STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**05/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	**231 WARNER STREET** **TOMS RIVER, NJ 08755**

(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 000	INITIAL COMMENTS The nursing home building construction was stated to be 90's with no current major renovations or noted additions. It is a three-story building Type II (222) construction and is fully sprinklered. The facility is divided into 12-smoke zones, the Kohler 150 KW diesel generator does approximately 40% to 50 % of the building as per the Maintenance Director. The 3-story facility utilizes 3-elevators (2-passenger and 1-service device) The building is attached to a (Closed Daycare) 1-story structure now used for storage. The attached structure cannot be entered from the nursing home and was not observed. The facility utilizes an electric fire pump to support the fire sprinkler system. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 149 certified beds. At the time of	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/31/2023

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K 000	Continued From page 1 the survey the census was 138. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/01/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide a battery back-up emergency light above the electric fire pump transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 19.2.9.1.- 7.9.1 (general). This deficient practice was identified for 1 of 1 transfer switches and was evidenced by the following: On 3/29/23 at 11:31 AM, the surveyor in the presence of the Maintenance Director, observed one fire pump transfer switch, inside the fire pump electrical room. The general area was not provided with any emergency lighting. The Maintenance Director confirmed the finding at the time of the observation. The Administrator was informed of the findings at the Life Safety Code exit on 5/01/23.	K 291	Step 1 Emergency lighting independent of Facility Generator and Facility Electricity will be installed in the pump room to illuminate the transfer switch within. Step 2 All residents are at risk for not having emergency lighting in the pump room. Step 3 Inspection of emergency lighting in pump room will be added to monthly tasks on Facility building maintenance and compliance software. Step 4 Maintenance director will report on the status of monthly emergency lighting inspections to the Administrator at Quarterly QA Meeting for the next three quarters. Completion date May 31, 2023	5/31/23

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K 291	Continued From page 2 NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 321 SS=D	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 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 and interview on 5/01/23, in the presence of the Maintenance Director	K 321	1 Enclosure of hazardous area will be	6/15/23

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K 321	Continued From page 3 (MD), it was determined that the facility failed to provide a fire barrier with two hour fire resistance rating in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1 and 8.7.1. The deficient practice was ideintifie for 2 of 9 hazardous areas observed and was evidenced by the following: At 09:24 AM, the surveyor and Maintenance Director observed in the floor-2 mechanical room identified as C3-11F that 2 new boilers were installed. The protected metal decking was cut into to provide white flue pipe approximately 6"each, that were installed through the metal ceiling decking in both areas of the (2) new boilers. The flue pipe was then surrounded with non-fire rated press board plywood. The plywood was exposed at the ceiling approximately 2' at both pipe penetrations from the removed protected metal decking. The (2) two exposed areas were not fully encased in fire rated material. The findings were verified by the Maintenance Director at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e)	K 321	repaired with a two hour fire barrier between the boiler room and the roof. 2 All residents are at risk for not having an appropriately rated fire barrier in hazardous areas. 3 Maintenance Director will follow behind any outside contractors that may penetrate a fire barrier to ensure that repairs are done correctly. 4 The Maintenance Director will report to the Administrator at Quarterly QA meeting the results of any inspections and repairs.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		6/7/23

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K 353	Continued From page 4 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review on 4/28/23 and 5/01/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to a.) annually inspect 3 of 3 private property fire hydrants as per NFPA 25 and b.) ensure that their automatic sprinkler system fire pump was in optimal condition in accordance with the National Fire Protection Association (NFPA) 20 & 25 and c.) ensure that the electric fire pump was tested monthly and documented as per NFPA 25. This deficient practice was evidenced by the following: a.) On 4/28/23 at approximately 11:30 AM, the surveyor reviewed all related documentation from the fire sprinkler vendor. The reports did not indicate any annual inspection of the three (3) private fire hydrants on the facility's property as required by NFPA 25. The Maintenace Director indicated that the annual fire hydrant inspection requirement was	K 353	1 The 3 Fire hydrant has been scheduled for inspection on June 6. Fire pump repair is scheduled for June 6. The Monthly Fire Pump inspection log has been updated to now include: visually inspecting gauges for proper water pressures, any leaks and to ensure pump switches are in automatic position. 2 All residents are at risk for the Facility not in compliance with sprinkler inspection requirements. 3 Annual Fire Hydrant inspection has been added to the Facility Maintenance & Compliance building software. Monthly Fire Pump testing to covering all regulatory aspects of NFPA 25 has been added to the Building Facility Maintenance & Regulatory Compliance Software The Administrator will audit the monthly logs in the Facility Maintenance & Regulatory Compliance Software to	

