.4(b)(1) in the hallway.	F 677	1. Resident #3 was provided with NJ Ex Order 26.4(b)(1) care on 10/21/24 at 8:45 AM, 10/23/24 at 9:04 AM and 10/24/24 at 8:32 AM. Resident #184 was provided with NJ Ex Order 26.4(b)(1) care on 10/21/24 at 9:30 AM. 2. All incontinent residents have the potential to be affected. Incontinence rounds were done on 10/24/24 and no other residents were found to have been affected. 3. The Director of Nursing/designee educated all licensed nursing staff regarding incontinent care as well as frequency of incontinence checks and	11/15/24

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

Electronically Signed | 11/06/2024

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 677	Continued From page 1 On 10/21/24 at 8:21 AM, the surveyor observed Resident #3 in bed in their room. The surveyor inquired regarding the care received at the facility, and Resident #3 stated that they were [redacted] and needed to [redacted]. The resident, then activated the call light, and stated that staff took a long time to answer the call light. Resident #3 stated sometimes it could take one hour for staff to answer the call light and [redacted] care was not provided timely. The surveyor exited the room and informed the certified Nursing Assistant (CNA #1) in the next hallway of Resident #3's request. The CNA informed the surveyor that she was on light duty but she would get another CNA to assist. On 10/21/24 at 8:45 AM [24 minutes later], CNA #2 entered the room to provide [redacted] care to Resident #3. The surveyor observed that the [redacted] was [redacted] from the [redacted] to the [redacted] and Resident #3 was [redacted] which were [redacted] with [redacted]. The surveyor observed that the [redacted] was [redacted]. CNA #2 then informed the surveyor that she had not yet provided care to the resident. On 10/21/24 at 11:30 AM, the surveyor interviewed CNA #1 who confirmed she delivered the breakfast tray to the resident around 7:50 AM. CNA #1 stated she did not ask the resident if they were [redacted] and did not check to see if they needed [redacted] care prior to providing the resident with the breakfast meal. On 10/23/24 at 9:04 AM, the surveyor entered the room and observed Resident #3 was in bed. A CNA was also in the room and Resident #3 stated in the presence of the CNA the they were	F 677	resident changes. The Director of Nursing/Unit Manager/Designee will continue to make rounds daily to ensure staff are completing incontinence care and checks as required. 4. The Director of Nursing/designee will conduct a random audit of 10 incontinent residents, who were dependent on staff for Activities of Daily Living, to ensure that the residents were provided with consistent, appropriate and timely incontinence care. Audits will continue weekly x4 weeks. Findings of the audit will be presented at the QAPI committee until sustained compliance is achieved.	

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F 677	Continued From page 2	F 677		

last changed yesterday, referring to the 3:00 PM to 11:00 AM shift. The NJ Ex Order 26.4(b)(1) was again observed NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1) and Resident #3 was NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) was again observed NJ Ex Order 26.4(b)(1).

On 10/24/24 at 8:32 AM, the surveyor observed Resident #3 in bed. Resident #3 stated that they already ate breakfast. When inquired if they received NJ Ex Order 26.4(b)(1) care, Resident #3 stated in the presence of the US FOIA (b)(6), "I was last NJ Ex Order 26.4(b)(1) yesterday." The US FOIA (b)(6) checked the resident with the surveyor present and observed that the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1).

On 10/24/24 9:40 AM, a telephone interview was conducted with CNA #2 who provided care to Resident #3 on 10/21/24 who stated that she provided NJ Ex Order 26.4(b)(1) care to the resident at 5:00 AM. CNA #2 stated that she placed two NJ Ex Order 26.4(b)(1) on Resident #3 because the resident requested NJ Ex Order 26.4(b)(1). She then stated that did not inform the nurse that she had been placing NJ Ex Order 26.4(b)(1) on the resident. When inquired about what could happen with NJ Ex Order 26.4(b)(1) that were NJ Ex Order 26.4(b)(1), she stated the NJ Ex Order 26.4(b)(1) could NJ Ex Order 26.4(b)(1).

On 10/24/24 at 10:30 AM, the surveyor reviewed Resident #3's medical record which revealed the following:

-Admission Record (AR) revealed, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1).

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F 677	Continued From page 3	F 677		

-The quarterly Minimum Data Set (MDS) assessment tool dated [redacted], revealed that Resident #3 had [redacted]. Resident #3 received a score of [redacted] out of 15 on the Brief Interview for Mental Status (BIMS). Section G of the MDS which referred to Activities of Daily Living (ADLs) revealed that Resident #3 was [redacted] on staff for [redacted]

-Review of the Care Plan for Resident #3 initiated on [redacted], included a "Focus" for ADL [redacted] related to: [redacted], [redacted] and [redacted]. The goal was for Resident # 3 to improve current level of [redacted] in [redacted] and [redacted] through the review date. Revised [redacted].

The interventions were to provide all necessary supplies for each ADL task and [redacted] as needed. The care plan did not indicate the frequency for staff to provide [redacted] care to the resident.

On 10/24/24 at 9:39 AM, the surveyor interview the [redacted]) regarding Resident #3's [redacted] care. The [redacted] revealed that she was not aware that direct care staff were placing [redacted] the resident. The [redacted] stated she was made aware on 10/21/24 of the [redacted] being used on residents. The [redacted] added that [redacted] should not be used on residents as they could cause [redacted]. When inquired regarding the frequency of [redacted] care should be provided, the [redacted] stated that [redacted] should be provide every two hours. The 7:00 AM- 3:00 PM shift were supposed to check residents for [redacted]

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F 677	Continued From page 4 care as soon as they received their assignment. The surveyor asked about Resident #3 NJ Ex Order 26.4(b) [redacted] and she stated that staff should only apply only NJ Ex Order 26.4(b)(1) and Resident #3 did not request NJ Ex Order 26.4(b)(1). 2. On 10/21/24 at 9:30 AM, the surveyor entered a room and observed Resident #184 in bed. Resident #184 stated that NJ Ex Order 26.4(b)(1) care was not being provided in a timely manner. Resident #184 stated that they wore a NJ Ex Order 26.4(b)(1) [redacted]) and all the staff did not know how to properly apply the NJ Ex Order 26.4(b)(1). The resident stated that most of the time the NJ Ex O would be NJ Ex Order 26.4(b)(1) and they would NJ Ex Order 26.4(b and staff did not check for NJ Ex Order 26.4(b)(1) care in a timely manner. Resident #184 added sometimes staff would not be available for 4 to 5 hours. The CC would be NJ Ex Order 26.4 and they would be NJ Ex Order 26.4([redacted]. The surveyor then asked Resident #184 to activate the call light, and a CNA entered the room within 5 minutes and inquired regarding the call light. The CNA assisted with the NJ Ex Order 26.4(b)(1) care and the surveyor observed Resident #184's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) [redacted] was NJ Ex Order 26.4(b)(1). Resident #184 informed the surveyor that they were not NJ Ex Order 26.4(b)(during the night, or before breakfast. The CNA confirmed that she did not check Resident #184 prior to serve the breakfast meal. On 10/23/24 at 8:00 AM, the surveyor reviewed Resident #184's medical record which revealed the following: - The admission Face Sheet, an admission summary revealed that Resident #184 had diagnoses which included but were not limited to;	F 677		

