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

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 11/18/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING 01		COMPLETED			
		315454	B. WING		04/05/2021
	ROVIDER OR SUPPLIER	SING CENTER	2:	TREET ADDRESS, CITY, STATE, ZIP CODE 31 WARNER STREET OMS RIVER, NJ 08755	3 1/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments		E 000		
K 000	Appendix Z-Emergener Provider and Supplier Guidance 483.73, ReCare (LTC) Facilities.	stantial compliance with cy Preparedness for All Types Interpretive quirements for Long Term	K 000		
	LIFE SAFETY CODE	: 101:2012			
K 355 SS=E	THIS FACILITY IS NO COMPLIANCE WITH SAFETY CODE REQ SURVEYED UNDER Portable Fire Extingui CFR(s): NFPA 101	THE MINIMUM LIFE UIREMENTS AS CMS-2786R.	K 355		5/11/21
	inspected, and mainta NFPA 10, Standard for Extinguishers. 18.3.5.12, 19.3.5.12, This REQUIREMENT by: Based on observation review, in the presence Director, it was determ to maintain fire exting condition, in accordant Protection Association	hers are selected, installed, ained in accordance with a Portable Fire  NFPA 10 is not met as evidenced  n, interview, and record are of the facility Maintenance anined that the facility failed uishers in proper working are with National Fire in (NFPA 10).		K tag 355  1. The fire extinguishers in question wer replaced with new extinguishers and inspected and tagged by the fire extinguisher company.	e
	During the building to presence of the Maint	videnced by the following:  ur on 3/23/21, in the enance Director, 12 of 15 hers were observed with		2. All residents and staff are affected by this deficient practice due to the fact that should the fire extinguisher malfunction, can create a danger in life safety. A malfunctioning fire extinguisher can cause	it
ABODATODY		I IPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

(X2) MULTIPLE CONSTRUCTION

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.

**Electronically Signed** 

04/30/2021

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

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION 1		E SURVEY IPLETED
		315454	B. WING _			0.	4/05/2021
	ROVIDER OR SUPPLIER  EADOWS REHAB & NUF	RSING CENTER	•	23	TREET ADDRESS, CITY, STATE, ZIP CODE 31 WARNER STREET OMS RIVER, NJ 08755	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 355	Red-tags indicating in having the required 6 performed.  In an interview with the during the observation aware that 12 of 15 performed.  The administrator produced that a proposal for the additional testing wowere completed. The on 3/08/21 by the factive nection where extinguishers reveal action shall be taken.	on-compliance for not e-year hydrostatic test  ne Maintenance Director ens, he stated that he was cortable fire extinguishers the facility vendor for the required 6-year  vided a document stating extinguishers that needed ald be sent once the reports inspection was completed extinguisher  0-4.3.3, fire extinguisher en inspections of fire deficiencies, immediate  s notified of the deficiency at exit conference.	K	355	a delay in the extinguishing of a fire the causing the fire to spread resulting in a great danger to the residents and other occupants of the building.  3. An in-service was done with all Maintenance staff as well as the Administrator by the Corporate Maintenance Director as to the danger having malfunctioning fire extinguishers the building. The Corporate Maintenan Director reviewed with the Administrator and the Maintenance staff the fire safet code in regards to fire extinguishers.  4. The Administrator as well as the Maintenance staff will check the fire extinguishers on a monthly basis and ongoing to ensure that the extinguisher are not expired and are working proper Should any extinguisher be found non-compliant the vendor will be notified immediately to come and exchange the extinguisher. All findings will be reviewed at the Quality Assurance Meeting x 2 quarters.	of s in ce or ty	