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K 353	Continued From page 5 not performed, and no further documentation was provided. b.) At 11:33 AM, the surveyor and Maintenace Director observed in the fire pump electrical room, that the red fire pump was observed to be leaking, along with rust on the bottom of the pump motor that was attached to the concrete pad. The Maintenance Director confirmed the finding during the observation. c.) During document review, the surveyor observed that the electric fire pump monthly test reports were not provided. The Maintenance Director confirmed that he could not provide any documentation for the testing of the electric fire pump. He indicated the fire pump was tested weekly, but could not provide any documentation testing logs indicating so. The Administrator was notified of the findings at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 20: Standard for the Installation of Stationary Pumps for Fire Proctetion NFPA 25: Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems	K 353	ensure monthly tests of Fire Pump & inspections including visual inspections of gauges, leaks & switches are in compliance for the next three months. 4 The Maintenance Director will report the status of all items on the monthly fire pump inspection log at Quarterly QA meeting for the next three quarters.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		6/14/23

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K 363	Continued From page 6 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/01/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to	K 363	1 Hardware was replaced with appropriate hardware utilizing existing holes in doors.	

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K 363	Continued From page 7 ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in 31 of 50 resident room (RR) doors observed and was evidenced by the following: During the building tour on 5/01/23 from 9:15 AM, to 01:45 PM, the surveyor in the presence of the Maintenance Director toured the facility and observed the following compromised RR doors: RR 316 loose hardware RR 318 approximately 1/4 hole in door, above the hardware RR 321 approximately 1/4 hole in door, above the hardware RR 326 loose hardware RR 331 loose hardware RR 332 will not latch into frame RR 334 loose hardware RR 202 loose hardware RR 203 loose hardware RR 205 will not latch into frame RR 206 approximately 1/4 hole in door, above the hardware RR 207 loose hardware RR 211 loose hardware RR 214 loose hardware RR 215 loose hardware and door sticks into frame RR 218 loose hardware RR 221 loose hardware RR 224 approximately 1/4 hole in door, above the	K 363	Any holes listed on the report are now covered by the existing metal door closure hardware. Doors repaired so that they no longer rub. 2 All residents are at risk for failure to have doors that properly resist the passage of smoke or fire. 3 All doors will be inspected by the Director of Maintenance on a monthly basis for the next three months and Quarterly thereafter. The inspection will include ensuring the latching hardware is in proper condition, door latches properly and that the door closes freely and does not rub onto the frame. 4 The Maintenance Director will report the status of all items on the room door inspection checklist at Quarterly QA meeting for the next three quarters.	

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K 363	Continued From page 8 hardware RR 226 approximately 1/4 hole in door, above the hardware RR 229 loose hardware RR 230 loose hardware (latch NG) RR 231 loose hardware (latch NG) RR 233 door rubs into frame and approximately 1/4 hole above hardware RR 234 approximately 1/4 hole in door, above the hardware RR 101 door rubs into top of the frame RR 104 door rubs into top of the frame RR 107 door will not latch RR 109 door rubs into frame RR 111 door will not latch RR 113 loose hardware RR 115 door rubs into top of frame At the time of observations, the surveyor interviewed the MD who confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	K 741		6/16/23

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K 741	Continued From page 9 area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/01/23, in the presence of the Maintenance Director (MD) and Administrator (Admin), observed that the facility failed to maintain smoking areas in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. This deficient practice was identified for 1 of 1 smoking areas observed and was evidenced by the following: At approximately 01:00 PM, the Surveyor, Maintenance Director and Administrator observed the first floor exterior smoking area. The outer perimeter of the smoking area was dried grass and dirt. The surveyor observed 100-plus ciggerate butts in that area, along with ciggerate	K 741	1 Proper ashtrays were provided in the smoking area. The cigarette butts in the outer perimeter of the smoke patio were removed. 2 All residents who use the patio for either smoking or leisure can be at risk for failure to maintain a proper smoke area. 3 Ashtrays will be cleaned out on a weekly basis and placed on weekly Maintenance rounds in Facility building Maintenance software. Residents were educated to use ashtrays and will be reminded weekly by Facility staff.	

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K 741	Continued From page 10 butts on the occupied concrete pad. The occupied resident smoking area was provided with 6-oasis type ashtrays, but a metal container with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted was not observed at the time of the observation. The Maintenance Director and Administrator confirmed the finding's during the observations. The Administrator was informed of the finding's at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e)	K 741	4 The Maintenance Director will report on the status of the smoking area at Quarterly QA meeting for the next three quarters.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		6/16/23

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K 914	Continued From page 11 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 5/01/23, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 50 of 50 resident rooms observed by the following: From approximately 9:30 AM to 1:30 PM, the surveyor and MD, observed that resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The annual electrical inspection from the facility vendor dated: 11/22/22 did not indicate any testing of resident room outlets and did not indicated the identification of the outlets as hospital or non-hospital grade. The MD confirmed that the resident rooms had non-hospital grade outlets installed during the resident room observations and could not provided any further testing documentation. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e) NFPA 99	K 914	1 The Facility will test all room electrical receptacles for grounding, polarity and blade tension. 2 All residents are at risk for failing to test all room electrical receptacles for grounding, polarity and blade tension. 3 Annual Electrical testing of all room electrical receptacles for grounding, polarity and blade tension to be performed by the Director of Maintenance has been added to the Facility tasks software for annual testing. 4 The Maintenance Director will report to the Administrator on the status of annual electrical receptacle testing at Quarterly QA Meeting.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101	K 921		6/2/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 12 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 5/01/23, it was determined that the facility failed to ensure electrical equipment wiring was safe and in accordance with NFPA 70 and 99. This deficient practice was evidenced for 3 of 9 bug lights observed and installed in exit/egress	K 921	1 bug lights with modified spliced plugs were removed from service and discarded. Maintenance staff were in-serviced on maintenance and inspection of electrical equipment. 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**05/11/2023**

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K 921	Continued From page 13 corridors. 1.) At 09:59 AM, the surveyor and Maintenace Director observed in the exit/egress corridor on floor #2 by resident room 213, that a wall mounted bug light was plugged into a duplex wall outlet. The bug light fixture wire had a modified spliced plug attached (not the orginal) to the fixture. 2.) At 10:02 AM, the surveyor and Maintenace Director observed in the exit/egress corridor on floor #2 by resident room 224, that a wall mounted bug light was plugged into a duplex wall outlet. The bug light fixture wire had a modified spliced plug attached (not the orginal) to the fixture. 3.) At 10: AM, the surveyor and Maintenace Director observed in the exit/egress corridor on floor #2 by resident room 233, that a wall mounted bug light was plugged into a duplex wall outlet. The bug light fixture wire had a modified spliced black cord spliced into the orginal cord. During an interview, at the time of observation, the Maintenance Director confirmed that the replacement cords and plugs were not permitted and should not be like that in the facility. The Administrator was informed of the finding's at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e) NFPA 70 (National Electrical Code) NFPA 99 (Health Care Facilities Code)	K 921	All residents can be at risk for failure to maintain electrical equipment. 3 All bug lights and other electrical equipment plugged into outlets in exit/ egress corridors were inspected and any electrical item found with a modified spliced plug was removed from service and discarded. An inspection of all electrical equipment plugged into outlets in exit/ egress corridors will be placed on the Maintenance Director□s monthly tasks list. 4 The Maintenance Director will report the results of these monthly inspection to the Administrator at quarterly QA meeting for the next three quarters.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		6/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**05/11/2023**

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K 923	Continued From page 14 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**05/11/2023**

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K 923	Continued From page 15 Based on observations and interview on 5/01/23, in the presence of the Maintenance Director, it was determined that the facility failed to prohibit combustible storage within 5-feet of quantities of oxygen exceeding 300 cubic feet in accordance with NFPA 99. This deficient practice was identified for 41 of 41 portable oxygen cylinders and was evidenced by the following: At 10:18 AM, the surveyor, Maintenance Director observed in the floor #2 main oxygen storage closet, that 41-portable oxygen cylinders were observed to be stored within 3' of combustible cardboard boxes. An interview was conducted with the Maintenance Director who stated that the cylinders must be separated by five-feet (5') from combustibles when an automatic fire sprinkler system is provided. The building has a fully functional sprinkler system. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e) NFPA 99	K 923	1 Combustible items were removed from within 5 feet of stored oxygen in the storage area. The area was marked off to alert staff not to store combustibles and central supply & Maintenance staff were in-serviced accordingly. 2 All residents can be at risk for failure to store oxygen in a safe manner. 3 The Central Supply clerk has been in-serviced on oxygen storage requirements. Weekly inspection of the oxygen storage area to be done by Director of Maintenance or designee has been added to weekly tasks on the Facility Maintenance software. 4 The Maintenance Director will report on the status of weekly oxygen storage area compliance at Quarterly QA meeting for the next three quarters.	

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
315454 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	05/31/2023	LSC K0321	06/15/2023	LSC K0353	06/07/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	06/14/2023	LSC K0741	06/16/2023	LSC K0914	06/16/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0921	06/02/2023	LSC K0923	06/16/2023	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	
5/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO