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 06/15/2023

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 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint NJ #: 153047; 155078; 161130 Survey Date: 6/15/23 Census: 80 Sample: 22 + 2 + 3 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain a homelike environment that accommodated resident needs and preferences. This deficient practice was identified for 1 of 22 residents reviewed (Resident	F 558	1. Upon being made aware of the deficient practice, resident #59 was moved into another room to accommodate the residents needs. Interdisciplinary Team escorted resident #59 to the new room. The resident was	7/17/23

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

Electronically Signed | 07/03/2023

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 558	Continued From page 1 #59) and was evidenced by the following: On 6/6/23 at 10:46 AM, the surveyor observed Resident #59 attempting to navigate their room. Resident #59's bed was located closest to the door. Due to their height, the resident's bed was NJ Exec Order 26.4b1 . In order to get to the opposite side of the bed, the surveyor observed Resident #59 remove the bed NJ Exec Order 26.4b1 in their wheelchair past the foot of the bed, then reattach the NJ Exec Order 26.4b The surveyor reviewed the medical record for Resident #59. A review of the Admission Record face sheet (an admission summary) reflected the resident was NJ ex order 26.4b1 , with diagnoses which NJ ex order 26.4b1 A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b , reflected a brief interview for mental status (BIMS) score of NJ ex out of 15, which indicated a NJ ex order 26.4b1 . On 6/9/23 at 10:39 AM, the surveyor interviewed Resident #59's unsampled roommate, who confirmed that resident was not able to easily access the entirety of the room. The roommate also confirmed that they have witnessed Resident #59 remove the NJ Exec Order 26.4b1 to get past their bed. On 6/13/23 at 10:43 AM, the surveyor interviewed Resident #59 who agreed that they had a difficult	F 558	moved into a NJ Exec Order 26.4b1 . The resident was acclimated to the surroundings and was able to demonstrate access to bathroom and closet. 2. All Residents can be affected by this deficient practice. 3. Director of rehabilitation did a complete audit in the building to ensure that all residents needs are being accommodated for. Specifically, mobility. 4. The Director of Rehabilitation will conduct a monthly audit for 3 months to ensure that all residents rooms can accommodate mobility around the room. Findings of the audit will be presented at the Quarterly QAPI meeting. Action plans for any negative findings will have a plan to monitor finding (s) put into place for additional 3 months and reported to the Quarterly QAPI meeting. Once successful resolution has been established this area will be audited once per quarter for the remainder of the year with a report to the Quarterly QAPI meetings.	

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F 558	Continued From page 2	F 558		

time getting around the room. When asked if they were able to open the bathroom door all the way, Resident #59 stated "no". The surveyor observed the closed bathroom door that was located directly across from the foot of Resident #59's bed. The surveyor tested the bathroom door. When in the opened position, the door was obstructed by the [redacted] which blocked the passage to the room.

On 6/13/23 at 11:20 AM, the surveyor interviewed the Director of Rehabilitation (DOR) who confirmed that nursing should identify if a room was not accessible or if there were accessibility concerns. The DOR advised that the process for environmental evaluations was "situational", and they could be notified of any concerns through various means. The DOR indicated that room accessibility was important for the resident's quality of life and that the facility does not "want to take away any accessibility." The DOR continued to state that a room modification would make residents more independent in the room and prevent any fall or injury.

On 6/14/23 at 8:35 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that part of their role and responsibility was to make sure residents can "get around the room". When asked if the bathroom doors were supposed to be able to open all the way CNA #1 responded, "yes and make sure there is obstruction in the way."

On 6/14/23 at 8:47 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who confirmed that resident rooms were to be wheelchair accessible meaning that residents in wheelchairs were able to easily navigate the

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F 558	Continued From page 3	F 558		

room. When asked if the bathroom door should be able to be opened all the way CNA #1 stated, "yes it should."

On 6/14/23 at 8:55 AM, the surveyor interviewed Unit Manager/Registered Nurse (UM/RN) who stated that the resident should not have to force the bathroom door open. The UM/RN confirmed that the bathroom door should open all the way and residents should not have to remove a bed extension in order to access the entirety of their room. When asked who had the responsibility to ensure that resident rooms were wheelchair assessable, UM/RN responded, "everyone is responsible and, of course, the aide is the one that would report first thing." The UM/RN stated they were not aware of any issues with Resident #59's room. In the presence of the surveyor, the UM/RN attempted to open Resident #59's bathroom door. The UM/RN confirmed that the door did not open all the way. At this time, the DOR and UM/RN together confirmed that the bathroom door should open all the way to allow access for Resident #59 and the roommate.

On 6/15/23 at 9:44 AM, the Licensed Nursing Home Administrator (LNHA) confirmed that their expectation for resident rooms and wheelchair accessibility was that rooms "should always be accessible." The LNHA further confirmed that residents should not have to remove a bed extension to access their room and bathroom doors should not be obstructed when opening.

A review the facility's "Homelike Environment" policy dated November 2021, included...1. Staff provides person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences...

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F 558	Continued From page 4 A review the facility's "Accommodation of Needs" policy dated March 2021, included...1. The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. 2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis. 3. In order to accommodate individual needs and preferences, adaptions may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. 4. In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well being to the extent possible and in accordance with residents' wishes... NJAC 8:39-4.1(a)11	F 558		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		7/24/23

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F 761	Continued From page 5 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain medication carts free from unmarked and unwrapped medications and b.) accurately document the administration of controlled medications on the Controlled Drug Administration Record Tablet (declining inventory sheet) for an unsampled resident. This deficient practice was identified for 1 of 2 medication carts on 1 of 2 nursing units (Wedgewood low- side) and was evidenced by the following: On 6/6/23 at 12:53 PM, the surveyor in the presence of the Licensed Practical Nurse (LPN) inspected the Wedgewood nursing unit's low-side medication cart and observed the following: 1. Inside the top drawer on the right side of the medication cart, a small plastic medication cup which contained two unmarked tablets. At this time, the LPN identified the tablets as an iron supplement and repaglinide (diabetic medication)	F 761	1. Upon being made aware of this deficient practice, the LPN was in-serviced by the unit manager on maintaining medication cart free from unmarked and unwrapped medication. The unit manager also in-serviced the LPN on accurately documenting the administration of Controlled Drug Administration Record Tablet (declining inventory sheet). 2. All residents can be affected by this deficient practice. 3. All Licensed practical Nurse/registered nurses were in-serviced by the Director of Nursing / Designee on maintaining the medication cart free from unmarked and unwrapped medication and accurately documenting the administration of Controlled Drug Administration Record Tablet (declining inventory sheet). 4. The Director of Nurses/ Designee will audit for compliance weekly for 4 weeks then once monthly for 5 months then	

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F 761	Continued From page 6 that she had just poured into the cup for an unsampled resident and meant to administer it, but "got busy." 2. A review of the narcotic medication located in the secured and locked narcotic box, when the narcotic medication inventory was compared to the corresponding Controlled Drug Record Tablet (declining inventory sheet), the surveyor identified an unsampled resident's oxycodone/acetaminophen 5/325 milligram (mg) tablets, a medication used for pain, did not match. The blister pack contained 22 tablets and the declining inventory sheet indicated there should be 23 tablets remaining. At this time, the surveyor interviewed the LPN who stated that she administered the unsampled resident's oxycodone at 11:30 AM, and forgot to sign the declining inventory sheet. The LPN further stated that her regular practice was to sign the declining inventory sheet after she administered the medication. On 6/6/23 at 1:22 PM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) who stated when the nurse removed the controlled medication from the blister pack in inventory, they immediately signed the declining inventory sheet which indicated the medication had been removed from inventory. The UM/RN continued that once the medication was administered to the resident, the nurse signed the Medication Administration Record (MAR) to document the resident received the medication. The UM/RN acknowledged the LPN should have signed the declining sheet immediately after removing the medication from inventory. On 6/13/23 at 1:45 PM, the surveyor informed the	F 761	every quarter for the remainder of the year. Action plan for any negative finding/ findings will have a plan to monitor the finding/ findings put into place for 3 additional months and reported to the quarterly QAPI meetings. Once a successful resolution has been established these areas will be audited once quarterly for the remainder of the year.	

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F 761	Continued From page 7 Licensed Nursing Home Administrator (LNHA), Assistant Licensed Nursing Home Administrator (ALNHA) and Director of Nursing (DON) the above concerns. The DON confirmed the nurse should have signed the declining inventory sheet for the oxycodone when she removed the medication from inventory, and not after she administered the medication to the resident. On 6/15/23 at 9:43 AM, the LNHA in the presence of the DON, ALNHA, and survey team confirmed that once medication was removed from its packaging, it should immediately be administered to the resident and not stored in a medication cup in the medication cart. A review of the facility's "Controlled Substances" policy dated revised November 2022, included...controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-u ...the system of reconciling the receipt, dispensing and disposition of controlled substances includes...declining inventory records... A review of the facility's undated "Storage of Medications" policy included...the facility stores all drugs and biologicals in a safe, secure, and orderly manner...drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received... NJAC 29.4 (a),(h)	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		7/17/23

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F 812	Continued From page 8 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to maintain kitchen equipment in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 6/6/23 at 10:01 AM, the surveyor toured the kitchen with the Food Service Director (FSD). The surveyor observed the following: In the meat kitchen hanging above the tray serving line on a utensil rack, one large and one medium rubber spatula. The spatulas were both cracked and discolored, and the medium rubber spatula was missing rubber in parts. The FSD confirmed the spatulas should not be in use. In the dairy kitchen hanging above the tray	F 812	1. Upon being made aware of this deficient practice, the 3 spatulas in the kitchen were immediately replaced. The 6 cutting boards were thrown away and replaced as well. 2. All residents have the potential to be affected by this deficient practice. 3. All dietary staff have been in-serviced by the Dietary director on prevention of microbial growth on food contact surfaces in the kitchen. 4. The food service director will be doing a monthly audit to ensure that all equipment is being maintained properly for 3 months. Findings of said audit will be presented at quarterly QAPI meetings. Once successful, resolution has been established the kitchen will be audited	