	POST-CERTIFICATION REVISIT REPORT									
	R / SUPPLIER / CI CATION NUMBER		MULTIPLE CONS A. Building B. Wing	STRUCTION					DATE 0	F REVISIT
		Y1	B. Willig			T		Y2	0/23/20	Y3
	FACILITY	A DIL ITAT	TON AND NUIDO	INC CENTED	STREET ADDRESS, CITY, STATE, ZIP CODE					
SHUKE	SHORE GARDENS REHABILITATION AND NURS					231 WARNER STREET TOMS RIVER, NJ 08755				
						1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -				
program, corrected provision	to show those d I and the date su	eficiencie ch correc	es previously repo ctive action was a	orted on the CMS-2 accomplished. Eacl	567, Staten n deficiency	and/or Clinical Laborator ment of Deficiencies and r should be fully identifie 2567 (prefix codes shov	Plan of Correc d using either tl	tion, that have he regulation o	LSC	
ITE	M		DATE	ITEM		DATE	ITEM			DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix	F0842		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	483.20(f)(5), 483. (5)	70(i)(1)-	Completed	Reg. #		Completed	Reg.#			Completed
LSC			05/11/2021	LSC			LSC _			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
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STATE AC		REVIEW (INITIAL		DATE	SIGNATUR	RE OF SURVEYOR			DATE	
PEVIEWED BY PEVIEWED BY			/ED BY	DATE	TITI F				DATE	

FOLLOWUP TO SURVEY COMPLETED ON

(INITIALS)

CMS RO

4/5/2021

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

			STATE FO	RM: REVISIT REPORT						
	R / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CONS A. Building B. Wing	STRUCTION			Y2	DATE OF REVISI 6/29/2021	IT Y3		
	FACILITY GARDENS REHABILITA	ATION AND NURS	ING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  231 WARNER STREET  TOMS RIVER, NJ 08755						
correctiv	e action was accomplish tion prefix code previous	ned. Each deficien	cy should be fully ide	previously reported that have be ntified using either the regulation prefix codes shown to the left of o	or LSC provision	on number and t	the			
ITE	М	DATE	ITEM	DATE	ITEM		DATE			
Y4		Y5	Y4	Y5	Y4		Y5			
ID Prefix	S0670	Correction	ID Prefix	Correction	ID Prefix		Correc	tion		
Reg.#	8:39-7.2	Completed	Reg. #	Completed	Reg. #		Comple	eted		
LSC		05/11/2021	LSC		LSC					
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correc	tion		
Reg.#		Completed	Reg. #	Completed	Reg. #		Comple	eted		
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Reg.#		Completed	Reg. #	Completed	Reg. #		Comple	eted		
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Reg. #	Completed	Reg. #		Completed	Reg. #			Completed
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Reg. #	Completed	Reg. #		Completed	Reg. # LSC			Completed
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SU	RVEYOR			DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY C 4/5/2021	OMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO T						
STATE FORM: REVISIT REF	PORT (11/06)		Page 1 of 1			EVENT ID:	7CZZ12	

			STATE FO	RM: REVISIT REPORT						
	R / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CONS A. Building B. Wing	STRUCTION			Y2	DATE OF REVISI 6/29/2021	IT Y3		
	FACILITY GARDENS REHABILITA	ATION AND NURS	ING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  231 WARNER STREET  TOMS RIVER, NJ 08755						
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ITE	М	DATE	ITEM	DATE	ITEM		DATE			
Y4		Y5	Y4	Y5	Y4		Y5			
ID Prefix	S0670	Correction	ID Prefix	Correction	ID Prefix		Correc	tion		
Reg.#	8:39-7.2	Completed	Reg. #	Completed	Reg. #		Comple	eted		
LSC		05/11/2021	LSC		LSC					
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correc	tion		
Reg.#		Completed	Reg. #	Completed	Reg. #		Comple	eted		
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ID Prefix	_	Correction	ID Prefix	Correction	ID Prefix		Correc	tion		
Reg.#		Completed	Reg. #	Completed	Reg. #		Comple	eted		
LSC		_	LSC		LSC _					
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Reg. #	Completed	Reg. #		Completed	Reg. #			Completed
ID Prefix	Correction	ID Prefix		Correction	ID Prefix			Correction
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REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SU	RVEYOR			DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY C 4/5/2021	OMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO T						
STATE FORM: REVISIT REF	PORT (11/06)		Page 1 of 1			EVENT ID:	7CZZ12	