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F 677	Continued From page 5 NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). -The Admission Minimum Data Set (MDS), dated NJ Ex Order 26.4(, an assessment tool used by the facility to prioritize care reflected that Resident #184 was NJ Ex Orde and able to make their needs known. Resident #184 received a score of NJ Ex on the Brief Interview for Mental Status (BIMS) indicative of NJ Ex Order 26.4(b)(1) -Resident #184 care plan had a Focus for ADLs NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) initiated NJ Ex Order 26.4(b)(1) . The goal was for Resident #184 to improve current NJ Ex Order 26.4 . Interventions included: Provide all necessary supplies for each ADL task and NJ Ex Order 2 as needed. Resident #184 is NJ Ex Order 26.4(b)(1) on staff for NJ Ex Order 26.4(b)(1) . On 10/23/24 at 11:30 AM, the surveyor reviewed the TASK (electronic record where the CNA documented the care provided to each resident). The ADL task page which included NJ Ex Order 26.4(b) was left blank for NJ Ex Order 2 and NJ Ex Order 2 . On 10/24/24 at 12:30 PM, during the pre-exit conference with the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), the above findings were presented. A review of the facility policy titled, Activities of Daily Living (ADL) Supporting, last revised 2018, indicated the following: Policy Statement revealed: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily	F 677		

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F 677	Continued From page 6 living (ADLs) Residents who are NJ Ex Order 26.4(b)(1) activities of daily living NJ Ex Order 26.4(b)(1) will receive the services necessary to maintain good nutrition, grooming and persona and oral hygiene. NJAC 8:39-27.1 (a)	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to follow a physician order for a treatment to treat a NJ Ex Order 26.4(b)(1) identified on NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 21 residents reviewed (Resident #3) for quality of care and was evidenced by the following: On 10/21/24 at 8:45 AM, with the Certified Nursing Assistant (CNA) present and observed that Resident #3, a CNA #2 entered the room to provide NJ Ex Order 26.4(b)(1) care to Resident #3. The surveyor observed that the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(from the NJ Ex Orde to the NJ Ex Order 2 and Resident #3 was wearing NJ Ex Order 26.4(b)(1) which were both NJ Ex Order 26.4(b)(1). The surveyor	F 684	1. An order was immediately obtained for the treatment of Resident #3's NJ Ex Order 26.4(b)(1). 2. All incontinent residents have the potential to be affected by this deficient practice. An audit was done on all residents identified with moisture associated dermatitis, no other residents were found to have been affected. 3. The Director of Nursing/designee educated all licensed nurses regarding reviewing wound consult recommendations with the primary care physician and the transcription of wound consultant recommendations into an order	11/15/24

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F 684	Continued From page 7 observed that the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1). CNA #2 then informed the surveyor that she had not yet provided care to the resident had NJ Ex Order 26. on the NJ Ex Order 26.4(b)(1) . The concerns were reported to the U.S. FOIA (b) (6) who then generated a NJ Ex Order 26.4 consult for Resident #3. On 10/23/24 at 11:00 AM, the surveyor reviewed the medical record for Resident #3 which revealed: -On NJ Ex Order 26.4(b)(1 the resident was evaluated by the NJ Ex Order 26.4 practitioner and diagnosed with NJ Ex Order 26.). The order indicated the resident was to have NJ Ex Order 26.4(b)(1) every shift for NJ Ex Order 26. after NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) , Pat it dry,leave open to air. -The diagnoses included, but were not limited to, NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). On 10/23/24 at 9:04 AM, the surveyor entered the room and observed Resident #3 was in bed. A US FOIA (b was also in the room and Resident #3 stated in the presence of the US FOIA (b the they were last NJ Ex Order 26.4(b)(yesterday, referring to the 3:00 PM to 11:00 AM shift. The NJ Ex Order 26.4(b)(1) was again observed NJ Ex Order 26.4(b) to the NJ Ex Orde and Resident #3 was NJ Ex Order 26.4(b)(1) . The NJ Ex Order 26.4(b) to protect the NJ Ex Or was again observed NJ Ex Order 26 . The surveyor observed that the NJ Ex Order and NJ Ex Order 26.4(b)(1) were still NJ Ex Order 26.4(b)(1) The surveyor reviewed the Treatment Administration Record (TAR) and could not locate the order from the NJ Ex Order 26. practitioner.	F 684	to be documented on the treatment administration record. 4. The Director of Nursing/designee will conduct an audit of 10 residents wound consult reports to ensure recommendations were reviewed with the physician and treatment orders were transcribed to the treatment administration record. Audits will continue weekly x4 weeks. Findings of the audit will be presented at the QAPI committee until sustained compliance is achieved.	

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F 684	Continued From page 8 On 10/24/14 at 1:30 PM, the surveyor reviewed the U.S. FOIA (b) (6) consultation with the U.S. FOIA (b) (6)) who confirmed that Resident #3 had been evaluated and was ordered to have the NJ Ex Order 26.4(b)(1) applied to NJ Ex Order 26.4(b)(1) . The surveyor reviewed the Physician Order Sheet (POS) and the TAR dated NJ Ex Order 26.4(b)(1), that was provided by the U.S. FOIA (b) (6)) with the U.S. FOIA (b) (6)) that was assigned to the unit. The order was not transcribed on the TAR and could not be located. Resident #3 did not receive the treatment ordered on NJ Exec Order 26.4b1 as ordered by the physician. On 10/24/14 at 1:30 PM during an interview with the U.S. FOIA (b) (6)) and the U.S. FOI the U.S. FOIA (b stated if a medication was ordered that the medication should be administered immediately. The U.S. FO informed the survey team that she was not aware that Resident #3 did not receive the treatment as ordered by the physician. On 10/25/24 at 11:00 AM, the U.S. FO informed the survey team that the U.S. FOIA (b) (6) failed to transcribe the order. No further information was provided.	F 684		
F 686 SS=E	NJAC 8:39-27.1 (a) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		11/15/24

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F 686	Continued From page 9 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure a system was in place to ensure a resident with a NJ Ex Order 26.4(b)(1), who was NJ Ex Order 26.4(b)(1) on staff for care, was NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 1 resident (Resident #56) reviewed for care and services for NJ Ex Order 26.4(b)(1) and was evidenced by the following: On 10/21/2024 at 8:32 AM, the surveyor observed Resident #56 lying in bed on their back on a NJ Ex Order 26.4(b)(1)) and a Certified Nursing Aide (CNA) was assisting the resident with breakfast. CNA #1 stated that she was not too sure about the resident but knew there was NJ Ex Order 26.4(b)(1) on the resident's NJ Ex Or On 10/22/2024 at 9:48 AM, the surveyor observed Resident #56 lying on their back in bed on a NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b) on one side and the bed pushed against one wall. On 10/23/2024 at 9:05 AM, the surveyor, again, observed Resident #56 lying on their back in bed	F 686	1. Resident #56 was immediately, on 10/23/24 at 4:00 PM NJ Ex Order 26.4(b)(1) by the CNA. A NJ Ex Order 26.4(b)(1) documentation form was initiated so that staff could document NJ Ex Order 26.4(b)(1) for resident #56. 2. All residents who required turning and repositioning assistance have the potential to be affected. 3. A turning and repositioning documentation form was initiated for all resident's dependent for turning and repositioning as a pressure ulcer preventative measure. The Director of Nursing educated all direct care staff regarding use of the turning and repositioning documentation form. The education also included turning and repositioning all residents who are dependent on staff for care. The Unit Manager/Designee will review the turning and positioning forms weekly to ensure completion.	

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F 686	Continued From page 10 on NJ Ex Order 26.4(b)(1). At 10:01, CNA #2 was in the room and showed the surveyor NJ Ex Order 26.4(b)(1) on the resident's NJ Ex Order 26.4(b)(1). CNA #2 stated that the staff should be NJ Ex Order 26.4 the resident every two hours but stated there was no documentation to show that all staff NJ Ex Order 26 the resident. On 10/23/24 at 11:00 AM, the surveyor reviewed Resident #56's medical record which revealed: -Admission Record with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) -The Order Summary Report included an order dated NJ Ex Order 26.4(b)(1), to document any disruptive behavior during the shift; dated NJ Ex Order 26.4(b)(1), to NJ Ex Order 26.4(b)(1) and apply NJ Ex Order 26.4(b)(1) and a NJ Ex Order 26.4(b)(1) day shift to the NJ Ex Order 26.4(b)(1); dated NJ Ex Order 26.4(b)(1), to apply NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) every shift; dated NJ Ex Order 26.4(b)(1), for a NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) and dated NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) every shift. -The ongoing resident-centered on-going Care Plan (CP) included but was not limited to; a focus area of at risk for NJ Ex Order 26.4(b)(1) ... NJ Ex Order 26.4(b)(1) date initiated NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) to resolve, date initiated NJ Ex Order 26.4(b)(1). Interventions included but were not limited to; NJ Ex Order 26.4(b)(1) q (every) 2-3 hours and prn (as needed). A focus area of NJ Ex Order 26.4(b)(1) r/t (related to) NJ Ex Order 26.4(b)(1) date initiated NJ Ex Order 26.4(b)(1) and revised NJ Ex Order 26.4(b)(1).	F 686	4.The Director of Nursing/Unit Manager/Designee will continue to make rounds daily to ensure residents who require assistance with turning and repositioning are turned and repositioned appropriately. The DON/ Designee will audit 5 turning and repositioning documentation forms to ensure the turning and repositioning of residents is documented according to their care plan. Audits will continue weekly x4 weeks. Findings of the audit will be presented at the QAPI committee until sustained compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315299	A. BUILDING _____ B. WING _____	C 10/25/2024

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F 686	Continued From page 11 Goals which included remain free of NJ Ex Order 26.4(b)(1). Interventions included NJ Ex Order 26.4(b)(1) to bed for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and nursing restorative program NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1)). -A review of the quarterly Minimum Data Set (MDS) an assessment tool used to facilitate resident care, dated NJ Ex Order 26.4(b)(1), included but was not limited to; the resident was not able to complete a Brief Interview for Mental Status; there were NJ Exec Order 26.4b1 during a 7-day look back period; the resident was NJ Ex Order 26.4(b)(1) staff for Activities of Daily living and for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) the resident was documented as having NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) and not on a NJ Ex Order 26.4(b)(1) program. -The facility provided, NJ Ex Order 26.4(b)(1) for Predicting NJ Ex Order 26.4(b)(1) " dated NJ Ex Order 26.4(b)(1) included but was not limited to; 'NJ Ex Order 26.4(b)(1) ", 'NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . Resident #56's score was NJ Ex Order 26.4(b)(1) which indicated NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1). On 10/23/2024 at 10:03 AM, the U.S. FOIA (b) (6) caring for Resident #56 stated that the NJ Ex Order 26.4(b)(1) was to NJ Ex Order 26.4(b)(1). She stated that the resident had NJ Ex Order 26.4(b)(1) and that the CNAs would NJ Ex Order 26.4(b)(1) the resident and that would be documented in the electronic medical record. The U.S. FO accessed the electronic medical record in the presence of the surveyor and acknowledged there was no documentation that Resident #56 was being NJ Ex Order 26.4(b)(1).	F 686		

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F 686	Continued From page 12 On 10/23/2024 at 10:29 AM, the U.S. FOIA (b) (6) stated that the NJ Exec Order 2 team would come once or twice a week. She stated that she was in charge of that unit at that time and would be responsible for tracking, trending, and NJ Exec Order 2 assessments. The U.S. FOIA (b stated, "the buck stops with me". On 10/23/24 at 1:10 PM, the U.S. FOIA (b) (6)) stated that the NJ Ex Order 26.4(b)(1) was used to help keep Resident #56 'NJ Ex Order 26.4(b)(1) and that it was ordered previously by hospice in NJ Ex Order 26.4(b)(1), and not the facility. The U.S. FO stated, "the NJ Ex Order 26.4(b)(1)) was to keep the residen NJ Ex Order 26.4(b)(and lays on [Resident #56's] back, but [Resident #56] can't move." The U.S. FO NJ Ex Or further stated that the staff would need to and NJ Ex Order 26.4(b)(1) the resident and that there was a U.S. FOIA (b) (6) who was responsible. The U.S. FO stated that when the resident was not on NJ Ex Order 26.4(b any longer that she would have expected the resident to have been put on a NJ Ex Order 26.4(b)(1) On 10/24/2024 at 8:19 AM, the U.S. FOIA (b) (6)) stated she was unable to locate any documentation that Resident #56 was on a NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) schedule. She stated a restorative log noted 'NJ Ex Order 26.4(b)(1)", but the U.S. FO was unable to explain what that entailed and that the NJ Ex Order 26.4(b)(1) activities were for 15 minutes a day only. A review of the facility provided, 'NJ Ex Order 26.4(b)(1) Progress Report" dated NJ Ex Order 26.4(b)(1), included Resident #56 was being provided NJ Ex Order 26.4 to NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); and NJ Ex Order 26.4(b)(1) to	F 686		

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F 686	Continued From page 13 NJ Ex Order 26.4(b)(1) or to be worn throughout the day all for only 15 minutes a day. A review of the facility provided policy, "Prevention of Pressure Ulcers/Injuries" revised July 2017, included but was not limited to; Purpose " ... to provide information regarding identification of pressure ulcer/injury risk factors and interventions ..." Risk Assessment 4.e. "reposition resident as indicated on the care plan". Mobility/Repositioning. "1. Choose a frequency for repositioning based on the resident's mobility ... 2. At least every hour, reposition residents who are chair-bound or bed-bound ... 3. At least every two hours, reposition residents who are reclining and dependent on staff for repositioning. 4. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort." Support Surfaces and Pressure Redistribution "select appropriate support surfaces ..." Monitoring "2. Review the interventions and strategies for effectiveness on an ongoing basis." On 10/24/2024 at 11:15 AM, the above concerns were presented to the facility. On 10/25/2024 at 8:29 AM, the U.S. FO and U.S. FOIA (b were in the conference room with the survey team. The U.S. FO acknowledged there was no documented NJ Ex Order 26.4(b)(1) program for Resident #56.	F 686		
F 698 SS=E	NJAC 8:39-27.1(a)(e) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		11/21/24

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F 698	Continued From page 14 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to follow the Facility Assessment and facility policy to ensure that staff were educated to care for residents who required NJ Ex Order 26.4(b)(1) and had different types of NJ Ex Order 26.4(b)(1). The deficient practice was identified for 2 of 2 residents reviewed for NJ Ex Order 26.4((Resident #57 and #185) and was evidenced by the following: A review of the facility provided, "Facility Assessment" dated 2023-2024, included but was not limited to; "Requirement ... resident population and the resources our facility needs to care for our residents as per the recommended guidelines:" "The facility assessment must address or include: (1) the facility's resident population, including, but not limited to, ... b. the care required by the resident population considering the types of diseases, conditions, physical, and cognitive disabilities, overall acuity, and other pertinent facts that are present with in that population; c. the staff competencies that are necessary to provide the level and types of care needed for the resident population;" ... Additional References to the Facility Assessment: "1. Nursing Services - the facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental,	F 698	1. The physician discontinued the order to check the NJ Ex Order 26.4(b)(1) for NJ Ex Ord for Resident #185 and a new order was initiated to assess the NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) and ensure the NJ Ex Order 26.4(b)(was clean. The Unit Manager and DON immediately assessed Resident #57□s NJ Ex Order 26.4(b)(1) for any signs and symptoms of infection, no signs and symptoms were observed. The Director of Nursing completed a competency for RN #1 for the assessment and care of a NJ Ex Order 26.4(b)(1). The Director of Nursing completed a competency for RN #2 for the assessment and care of a NJ Ex Order 26.4(b)(1) . 2. All residents on hemodialysis with an access site have the potential to be affected. All residents with dialysis access sites were assessed. No complications or signs of infection were observed. 3. The Director of Nursing/Designee educated all licensed nurses regarding the different types of Hemodialysis access sites.	

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F 698	Continued From page 15 and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care ... 7. Training Requirements. A facility must develop, implement, and maintain an effective training program ... consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified." Acuity "describe your residents' acuity levels ... to understand potential implications regarding the intensity of care and services needed." Special Treatments: Other "Dialysis' Staff Training and Education: "based upon our population, the following staff training and educational topics will be offered throughout the year and available for all staff to attend. We will reach out to our vendors for specialty in-services in their areas of expertise ... Competency Assessed .... Dialysis AVF (arteriovenous fistula)/Perma Cath Care". 1. On 10/22/2024 at 9:54 AM, the surveyor observed Resident #185 sitting in a wheelchair (w/c). The resident stated that they had to go to [redacted] later in the day, and that they had a [redacted]). A subsequent review of the medical records revealed that Resident #185 was admitted with diagnoses which included but were not limited to; [redacted]. A review of the resident-centered Care Plan included a focus area of receiving [redacted] for [redacted] via a [redacted]. Interventions included but were not limited to: monitor for signs and symptoms of [redacted] to the [redacted]. A review of the Order Summary Report included an order dated [redacted], check for [redacted] on the [redacted]	F 698	The Nephrology Nurse Practitioner completed competencies for all licensed nurses regarding the assessment and care dialysis access sites. Orientation for licensed nurses will include education regarding the different types of hemodialysis access sites as well as competencies regarding the assessment and care of dialysis access sites. The Director of Nursing/Designee will review new admissions receiving Hemodialysis to ensure appropriate orders for assessment/care are in place for the resident□s access site. 4. The Director of Nursing/designee will audit the care and assessment of 2(or all if the number is less than 2) dialysis access sites. Audits will continue weekly x4 weeks. Findings of the audit will be presented at the QAPI committee until sustained compliance is achieved.	

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F 698	Continued From page 16	F 698		

NJ Ex Order 26.4(b)(1)) or NJ Ex Order 26.4(b)(1). A review of the Treatment Administration Record (TAR) revealed that staff had been signing off that they had checked the NJ Ex Order 26.4(b)(1) every shift for a NJ Ex Order

On 10/23/2024 at 9:03 AM, the Registered Nurse (RN) #1 stated that her responsibility was to monitor the NJ Ex Order 26.4(b)(1).

On 10/23/2024 at 9:31 AM, during a second interview, RN #1 reviewed the resident's medical record with the surveyor and stated that the staff were to check the NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1)). RN #1 stated she would, "put my finger on NJ Ex Order 26.4(to feel NJ Ex Order 26.4(b) or I can use a NJ Ex Order 26.4(b)(1)" RN #1 further stated, "as far as my practice, we don't do NJ Ex Order 26 for a NJ Ex Order 26.4(b)(1)

On 10/23/2024 at 11:44 AM, RN #1 informed the surveyor that she had never had a competency on the assessment and care of the NJ Ex Order 26.4(

2. On 10/22/2024 at 11:34 AM, the surveyor observed Resident #57 in a w/c in their room. The resident stated the facility staff did not check their NJ Ex Order 26.4(b)(1). Resident #57 showed the surveyor their NJ Ex Ord on the NJ Ex Order 26.4(b)(1) and showed the surveyor how they NJ Ex Order 2 their own NJ Ex Orde

A review of the medical record revealed that Resident #57 had been admitted with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) . A review of the Order Summary Report revealed an order dated NJ Ex Order 26.4(b)(1), to check NJ Ex Order 26.4(b)(1) for NJ Ex Ord and NJ Ex Ord every shift and

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F 698	Continued From page 17 to monitor for [redacted]. A review of the resident-centered Care Plan included a focus area of NJ Ex Order 26.4(b)(1) receiving [redacted] Interventions included to monitor for any signs of [redacted] Monitor [redacted] for [redacted] and [redacted] On 10/23/2024 at 12:18 PM, RN #2 stated that she would monitor Resident #57 for "[redacted] and [redacted]" and for a [redacted] and [redacted] RN #2 stated that she had never had any competencies on the assessment and care of the [redacted]. On 10/23/2024 at 12:05 PM, during a telephone call, Resident #185's physician stated that her expectation would be to assess the [redacted] for [redacted] and to ensure [redacted] was clean. The physician stated there was no [redacted] for a [redacted] but only for [redacted] On 10/24/2024 at 8:32 AM, the [redacted] stated that the facility did not have nurse competencies for the assessment and care of the [redacted]. A review of the facility provided policy, "Hemodialysis Catheters - Access and Care of" undated, included but was not limited to; Purpose "hemodialysis catheters will only be accessed by medical staff who have received training and demonstrated clinical competency regarding use of this catheter." Types of Hemodialysis Catheters: 1. AVF ... AVG (arteriovenous graft) ... Central catheters [Permacatheter]. NJAC 8:39-27.1(a)	F 698		
F 880 SS=D	Infection Prevention & Control	F 880		11/21/24

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F 880	Continued From page 18 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 19 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to consistently perform hand hygiene to prevent the spread of potential infection. This deficient practice was identified for 1 of 2 licensed nurses observed during the medication administration observation, and for 2 staff members observed assisting during the meal service and was evidenced by the following:	F 880	1. The U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were all immediately educated, on 10/21/24 at 3:00 PM by the Director of Nursing regarding proper hand hygiene as well as proper hand washing technique. 2. All residents have the potential to be affected.	

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F 880	Continued From page 20 1. On 10/22/24 at 8:27 AM, Surveyor #1 observed a US FOIA (b)(6) during the medication administration pass. The US FOIA (b) was observed to enter a resident bathroom, turn on the water, applied soap to her hands, and washed her hands under the stream of water for 12 seconds. Next, the US FOIA (b) dried her hands and used a paper towel to turn off the water. On 10/22/24 at 8:53 AM, the same US FOIA (b) was observed in another resident bathroom. She turned on the water, applied soap, applied friction for 8 seconds outside the flow of water and next proceeded to wash her hands for 13 seconds under the flow of water. On 10/22/24 at 9:09 AM, the US FOIA (b) stated that the procedure for hand washing was to turn on the water, use soap and wash for 10 to 15 seconds "outside the stream of water to kill germs", rinse the hands, use a paper towel to dry her hands, and a new paper towel to turn off the water. When asked about the two observations, the US FOIA (b) stated, "I don't know why I did it that way." A review of the facility provided, "Medication Pass Observation" dated 09/17/2024, included but was not limited to; "10. Hand washing (alcohol-based hand rub or soap and water per facility policy) ... c. between every resident even if patient contact is not made." The medication observation was for the US FOIA (b) and signed that the US FOIA (b) successfully performed hand hygiene. A review of the facility provided policy and procedure, "Administering Medications" revised April 2019, included but was not limited to; "25. Staff follows established facility infection control	F 880	3. The Infection Preventionist/Designee educated all facility employees on infection control, proper hand hygiene and proper hand washing technique. Orientation and annual education for all staff will include education regarding proper hand hygiene and as well as proper hand washing technique. Orientation and annual education for all staff will continue to include infection control education. The Director of Nursing/Infection Preventionist/Designee will continue to make rounds daily to ensure staff have proper hand hygiene practices and as well as proper hand washing technique 4. The Infection Preventionist/designee will observe hand hygiene of 3 employees (to include nursing and activities departments) to ensure proper hand hygiene and proper hand washing technique. Audits will continue weekly x4 weeks. Findings of the audit will be presented at the QAPI committee until sustained compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315299	A. BUILDING _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE 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
F 880	Continued From page 21 procedures (e.g. handwashing, ...) for the administration of medications, as applicable." 2. On 10/21/24 at 12:14 PM, Surveyor #1 observed a staff member identified as the U.S. FOIA (b) (6)) enter the dining room with a NJ Ex Order 26.4(b)(1). She attached the NJ Ex Order 26.4(b)(1) on the back of a resident's wheelchair. The U.S. FO then touched the resident's back then without performing hand hygiene (HH) went to the front of the dining room to the drink cart and poured two sodas that were distributed to residents. On 10/21/24 at 12:19 PM, the U.S. FO used her hands to open a drink container for a resident, then without first performing hand hygiene, she went to another table, Table 7, and placed both her bare hands on the table while speaking to the residents. On 10/22/24 at 11:26 AM, Surveyor #2 observed the lunch meal in the facility dining room. Surveyor #2 observed a US FOIA (b)(6) was wearing gloves, removed her gloves and discarded the gloves in the trash next to Surveyor #2. The US FOIA (b) failed to perform HH, and proceeded to assist residents at a table of three by opening the hand wipes for each and washing their hands, and without first performing HH she began opening drinks and assisting with the meal set up. The US FOIA (b) left the used dirty hand wipes that the residents used on the table and walked away. On 10/22/24 at 11:57 AM, Surveyor #1 observed the US FOIA (b) pour a resident's milk and place a spoon on the plate. The US FOIA (b) next, without first performing HH, tried to place a NJ Ex Order 26.4(b)(1)	F 880		

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F 880	Continued From page 22 on another resident at the same table. She then sat next to the first resident and used her bare hand to brush away the residents hair. The [redacted] had not performed any hand hygiene in between residents. On 10/22/24 at 12:01 PM, Surveyor #1 observed the [redacted] deliver a grilled cheese sandwich to a resident. The [redacted] next walked to supply closet for a cup, poured water and delivered the water to another resident without first performing HH. On 10/22/24 at 12:21 PM, during an interview with Surveyor #1, the [redacted] stated that HH must be performed by staff upon entering the room, during passing out meals, "absolutely yes use [HH] between different residents". She stated the purpose of hand hygiene was to stop the spread of infection. The [redacted] stated that the hand washing process was to use friction for 20-30 seconds. She further stated that friction for 20 seconds was to be performed outside the stream of water, so the soap is not rinsed off. On 10/22/24 at 12:29 PM, the [redacted] stated, "it's my fault I'm just too quick" when asked about performing hand hygiene in between residents and tasks. On 10/22/24 at 12:33 PM, the [redacted] stated the process was to use hand hygiene in between residents and when hands were visibly dirty. A review of the facility provided, "Hand Hygiene Competency Validation" dated 09/04/24, revealed that the DA had performed the competency successfully and was signed.	F 880		

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F 880	Continued From page 23 A review of the facility provided, "Hand Hygiene Competency Validation" dated 02/06/24, revealed the CNA performed the competency successfully and was signed. A review of the facility provided, "Hand Hygiene" policy and procedure revised 04/26/24, included but was not limited to; Purpose: prevent the spread of infection and to ensure the safety of employees, residents, vendors, and visitors. Handwashing: "hands should be washed for at least 20 seconds" ... "wash your hands for at least 20 seconds" Hand Hygiene: ... "before and after contact with a resident, equipment, food or drink, medication, soiled material, objects in the immediate vicinity of a resident ... before, after, and during preparing food or drink". NJAC 8:39-19.4(a); 27.1(a)	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/22/2024 in the presence of the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that the call bell system was properly	F 919	1. The call bell button for room #[redacted] window was immediately fixed. No residents were affected as this room was vacant.	11/15/24

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F 919	Continued From page 24 functioning in 1 of 5 tested rooms and was evidenced by the following: An observation at 1:45 PM revealed, the call bell button for room [NJ Ex] window bed did not function when tested by the [U.S. FOIA (b) (6)] The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e)	F 919	2. All residents have the potential to be affected. All other call bells in the facility were checked and found to be in proper functioning condition. 3. The administrator in serviced the maintenance team on the importance of ensuring that the call bell at each bed is properly functioning. The Maintenance Director/Designee will continue to complete facility rounds and call bell function audits weekly to ensure call bells are functioning properly. Admissions/Designee will continue to check vacant rooms for readiness prior to placing admission or room changes into any room. Readiness checks include checking call bell for proper function. 4. The maintenance director/designee will audit weekly for 4 weeks to ensure that the call bell system and all call bells are functioning properly. Findings of the audit will be presented at the QAPI committee until sustained compliance is achieved.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061341	A. BUILDING: _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CE	2303 WEST BANGS AVE NEPTUNE, NJ 07753

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S 000	Initial Comments Complaint #:168449, 178432, 171700, 178432 Survey Date: 10/25/24 Census: 87 Sample: 21 + 2 (closed Records) = 23 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and a 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:	S 560	1. The facility leadership team has met on ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified staffing needs. Staffing coordinator was immediately reeducated by the administrator on the staffing guidelines as	11/15/24

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

Electronically Signed — 11/06/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061341	A. BUILDING: _____ B. WING _____	C 10/25/2024

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S 560	Continued From page 1 Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.	S 560	mandated by the state of New Jersey. 2. All residents have the potential to be affected. No residents were identified as having been affected. 3. The Administrator educated the staffing coordinator on the New Jersey staffing requirements. The facility offers competitive rates for nurses and certified nursing assistants, sign on bonuses to new staff and referral bonuses for employees referring staff. The facility has an expedited onboarding process for new hires. As well as offering immediate interviews and contingency offers. The facility will use agency staff as needed to meet staffing needs/requirements. The facility is contracted with several agencies to ensure highest probability of filling schedule openings. Advertisement / Job postings for CNAs have been posted on social media websites as well as flyers posted in local supermarkets and stores that we are hiring. The facility implemented an incentive program including bonuses for picking up shifts to current facility staff. The facility continues to make every effort to recruit and retain staff in this very competitive and struggling market.	

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S 560	Continued From page 2 c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks of staffing prior to survey from 10/06/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -10/06/24 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs. -10/12/24 had 7 CNAs for 84 residents on the day shift, required at least 10 CNAs.	S 560	The Director of Nursing/Designee meets with the staffing coordinator daily to review facility census, call outs if any, and staffing needs to meet required ratios. 4.The Staffing Coordinator/Designee will audit call outs and staffing ratios daily until the staffing requirements are consistently met. The results of the audits will be forwarded to the facility Administrator and QAPI Committee for further review and recommendations as needed, until sustained compliance is achieved.	

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 3 -10/13/24 had 7 CNAs for 84 residents on the day shift, required at least 10 CNAs. -10/19/24 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs. On 10/23/24 at 11:33 AM, the surveyor interviewed a certified nurse aide (CNA) on the Wedgewood Unit, who has been working in the facility for eight years regarding staffing. The CNA stated, we work short sometimes once a week on 7-3 shift. Usually, they find someone and if not, we do the best we can, but they do try to find help and the weekends are the same. On 10/25/24 at 9:15 AM, the ALNHA provided the most current Policy and Procedure titled "Staffing" revised in October 2017 which revealed, "Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care."	S 560		

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
315299 Y1	A. Building B. Wing Y2	1/2/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE 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 F0677	Correction	ID Prefix F0684	Correction	ID Prefix F0686	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	11/15/2024	LSC	11/15/2024	LSC	11/15/2024
ID Prefix F0698	Correction	ID Prefix F0880	Correction	ID Prefix F0919	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(g)(1)(2)	Completed
LSC	11/21/2024	LSC	11/21/2024	LSC	11/15/2024
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	

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?
10/25/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061341 Y1	A. Building B. Wing Y2	1/2/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/15/2024	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/25/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315299	A. BUILDING **01** B. WING _____	**10/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	**2303 WEST BANGS AVE** **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 An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 10/22/2024 thru 10/23/2024. Daughters of Israel was found to be in non compliance with 42 CFR 483.73.	E 000		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E 006		12/13/24

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

Electronically Signed | 11/06/2024

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
	315299	A. BUILDING **01** B. WING _____	**10/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	**2303 WEST BANGS AVE** **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 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 10/22/2024 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 that an annual, documented, facility-based and community -based risk assessment was	E 006	1) The facility updated the Emergency preparedness book on 11/6/24 with an updated annual facility-based and community-based risk assessment. 2) All residents can be affected by this practice.	

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E 006	Continued From page 2 conducted and provided in the Emergency Preparedness book. This deficient practice had the potential to affect all residents and was evidenced by the following: Documentation review revealed that the EP book did not contain an annually updated facility-based and community -based risk assessment risk. In an interview at the time the U.S. FOIA (b) (6) confirmed that an annually updated risk assessment was not conducted or provided in the Emergency Preparedness book. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 1:30 PM.	E 006	3) The U.S. FOIA (b) (6) was educated on the importance of ensuring the Emergency preparedness book contains an annually updated facility-based and community-based risk assessment. 4) The Maintenance Director or his designee will audit monthly for 3 months to ensure Emergency preparedness book contains an annually updated facility-based and community-based risk assessment and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved.	
E 037 SS=F	N.J.A.C 8:39-31:2(e) EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		12/13/24

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E 037	Continued From page 3 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 4 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training	E 037		

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E 037	Continued From page 5 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 6 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 10/23/2024 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 that staff were provided with EP training annually and	E 037	1) The facility initiated annual Emergency Preparedness training and documentation filing of training for all employees on 11/12/24 and it was completed on 11/13/2024.	

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E 037	Continued From page 7 documentation of the training is maintained. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed that annual EP training was not conducted. In an interview at the time, the U.S. FOIA (b) (6) confirmed that staff are trained upon hire but could not provide documentation that staff were trained annually and would implement annual training and documentation of the training as soon as possible . The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31.2(e)	E 037	2) All residents can be affected by this practice. 3) The U.S. FOIA (b) (6) educated the [redacted] the importance of ensuring all employees are provided with annual training on emergency preparedness and that this education is documented and maintained. 4) The Administrator/Designee will audit monthly for 3 months to ensure all employees have been provided with annual Emergency Preparedness training and that documentation of the training is maintained. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved.	
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 10/22/24 and 10/23/24 and King Manor 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. King Manor is a single-story, Type I Fire Resistant building with a basement area that was built in January 1967. The facility is divided into 7 smoke zones. The facility has one Diesel emergency generator with an above ground tank. The emergency generator provides power to 70% -	K 000		

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K 000	Continued From page 8 80% of the building as per Director of Maintenance. King Manor has 2 dumbwaitters.	K 000		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 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 observations and interview on 10/23/2024 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 that a sign with directional indicator showing the direction of travel was provided in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:00 AM revealed upon exiting the dining room, the directional indicator on the exit sign in front of the lobby area doors pointed away from the nearest exit. An observation at 10:05 AM revealed upon exiting zone 11 near the dietary office, there was no visible directional signage that leads to an exit	K 293	1) An exit sign was changed where the directional indicator showed the nearest exit. Also, there was an exit sign put up showing directional signage that leads to an exit. 2) All residents can be affected by this practice 3) The Administrator and the Assistant Administrator did a review of the entire building with the Maintenance Director and identified that these are the only 2 locations that have failure with signage showing directional travel to proper exit. 4) The Maintenance Director or his designee will audit monthly for 3 months to ensure that a sign with directional indicator showing the direction of travel is provided in every location where the	12/13/24

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K 293	Continued From page 9 when facing to the left. In interviews at the time, the [U.S. FOIA (b)] and [U.S. FC] confirmed the observations. The facility's [U.S. FOIA (b) (6)] was informed of the deficient practices at the Life Safety Code exit conference at 1:30 PM.	K 293	direction of travel to reach the nearest exit and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved	
K 324 SS=F	N.J.A.C 8:39-31:2(e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		12/13/24

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K 324	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/23/2024 in the presence of the U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to ensure that cooking facilities were protected and complied with the conditions of NFPA 101:2012 Edition, Sections 19.3.2.5.4 and 19.3.2.5.3(1) through (10) and (13). This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:37 AM revealed that there was a residential 4 burner cooking range in the OT/PT room. In an interview at the time, the surveyor asked if the stove was functional or just a prop for rehab and requested a copy of the facility's policies and procedures for use of the cooking range. The U.S. FOIA (b) stated that it was functional and could be turned on. The surveyor asked if there were any protective devices such as a timer, keyed switch, locked switch, or a switch in a restricted location that deactivates the cooktop or range. The U.S. FOIA (b) and U.S. FOIA (b) were unsure. The U.S. FOIA (b) stated that there was a switch but was unsure exactly were it was located. Approximately 3 minutes later while heading out of the OT/PT room, the U.S. FOIA (b) was able to locate a switch that turned off the cooking range after emptying out the cupboard next to it. The switch was not on a timer to deactivate the cooktop independent of staff action.	K 324	1) Upon being made aware of the deficient practice the facility disabled the operation of the 4 burner cooking range in the OT/PT room. 2) All residents can be affected by this practice. 3) The Maintenance Director did an audit to ensure there are no other cooking ranges located in resident areas in the facility. 4) The Maintenance Director or his designee will audit monthly for 3 months to ensure that there are no other cooking ranges located in resident areas in the facility and submit his findings to the Administrator on a quarterly basis. The Administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved.	

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K 324	Continued From page 11 In an interview at 11:27 AM, the [U.S. FOIA (b)] was asked who used the cooking range. The [U.S. FOIA (b)] stated that patients used it to practice their ADLS by making grilled cheese sandwiches with assistance from OT/PT staff. The [U.S. FOIA (b)] also stated that the Activities department used the cooking range as well, to make items for LTC residents. The facility's policies and procedures on usage of the cooking range were not provided. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e) NFPA 96	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 10/22/2024 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 that semi-annual fire alarm inspections and	K 345	1) A sensitivity test was scheduled and it was completed on 11/11/24. 2) All residents can be affected by this practice.	12/13/24

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K 345	Continued From page 12 smoke detector sensitivity testing were conducted in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed fire alarm inspections were conducted on 8/30/23 and 9/13/24. The required semi-annual inspections were not conducted and neither report referenced smoke detector sensitivity testing. In an interview at the time the U.S. FOIA (b) (6) stated that he would get in contact with the fire alarm company and find out if smoke detector sensitivity testing was conducted. No further documentation regarding the fire alarm was provided. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e) NFPA 70, 72	K 345	3) The US FOIA (b)(6) did an in service with the US FOIA (b)(6) on the importance of having a semi-annual fire alarm inspections and ensuring a sensitivity testing for smoke detectors is conducted timely. 4) The Maintenance Director or his designee will audit monthly for 3 months and then quarterly for 2 quarters to ensure that semi-annual fire alarm inspections and sensitivity testing for smoke detectors are conducted timely. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on	K 355	1) The fire extinguishers near room 9, 39,	12/13/24

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(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 355	Continued From page 13 10/23/2024 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 that Class K portable fire extinguishers were provided with the required instructional signage and that fire extinguisher mounting locations were conspicuously marked so that they are highly visible even from a distance in accordance with NFPA 101:2012 Edition, Sections 9.7.5, NFPA 10:2010 Edition, Sections 6.1.3.1, 6.1.3.3.2, 5.5.5.3, and A 5.5.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 9:27 AM and 9:35 AM revealed the fire extinguishers near room 9, 39 and 47 were not provided with a means to identify their location from a distance. An observation at 9:45 AM revealed the kitchen contained two Class K fire extinguishers that were not provided with a placard near the extinguisher that stated that the fire protection system shall be actuated prior to using the fire extinguisher. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e) NFPA 10	K 355	47 will be provided a means to identify their location from a distance. The 2 class K fire extinguishers will be provided a placard near the extinguishers stating that the fire protection system shall be actuated prior to using the fire extinguisher. 2) All residents can be affected by this practice 3) The Administrator did a review of the entire building with the Maintenance Director & identified that these are the only 2 class K fire extinguishers in the facility. An audit will be conducted for all fire extinguishers that don't have a means to identify their location from a distance. 4) The Maintenance Director or his designee will audit monthly for 3 months to ensure all class K portable fire extinguishers are provided instructional signage, as well as all fire extinguishers mounting on walls are conspicuously marked so that they are highly visible even from a distance and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		12/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315299	A. BUILDING 01 B. WING	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE NEPTUNE, NJ 07753

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K 372	Continued From page 14 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/22/2024 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 that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105, and NFPA 80:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:08 PM revealed the smoke barrier wall near the dietary office contained an approximately 3-inch by 3-inch unprotected penetration. An observation at 1:29 PM revealed the smoke barrier wall near room 49 contained an approximately 4-inch by 4-inch unprotected penetration.	K 372	1) The hole in the smoke barrier wall near the dietary office was filled with NJ Exc Fire Barrier CP25WB+ Sealant and there is no more unprotected penetration through the smoke/fire barrier. The hole smoke barrier wall near room 49 was filled with NJ Exc Fire Barrier CP25WB+ Sealant and there is no more unprotected penetration through the smoke/fire barrier. The hole in the smoke barrier wall near room 40 was filled with NJ Exc Fire Barrier CP25WB+ Sealant to ensure there is no more unprotected penetration through the smoke/fire barrier. 2) All residents can be affected by this practice 3) The administrator did a review of the entire building with the Maintenance Director & identified that these are the only 3 locations that have unprotected penetration through the smoke/fire barrier doors.	

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	315299	A. BUILDING 01 B. WING _____	10/25/2024

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KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE NEPTUNE, NJ 07753

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K 372	Continued From page 15 An observation at 1:45 PM revealed the smoke barrier wall near room 40 contained an approximately 1-inch by 6-inch unprotected penetration. In interviews at the time, the [U.S. FOIA (b)] confirmed the observations. The facility's [U.S. FOIA (b) (6)] was informed of the deficient practices at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e) NFPA 105	K 372	4) The Maintenance Director or his designee will audit monthly for 3 months to ensure that penetrations through the smoke/ fire barriers are protected by a system or materials capable of restricting the transfer of smoke and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved.	
K 374 SS=F	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 observation and interview on 10/22/24 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 that	K 374	1) The food tray carts were removed from the smoke barrier doors so that they can close into their frames.	12/13/24

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	315299	A. BUILDING 01 B. WING _____	10/25/2024

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K 374	Continued From page 16 smoke barrier doors closed into their frames and were kept clear of anything that could interfere with the free operation of the door in accordance with NFPA 101:2012 Edition, Sections 19.3.7.6, 19.3.7.8, 19.3.7.9, NFPA 105 sections 5.2.2.1 and 5.2.2.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:08 PM revealed the pair of smoke barrier doors near the dietary office were both being blocked from closing by food tray carts. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e) NFPA 105	K 374	2) All residents can be affected by this deficient practice 3) The administrator or designee will in-service the staff on the importance of keeping the smoke barrier doors clear of anything so that they can close into their frames. 4)The Maintenance Director or his designee will audit monthly for 3 months to ensure that all smoke barrier doors can close into their frame properly and that they are clear of anything that can interfere with the free operation of the door and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved	
K 532 SS=F	Escalators, Dumbwaiters, and Moving Walks CFR(s): NFPA 101 Escalators, Dumbwaiters, and Moving Walks 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is	K 532		12/13/24

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K 532	Continued From page 17 being loaded or unloaded.) 19.5.3, 9.4.2.2 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 10/23/2024 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 that existing dumbwaiters were inspected annually in accordance with NFPA 101:2012 Edition, Section 9.4.2.2 and ASME A17.3, Safety Code for Existing Elevators and Escalators. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed that 2 of 2 dumbwaiters were last inspected on 2/9/2022 and their certificates of occupancy/compliance expired on 2/9/2023, over 20 months ago. In an interview at the time, the U.S. FOIA (b) (6) confirmed that they were overdue for an inspection and stated that have unsuccessfully attempted to contact someone for the inspections. No further documentation was provided regarding annual elevator inspections. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e) ASME A17.3	K 532	1) The state elevator safety unit was contacted to perform an annual inspection on the dumbwaiters in accordance with NFPA guidelines and the inspection was completed on 11/7/24. 2) All residents can be affected by this practice. 3) The U.S. FOIA (b) (6) was educated on the importance of ensuring an annual inspection on the dumbwaiters are conducted in a timely fashion. 4) the Maintenance Director or his designee will audit quarterly for 4 quarters and then Annually to ensure inspections for the dumbwaiters are conducted timely and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		12/13/24

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K 761	Continued From page 18 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/23/2024 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 that all fire door assemblies were inspected and tested annually in accordance with NFPA 80 Standard for Fire Door and Other Opening Protectives. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:05 AM revealed the stairway enclosure that leads down to the basement area contained a fire rated door assembly. In an interview at the time, the U.S. FOIA (b) confirmed the observation. A documentation review revealed the monthly inspections did not cover the minimum requirements of NFPA 80 annual inspections and the fire rated door assembly leading to the	K 761	1) The door that leads down to the basement was inspected on 11/6/24 in accordance with NFPA 80 standard for fire door and other opening protectives. 2) All residents can be affected by this deficient practice 3) The U.S. FOIA (b) (6) will be educated to ensure that all fire door assemblies are inspected and tested annually in accordance with NFPA 80 standards for fire door and other opening protectives. 4) The Maintenance Director or his designee will audit monthly to 3 months to ensure that all smoke barrier doors are checked monthly in accordance with NFPA 80 and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results	

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K 761	Continued From page 19 basement area was not included on the list of inspected doors. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e) NFPA 80	K 761	to the Quarterly QAPI committee meeting until sustained compliance is achieved.	
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 10/23/2024 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 that electrical panels were guarded to prevent unauthorized access, tampering, or potential hazards in resident accessible areas in accordance with NFPA 101: 2012 Edition, Sections 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99:2012 Edition, Sections 6.3.2.1, 15.5.1.2 and NFPA 70:2011 Edition, Sections 110.26, 110.27 and 110.16. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:42 AM revealed that 3 of 3	K 911	1) New locks were purchased and installed for the 3 electrical panels in the hallway near room 42 to ensure they are locked at all times. 2) All residents can be affected by this practice 3) The Maintenance Director did a review of the entire building & identified that these are the only 3 panels that were unguarded to prevent unauthorized access, tampering, or potential hazards in resident accessible areas. 4)The Maintenance Director or his	12/13/24

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K 911	Continued From page 20 electrical panels in the corridor hallway near room 42 were unlocked. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e) NFPA 70, 99	K 911	designee will audit monthly for 3 months to ensure that all electrical panels are guarded to prevent unauthorized access, tampering, or potential hazards in resident accessible areas and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved.	
K 928 SS=F	Gas Equipment - Labeling Equipment and Cylind CFR(s): NFPA 101 Gas Equipment - Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL." Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/23/2024 in the presence of the U.S. FOIA (b) (6)	K 928	1) The facility installed 2 holding racks for oxygen, one for full tanks and one for	12/13/24

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K 928	Continued From page 21 U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6) it was determined that the facility failed to ensure that when empty and full oxygen cylinders were stored in the same enclosure, empty cylinders were marked to avoid confusion and delay in accordance with NFPA 99: 2010 Edition, Sections 11.6.5.2 and 11.6.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:52 AM revealed that the oxygen transfilling room contained both filled and empty E-tank cylinders and portable liquid oxygen tanks. A handwritten sign was posted on the wall behind the door for placement of empty cylinders. There were 2 empty and 1 filled E-tank behind the door. On the right side of the room there were 2 full and 2 empty E-tanks. Hanging on the wall on the right side of the room were 4 empty and 2 filled portable liquid oxygen tanks. In an interview at the time, the U.S. Fo confirmed the observations and stated that the empty containers should be on the left side of the room behind the door and the filled containers should be on right. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e) NFPA 99	K 928	empty tanks on 11/27/2024. Proper clear signage was hung on 11/27/2024 to differentiate between full and empty racks. 2) All residents can be affected by this deficient practice 3) Nursing staff will be educated on properly placing empty and full oxygen tanks in the proper location. 4) The Maintenance Director or his designee will audit monthly for 3 months to ensure that all oxygen tanks are placed in the proper location and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting until sustained compliance is achieved.	

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
315299 Y1	A. Building B. Wing Y2	1/2/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE 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 E0006	Correction	ID Prefix E0037	Correction	ID Prefix	Correction
Reg. # 483.73(a)(1)-(2)	Completed	Reg. # 483.73(d)(1)	Completed	Reg. #	Completed
LSC	12/13/2024	LSC	12/13/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/25/2024	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315299 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/2/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
KING MANOR CARE AND REHABILITATION CENTER	2303 WEST BANGS AVE NEPTUNE, NJ 07753

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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 K0293	12/13/2024	LSC K0324	12/13/2024	LSC K0345	12/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	12/13/2024	LSC K0372	12/13/2024	LSC K0374	12/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0532	12/13/2024	LSC K0761	12/13/2024	LSC K0911	12/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0928	12/13/2024	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 10/25/2024

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