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F 812	Continued From page 9 serving line on a utensil rack, one large rubber spatula cracked and discolored. The FSD confirmed the spatula should not be in use. On a rack, two large white, one medium green, one medium yellow, and one medium red cutting boards all discolored and pitted. There was also a tan rubber cutting board discolored black. The FSD stated cutting boards were changed as needed and she had not changed the cutting boards since she started at the facility in February of 2023. The FSD confirmed the cutting boards needed to be replaced because of concern for contamination and could harbor bacteria. On 6/15/23 at 9:43 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Assistant Licensed Nursing Home Administrator (ALNHA), and survey team, acknowledged the above concerns. A review of the facility provided undated "Food Contact Surfaces" policy included...replace cutting boards that become deeply scratched, carved or grooved. Boards that are scored, gouged and chipped are no longer cleanable and therefore cannot be effectively cleaned and sanitized. Other food contact items, such as smallwares, cooking/serving utensils and pots and pans should also be monitored for such wear and tear. If present these items should be replaced as well. NJAC 8:39-17.2(g)	F 812	once per quarter for the remainder of the year, with a report to Quarterly QAPI meetings.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		7/17/23

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F 921	Continued From page 10 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain a safe and sanitary environment for 3 of 50 residents' rooms for hand sinks (Resident Room #1, #17, and #23). The deficient practice was evidenced by the following: On 6/6/23 at 9:32 AM, the surveyor observed in Resident Room #1, the cabinet sink in the bathroom was in a state of disrepair. The front of the cabinet had missing laminate covering that had exposed the particle board. The doors to the cabinet were misaligned, had a missing handle, and the laminate covering was missing, which exposed the particle board on the doors. On 6/6/23 at 10:45 AM, the surveyor observed in Resident Room #17, the molding in the front of the hand sink was missing and the wood was separated, exposing the particle board. The vertical molding of the sink was missing exposing the wood from the sink to the floor. On 6/623 at 11:34 AM, the surveyor observed in Resident Room #23, the front of the hand sink had missing molding exposing the particle board. The vertical molding of the sink was missing exposing wood from the sink to the floor. On 6/12/23 at 1:41 PM, the surveyor interviewed	F 921	1. Upon being made aware of this deficient practice the facility made the necessary repairs. Room #1 vanity and sink were replaced. Room #17 front sink wood and molding replaced. Room #23 front sink wood and molding replaced. All these repairs were made by the maintenance department. 2. All residents within the facility have the potential to be impacted by this deficient practice. 3. Maintenance staff have been in serviced by administrator as to the importance of identifying and documenting environmental conditions that pose a threat to a resident having a safe, comfortable and functional environment. 4. Maintenance Director/ designee will conduct an ongoing monthly audit to ensure that all areas of the facility meet the definition of a Homelike Environment. Negative findings of this audit will be shared with the Administrator and fixed in a timely fashion. Audits will be presented at the Quarterly QAPI meeting for one year.	

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F 921	Continued From page 11	F 921		

the Unit Manager/Registered Nurse (UM/RN) who stated the staff reported any maintenance issues in a maintenance book or verbally informed the Maintenance Department of any environmental problems. The UM/RN stated that she had not notified the Maintenance Department about the condition of the sinks.

On 6/12/23 at 1:47 PM, the surveyor interviewed the Maintenance Director (MD) who stated he made facility rounds, had no documented records of these rounds. The MD said that he knew the cabinet and the sink areas must be replaced and repaired and that the wing would be remodeled. The MD stated that the Lisenced Nursing Home Administrator (LNHA) made rounds as well, and he was aware of the condition of the sinks.

On 6/13/23 at 1:47 PM, the surveyor interviewed the LNHA who acknowledged the sinks and cabinets should not have been in disrepair, and after the surveyor's inquiry, the vanity was replaced, and the sinks were repaired.

A review of the facility's "Homelike Environment" policy dated revised 2021, included the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflects a personalized homelike setting. These characteristics include: a clean, sanitary and orderly environment ...inviting color, and décor.

NJAC 8:39-31.4(a)

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	061341	A. BUILDING: _____ B. WING _____	C 06/15/2023

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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) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 3 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1. The facility will schedule the nursing units as per state guidelines. This will be accomplished by offering extra shifts to current staff when needed and by using nursing agencies. 2. All residents have the potential to be affected by this cited practice. 3. The staffing coordinator was in serviced by the administrator on the staffing ratio for staff to resident as mandated by the state of New Jersey for each shift. 4. The Staffing Coordinator or designee will complete an audit weekly for 1 month and then monthly for an additional 2 months to ensure that the staffing ratio is compliant with the New Jersey Staffing	8/1/23

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

Electronically Signed | 07/03/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 2/1/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During entrance conference on 6/6/23 at 9:31 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) and Assistant Licensed Nursing Home Administrator (ALNHA) stated that the facility's staffing was great; and the facility utilized Agency staff as needed. At this time, the surveyor requested the facility to complete the "Nurse Staffing Report" for the past two weeks. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 5/21/23 to 5/27/23 and 5/28/23 to 6/3/23, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 5/21/23 had 7 CNAs for 79 residents on the day shift, required 10 CNAs. 5/27/23 had 7 CNAs for 75 residents on the day shift, required 10 CNAs. 6/3/23 had 7 CNAs for 78 residents on the day	S 560	requirements for Certified Nursing Assistants. The Staffing Coordinator will submit results to the Director of Nursing monthly. The Director of Nursing will report Audit results to the quarterly QAPI committee meeting for the 3rd and 4th quarters of 2023.	

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S 560	Continued From page 2 shift, required 10 CNAs. On 6/14/23 at 8:55 AM, the surveyor interviewed the Staffing Coordinator who stated one of her job responsibilities was to schedule all nursing staff which included nurses and CNAs. The Staffing Coordinator continued that staffing was completed based on the census with one assigned CNA to every eight residents for the day shift; one CNA for every ten residents for the evening shift; and one CNA for every fourteen residents for the night shift. The Staffing Coordinator stated at times the facility was short on staff; she reached out for Agency staff on those days to obtain staff, but was not always successful with staffing shortages. NJAC 8:39-5.1(a)	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	8/1/2023 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 F0558	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	07/17/2023	LSC	07/24/2023	LSC	07/17/2023
ID Prefix F0921	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/17/2023	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	
6/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061341 Y1	A. Building B. Wing Y2	8/1/2023 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	08/01/2023	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	
6/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315299	A. BUILDING **01** B. WING _____	**06/15/2023**

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

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 6/12/23 and 6/13/23 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 that was built in January 1967. The facility is divided into 7 smoke zones. The facility has one Diesel emergency generator.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility provided documentation on 6/12/23, the facility failed to ensure the means of egress was continuously maintained free of all obstruction or impediments to full instant use in the case of fire or other emergency for one (1) existing dead-end corridor in accordance with NFPA 101 Life Safety Code (2012 edition) section 7.1.10.1	K 211	1. Upon being made of this deficient practice all items were cleared from the hallway to ensure the means of egress was continuously maintained free of all obstruction or impediments to full instant use in the case of fire or other emergency for one (1) existing dead- end corridor in accordance with NFPA 101 Life Safety Code (2012 edition) section 7.1.10.1. The	7/10/23

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

Electronically Signed | 07/04/2023

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

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K 211	Continued From page 1 This deficient practice was evidenced by the following: During the survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms. A review of the facility provided lay-out identified the facility was a single-story building with a basement. Starting at approximately 9:24 AM on 6/12/23, the surveyor in the presence of the facility's Director of Admissions and MD, toured the facility's basement level. At approximately 9:40 AM, the surveyor observed and recorded measurements of an existing dead-end corridor that had storage on both sides of the corridor. This dead-end corridor was fifty-eight feet (58') long and had approximately a thirty-eight inch (38") wide path between the storage that was on both sides of the corridor. The MD confirmed the finding at the time of observations. The surveyor informed the LNHA of this finding at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. NJAC 8:39-31.1(c), 31.2(e)	K 211	Maintenance director was in serviced on the importance of being free of all obstruction or impediments to full instant use in the case of fire or other emergency. 2. All residents in the facility have the potential to be impacted by this deficient practice. 3. Staff that have access to the impacted area were in serviced on the importance of ensuring the means of egress was continuously maintained free of all obstruction or impediments to full instant use. All areas in the building was checked by the maintenance director to insure compliance with means of egress was continuously maintained free of all obstruction or impediments to full instant use in the case of fire or other emergency. 4. The Administrator/ Designee will audit all areas in the building for compliance with means of egress was continuously maintained free of all obstruction or impediments monthly for 3 months. The administrator will report the audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors	K 222		7/17/23

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K 222	Continued From page 2 Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic	K 222		

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K 222	Continued From page 3 fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation on 6/12/23 and 6/13/23, it was determined that the facility failed to provide 1 of 14 exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which	K 222	1. Upon being made of this deficient practice of not having a discharge door in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6, the thumb turn lock and fastening device on the door was removed and a door Push Bar Panic Exit Device was installed in its place. 2. All residents have the potential to be affected by this deficient practice. 3. The Maintenance director was in-serviced on all discharge doors in the means of egress readily accessible and free of all obstructions or impediments to	

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K 222	Continued From page 4 identified the various rooms. A review of the facility provided lay-out identified the facility was single-story building with a basement. The facility had two (2) exit discharge doors (illuminated exit signs above doors) out of the basement and twelve (12) exit discharge doors (illuminated exit signs above doors) on the first floor. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD toured the facility. On 6/12/23 at approximately 10:25 AM, the surveyor observed in the basement that Exit Discharge Door #6 had a thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The MD confirmed the finding at the time of observations. The surveyor informed the LNHA of this finding at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222	full instant use in the case of fire or other emergencies. The Maintenance director checked all discharge doors to ensure compliance. 4. Maintenance director/ Designee will audit all discharge doors for compliance monthly for 3 months. Findings of said audit will be presented at quarterly QAPI meetings. Based on the result of this audit the QAPI team will come to a conclusion if it warrants further audits	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.	K 281		7/17/23

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K 281	Continued From page 5 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 6/12/23 and 6/13/23, it was determined that the facility failed to ensure continuous illumination for 6 of 12 designated exit discharge doors was provided and arranged so that the failure of any single lighting unit did not result in an illumination level of less than 0.2 foot-candle in any designated area in accordance with NFPA 101 Life Safety Code (2021 edition) Sections 7.8.1.1, 7.8.1.2 and 7.8.1.4 This deficient practice was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms. A review of the facility provided lay-out identified the facility was single-story building with a basement that had twelve (12) designated exit discharge doors (illuminated exit signs above doors) in the facility for residents to use during an evacuation in the facility. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD a tour of the facility was conducted. During the two day building tour the surveyor observed the following: 1. On 6/12/23 at approximately 11:17 AM, the	K 281	1. Upon being made aware of the deficient practice exit Doors #3,#4,#10,#12, and the 2 exit doors in the dining room were fitted with 2 fixtures so that there is a 0.2 foot- candle light continuously in operation or capable of automatic operation without manual intervention. 2. All residents residing within the facility have the potential to be impacted by this deficient practice. 3. The maintenance director has been in-serviced on the importance in having 2 lights outside all exit doors and has checked all exit doors to make sure that its fitted with 2 fixtures so that there is a 0.2 foot- candle light continuously in operation or capable of automatic operation without manual intervention. 4. The maintenance director/designee will conduct monthly audits for 3 months to ensure compliance and will submit findings to the Administrator. The administrator will report the audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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

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K 281	Continued From page 6 surveyor observed two (2) outside designated exit discharge doors, Exit Discharge Doors #4 and Exit Discharge Door #3 in the Atrium area had no external lights outside of the doors. 2. On 6/12/23 at approximately 11:42 AM, the surveyor observed outside the designated Exit Discharge Door #10, had a single light bulb fixture. 3. On 6/12/23 at approximately 11:50 AM, the surveyor observed outside the designated Exit Discharge Door #12, had a single light bulb fixture. 4. On 6/12/23 at approximately 10:58 AM, the surveyor observed outside two (2) designated exit discharge doors, in the resident's dining room area, had no external lights outside of the doors. The MD confirmed the findings at the time. The surveyor informed the LNHA of the findings at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. NJAC 8:39 -31.2(e) NFPA 101 2012 -19.2.8	K 281		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6.	K 311		7/4/23

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	315299	A. BUILDING **01** B. WING _____	**06/15/2023**

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K 311	Continued From page 7 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 6/12/23 and 6/13/23, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 2 chute doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This deficient practice was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms. A review of the facility provided lay-out identified the facility was single-story building with a basement. The facility was divided into two units; Rosewood and Wedgwood nursing units. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD toured the facility. Along the two day tour, the surveyor tested two (2) 1-1/2 hour fire rated chute doors with the following results: On 6/12/23 at approximately 11:07 AM, when the surveyor opened the soiled linen chute door (Wedgwood unit) to a 90-degree opening to its	K 311	1. Immediately upon being made of this deficient practice that 1 of the chute doors tested were not capable of maintaining the 1-1/2 hour fire rated construction, the self-close bar was replaced and was able to positive latch into its frame as required to maintain the 1-1/2 hour fire rated construction between the floors. 2. All residents have the potential to be impacted by this deficient practice. 3. The administrator and Maintenance Director did a audit on both chute doors to confirm that they self close. The administrator in-serviced the maintenance staff about the requirement of positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke, and poisonous gases to enter the floor in the event of a fire in the basement. 4. The Maintenance Director or his designee will audit monthly for 6 months to make sure that the chute doors are able to positive latch into its frame as required to maintain the 1-1/2 hour fire rated construction between the floors and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the next Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any	

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K 311	Continued From page 8 frame and allowed the chute door to self-close, the door did not close and positive latch into its frame as required to maintain the 1-1/2 hour fire rated construction between the floors. The surveyor measured and recorded a 2-inch opening between the door and frame. This test was repeated two additional times with the same results. The chute door would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke, and poisonous gases to enter the floor in the event of a fire in the basement. The MD confirmed the finding at the time of observations. The surveyor informed the LNHA of the finding at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311	adjustments and the need for continued submission and reporting.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321		7/17/23

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K 321	Continued From page 9 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 6/12/23 and 6/13/23, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 5 fire-rated doors to hazardous areas were self-closing and were separated by smoke resisting partitions for in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which	K 321	1. Upon being made aware of the deficient practice the corridor door leading into the dietary storage room and the corridor door leading to the adjoining office were outfitted with an automatic self-closure device. 2. All residents residing within the facility have the potential to be impacted by this deficient practice. 3. The maintenance director has checked all hazardous area enclosures within the facility to ensure compliance. The maintenance department has been in serviced by the Administrator on the importance of maintaining compliance with the protection requirements of hazardous area enclosures. 4. The maintenance director or designee will conduct a check of all hazardous area	

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K 321	Continued From page 10 identified the various rooms. A review of the facility provided lay-out identified the facility was a single-story building with a basement. The facility was divided into two units; Rosewood and Wedgwood nursing units. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD toured the facility. Along the two day tour of the facility, the surveyor observed the following hazardous area that failed to have smoke resisting doors: On 6/12/23 at approximately 9:45 AM, an inspection of the Dietary Storage Room in the basement was performed. During a closure test of the corridor door leading into the Dietary Storage Room, the door did not self-close into its frame. The surveyor observed multiple combustible boxes, disposable plates, and cups in the room. This test was repeated two additional times with the same results. This Dietary Storage Room was not smoke resistant. The room was larger than 50 square feet. At the time of the observation, the surveyor measured and recorded the room. The room was sixteen-feet-six-inches by twelve-feet-six inches (16'-6" by 12'- 6"; 206 square feet). The surveyor also observed and measured one masonry wall of the room that was 12'- 6" long, that did not go up to the decking above. The wall was approximately three (3) feet short from the ceiling of the room. There was an office on the other side of this 12'- 6" wall. The surveyor observed the corridor door to the office had no means to self-close.	K 321	enclosures weekly for a minimum of three months until compliance is maintained. Findings of said audit will be presented to the Quarterly QAPI committee for review and evaluation if any additional measures are necessary.	

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K 321	Continued From page 11 With both corridor doors not self-closing this would allow fire, smoke, and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted on the corridor wall in the area identified you would need to pass these rooms as the primary and or secondary egress route out of the area in the event of a fire. The MD confirmed the findings at the time. The surveyor informed the LNHA of the findings at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 345 SS=D	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 observation and interview on 6/12/23, in the presence of facility management, it was determined that the facility failed to maintain the buildings fire alarm and detection system in	K 345	1. Upon being made aware of this deficient practice, the smoke detector mounted in the atrium that had a large accumulation of dust build up on the	7/17/23

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K 345	Continued From page 12 optimum functioning condition for 1 of 116 smoke detectors. This deficient practice was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and the mandatory inspections from January 1, 2022 through June 11, 2023 for review. A review of the facility provided lay-out identified the facility was a single-story building with a basement. The facility was divided into two units, Rosewood and Wedgwood nursing units. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD a tour of the facility was conducted. On 6/12/23 at approximately 9:35 AM, the surveyor conducted an inspection inside the Atrium room. The surveyor observed one (1) smoke detector mounted to the drop ceiling grid that was approximately 20 inches from a mounted ceiling fan. This smoke detector had a large accumulation of dust build up on the detector and dust was observed going into the sensing chamber of the detector. This would not allow the smoke detector to function properly in the event of a fire. The MD confirmed the finding at the time of observations.	K 345	detector and dust was observed going into the sensing chamber of the detector was cleaned out with compressed air duster (dust and lint remover) and tested for compliance. 2. All residents have the potential to be impacted by this deficient practice. 3. The administrator inserviced the maintenance team on the importance of maintaining the buildings fire alarm and detection system in optimum functioning and making sure that there is no dust blocking the sensing chamber. 4. The Maintenance Director or his designee will audit monthly for 6 months to make sure that the smoke detectors are clear of all dust and are in optimum functioning condition, and submit his findings to the Quarterly QAPI committee meetings for the third and fourth quarter of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 345	Continued From page 13 The surveyor informed the LNHA of the deficiency at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 345		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation on 6/12/23 and 6/13/23, in the presence of facility management, it was determined that the facility failed to properly install sprinklers as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and	K 351	1) upon being made aware of the deficient practices, 1. The sprinkler head in the atrium was configured with an escutcheon cap to cover the ¿ inch gap in the ceiling. 2.The sprinkler in the atrium closet was removed and installed a vertical pipe	7/17/23

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K 351	Continued From page 14 National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms. A review of the facility provided lay-out identified the facility was single-story building with a basement. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD, toured the facility. Along the two (2) day tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: 1. On 6/12/23 at approximately 9:32 AM, inside the commercial laundry room, the drop ceiling had an approximately eight-inch by ten-inch (8" by 10") hole through the rooms ceiling tile. 2. On 6/12/23 at approximately 9:49 AM, inside the basement dietary chute room, the drop ceiling was missing one two-foot by four-foot (2' by 4') and 2' by 2' ceiling tiles from the grid. The facility had 1/4-inch by 1/4-inch plastic open grid in the place of the ceiling tiles.	K 351	upwards and installed an upright sprinkler head at the correct height. 3. the commercial laundry room, the drop ceiling had an approximately eight-inch by ten-inch hole and maintenance put in a ceiling tile in its place. 4. inside the basement dietary chute room, the drop ceiling was missing one two-foot by four- foot(2' by 4') and 2' by 2' ceiling tiles from the grid. It was replaced with a proper ceiling tile 5. The facility had a 1/4-inch by 1/4-in plastic open grid in the place of the ceiling tiles. The plastic grid was removed and a proper ceiling tile was put in its place. 2) All residents have the potential to be affected by this deficient practice 3) The administrator in-serviced the Maintenance Department about the requirement of proper sprinkler installation and the importance of ensuring that all ceiling tiles are in the right place. 4) The maintenance director or his designee will conduct monthly audits for 6 months to ensure compliance and will submit findings to the Quarterly QAPI meetings for the third and fourth quarters of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 351	Continued From page 15 3. On 6/12/23 at approximately 11:12 AM, inside the Atrium room one (1) sprinkler head was missing an escutcheon cap. This left an approximately 1/4-inch gap around the sprinkler. 4. On 6/12/23 at approximately 11:14 AM, inside the Atrium room closet, the surveyor observed a down pendent fire sprinkler located 27" below the decking above. With the openings in the ceilings, in the event of a fire the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system. The MD confirmed the findings at the time of observations. The surveyor informed the LNHA of these findings at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		7/4/23

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K 353	Continued From page 16 _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and interview on 6/12/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition, in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. This deficient practice was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms. A review of the facility provided lay-out identified the facility was a single-story building with a basement. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD toured the facility. Along the two (2) day tour, the surveyor observed the following:	K 353	1. Upon being made aware of the deficient practice of observing in the basement level large storage room (next to the commercial laundry room) one fire sprinkler that was covered in a large accumulation of dust around the head, the sprinkler head was immediately cleaned of the dust. 2. All residents can be affected by this deficient practice. 3. the Administrator in-serviced the maintenance director about the requirement that all sprinklers maintain all parts of their automatic sprinkler system in optimal condition, in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. 4. The maintenance director/designee will conduct monthly audits for 3 months to ensure compliance and will submit findings to the Administrator. The administrator will report the audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued	

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K 353	Continued From page 17 On 6/12/23 at approximately 9:35 AM, the surveyor observed in the basement level large storage room (next to the commercial laundry room) one fire sprinkler that was covered in a large accumulation of dust around the head. The MD confirmed the finding at the time of observations. The surveyor informed the LNHA of the finding at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 25	K 353	submission and reporting	
K 355 SS=D	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, interview, and review of facility documentation on 6/12/23 and 6/13/23, in the presence of facility management, it was determined that the facility failed to perform a monthly examination for 2 of 26 portable fire extinguishers as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 4- 3, 4- 3.1, 4- 3.3 and 4- 3.4 and N.J.A.C. 5:70.	K 355	King Manor will continue to ensure that Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. To address survey concerns the facility will do the following: 1. Upon being made aware of this deficient practice the 2 spare fire extinguishers in the maintenance shop were checked by the maintenance	7/17/23

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	315299	A. BUILDING **01** B. WING _____	**06/15/2023**

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
K 355	Continued From page 18 Reference: NFPA 10 Edition 2010 Standard for portable fire extinguishers: - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. -7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD, toured the facility. During the two day building tour the surveyor observed and inspected	K 355	director and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 2. All residents can be affected by this deficient practice. 3. the Administrator in-serviced the maintenance director about the requirement that all fire extinguishers need to be checked monthly even if they are spare ones. 4. The maintenance director/designee will audit all Fire extinguishers whether they are in use or in storage, to ensure compliance monthly for 3 months, and will submit findings to the Administrator. The administrator will report the audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 355	Continued From page 19 twenty-six (26) portable fire extinguishers that were last annually inspected January 2023 in various locations with the following issues identified: On 6/12/23 at approximately 10:14 AM, one (1) "ABC-Type" fire extinguisher and one (1) "Silver" cylinder water fire extinguisher in the basement level maintenance area were last annually inspected January 2023. At this time, the surveyor asked the MD if the fire extinguishers were spare, and the MD responded, "yes." There was no evidence of monthly visual examination performed and documented for February, March, April, and May of 2023. The MD confirmed the findings at the time of observations. The surveyor informed the LNHA of the findings at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM.	K 355		
K 372 SS=D	NFPA 10 NJAC 8:39 -31.1(c); 31.2 (e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 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	K 372		7/17/23

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K 372	Continued From page 20 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 observations, interviews, and review of facility provided documentation on 6/12/23 and 6/13/23, in the presence of facility management, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for 1 of 6 smoke barrier walls. This deficient practice was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a single-story building and a basement with six (6) smoke barrier walls in the building. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD, toured the facility. Along the two day tour, the surveyor observed the following smoke barrier walls that failed to maintain the 1/2-hour fire rated construction as required by code in the following location: On 6/12/23 at approximately 10:43 AM, the	K 372	1. Upon being made aware of the deficient practice of failing to maintain the integrity of smoke barrier partitions for 1 of 6 smoke barrier walls the holes in corridor double smoke doors ceiling tiles next to Resident Room #1, one approximately one-and-one-half-inch by three-inch (1-1/2" by 3") penetration with two gray and three white wires and one approximately 1" penetration with two gray wires running through the smoke barrier wall. These holes were immediately sealed closed with fire block foam to prevent smoke, fumes, and fire from passing through to the other smoke compartments. 2. All residents can be affected by this deficient practice. 3. the Administrator in-serviced the maintenance director about the requirement that all smoke barrier walls indicating need to be sealed closed to prevent smoke, fumes, and fire from passing through to the other smoke compartment. 4. The maintenance director/designee will conduct monthly audits for 3 months to ensure compliance and will submit findings to the Administrator. The administrator will report the audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued	

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K 372	Continued From page 21 surveyor observed above the corridor double smoke doors ceiling tiles next to Resident Room #1, one approximately one-and-one-half-inch by three-inch (1-1/2" by 3") penetration with two gray and three white wires and one approximately 1" penetration with two gray wires running through the smoke barrier wall. These penetrations were observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes, and fire from passing through to the other smoke compartment. The MD confirmed the finding at the time. The surveyor informed the LNHA of the finding at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372	submission and reporting.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by:	K 511		7/17/23

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K 511	Continued From page 22 Based on observation and interview on 6/12/23 and 6/13/23, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 5 electrical outlets located next to a water source (within six feet) was equipped with safe and secured ground-fault circuit interrupter (GFCI) protection. This deficient practice was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a single-story building with a basement that was divided into two units; Rosewood and Wedgwood nursing units. Starting at approximately 9:24 AM on 6/12/23 and continued on 6/13/23, the surveyor in the presence of the facility's Director of Admissions and MD, toured the facility. During the two day building tour, the surveyor observed and tested five (5) electrical outlets (within six feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: 1. On 6/12/23 at approximately 11:03 AM, the surveyor observed inside the Wedgwood nursing unit Nourishment Room, one GFCI electrical outlet located twenty-two inches (22") to the left of the hand washing sink in the room. When the surveyor tested the GFCI electrical outlet with a	K 511	1. Upon being made aware of the deficient practice that 2 electrical outlets located next to a water source (within six feet) not was equipped with safe and secured ground- fault circuit interrupter (GFCI) protection, the maintenance director replaced both of the electrical outlets equipped with safe and secured ground- fault circuit interrupter (GFCI) protection. 2. All residents residing within the facility have the potential to be impacted by this deficient practice. 3. The maintenance director has checked all electrical outlets located next to a water source (within six feet) was equipped with safe and secured ground-fault circuit interrupter (GFCI) protection. The maintenance department has been in serviced by the Administrator on the importance of electrical outlets located next to a water source be equipped with safe and secure ground- fault circuit interrupter (GFCI) protection. 4. The maintenance director or his designee will conduct monthly audits for 6 months to ensure compliance and will submit findings to the Quarterly QAPI committee meetings for the third and fourth quarter of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 511	Continued From page 23 GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. 2. On 6/13/23 at approximately 10:11 AM, the surveyor observed inside the Resident Salon, one multiple electrical power strip mounted to a cabinet that was plugged into a duplex electrical wall outlet. The surveyor measured and recorded the power strip was mounted 29" to the left of the hair washing sink. When the surveyor tested the duplex electrical outlet with a GFCI tester to de-energize, the duplex electrical outlet did not de-energize as required by code. The MD confirmed the findings at the time of observations. The surveyor informed the LNHA of these findings at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. NJAC 8:39 -31.2(e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 511		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		7/17/23

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K 918	Continued From page 24 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/12/23, in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: During survey entrance on 6/12/23 at approximately 8:44 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Maintenance Director (MD) if the facility had	K 918	1. Upon being made aware of this deficient practice of failing to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1, a remote emergency stop button was installed on 07/05/2023 away from the generator. 2. all residents can be affected by this deficient practice 3. The administrator will in-service the maintenance department about the requirement to ensure a remote manual stop station for 1 of 1 emergency	

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K 918	Continued From page 25 an emergency generator. The MD responded yes; we have one diesel powered emergency generator. On 6/12/23 at approximately 9:55 AM, the surveyor in the presence of the Director of Admissions and MD inspected the outside of the building where the emergency generator was located. The surveyor observed that the emergency stop button was located inside the metal housing and on the front control panel of the generator. At this time the surveyor asked the MD, do you have a remote emergency stop button for the generator? The MD responded, "no." The MD confirmed the finding at the time of observation. The surveyor informed the LNHA of the finding at the Life Safety Code exit conference on 6/13/23 at approximately 1:35 PM. NJAC 8:39-31.2(e); 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	generators was properly functioning in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1 4. The Maintenance Director/ designee will conduct quarterly audit of the functionality of the remote stop switch and will submit the audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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	8/1/2023 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	07/10/2023	LSC K0222	07/17/2023	LSC K0281	07/17/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	07/04/2023	LSC K0321	07/17/2023	LSC K0345	07/17/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	07/17/2023	LSC K0353	07/04/2023	LSC K0355	07/17/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	07/17/2023	LSC K0511	07/17/2023	LSC K0918	07/17/2023
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	
6/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO