STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315490	A. BUILDING _____ B. WING _____	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEDICAL CENTER TCU	99 ROUTE 37 WEST 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
F 000	INITIAL COMMENTS Survey Date: 9/20/21 Census: 16 Sample: 8 + 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 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 documentation, it was determined that the facility	F 812	1. The two-compartment plastic dolly was removed from service and cleaned.	10/15/21

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

Electronically Signed | 10/07/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 1 failed to a.) properly clean and store dishes and food service equipment and b.) label and date food in a manner to prevent food-borne illness and cross contamination. This deficient practice was evidenced by the following: On 9/8/2021 at 9:58 AM, during the initial tour of the kitchen in the presence of the Hospitality Services Administrative Director (HSAD) and the Quality Resource Services Outcomes Coordinator, the surveyor observed the following: 1. There was a two-compartment plastic dolly holding disposable resident meal trays in one of the compartments. The empty compartment adjacent to the clean trays was visibly soiled with dust and debris. 2. There was a three-compartment, heated plate lowerator that was plugged in and turned on with two of the compartments heating clean dishes. The stainless-steel surface of the empty compartment had visible food particles and appeared greasy. 3. In the dry storeroom, there were three gallons of Honey Mustard dressing, two gallons of Golden Italian dressing, one gallon of Creamy French dressing, one gallon of Creamy Caesar dressing, one gallon of Yasou Feta Cheese Vinaigrette and one gallon of South West Cilantro Lime Vinaigrette. None of these unopened gallons of salad dressing were labeled with a date of any type. The HSAD stated that the cases they were delivered in would have had dates. However, there were no dates on the individual gallon jugs. The HSAD stated that there were	F 812	Additionally, the trays will be stored upside down when not in use. 2. The Plate Lowerators were removed from service and cleaned. 3. The ADHS is obtaining a list of all distributor-dating codes. An in-service to staff members will occur by October 15, 2021 to understand how to read the dating codes. A food expiration audit will be conducted weekly, and all food items will be checked for dating prior to use. Any expired items will be discarded immediately. Until the distributor-dating codes can be obtained, all original shipping containers dating will be written on the bulk container. 4. The unopened five-pound container of potato salad with the Use by date of 9/1/2021 was immediately discarded. At daily safety huddle, the staff members were re-educated on importance of checking for and discarding expired food items. A food expiration audit will be conducted weekly, and all food items will be checked for dating prior to use. 5. The plastic dish dollies were pulled from service and cleaned. Replacement dolly covers were obtained and put in to service. The top plate on each stack will be turned over to protect the other plates from dust and debris. 6. The ADHS contacted the kosher food vendor for clarification for reading product codes and expiration dates. An in-service	

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	315490	A. BUILDING _____ B. WING _____	09/20/2021

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F 812	Continued From page 2 codes on each container, and he could find out the dates. In addition, there were two gallons of mayonnaise that were not dated. The ASHD stated that they came in on 9/3/2021 and that the facility used six gallons of mayonnaise a week. The ASHD further explained that they rotated the stock. Once a product was taken out of the container it was delivered in, the facility would use it first. Once they opened the food containers, they would date that item. 4. In one of the walk-in refrigerators, there was an unopened five-pound container of potato salad with a manufacturer's "Use by" date of 9/1/2021 printed on the rim. The ASHD discarded the salad and stated, "that's out of date. We'll bring it up in our huddle." 5. In another walk-in refrigerator, there were two plastic dish dollies that could accommodate five stacks of plates. One dolly had a torn plastic cover protecting the plates. The second dolly had two stacks of plates, was uncovered and the top plate on each stack was not turned over to protect the other plates from dust. There was visible dirt and debris in the three sections of this dolly that were not in use. The ASHD stated that the covers were very brittle, and he had ordered new covers. 6. In one reach-in freezer, there were approximately 31 cases of frozen Kosher dinners and some baked goods that were not labeled with any type of a date. The ASHD stated that he ordered the Kosher meals twice a week. He would have to contact the distributor to determine a packing or expiration date. 7. The can opener blade was visibly worn and	F 812	to staff members will occur by October 15, 2021 to understand how to read the dating codes. A food expiration audit will be conducted weekly, and all food items will be checked for dating prior to use. Any out of date items will be discarded immediately. 7. The can opener was replaced and the base was cleaned prior to the surveyor□s departure. Spare blade parts for the can opener were ordered. The can openers are included in weekly sanitation audits. 8. The toaster was cleaned prior to the surveyor□s departure. 9. The damaged cutting boards were discarded and replaced with new cutting boards. The staff were instructed not to place hot pots from stove onto cutting boards. Placed on weekly sanitation audits. 10. The soiled linen container was replaced with a new bin. 11. The ice scoop was removed and placed in a perforated pan to allow for air-drying. A new ice scoop bin has been ordered and will be installed upon receipt 12. The pots and pans were removed from the racks and the racks were cleaned. " The bulk salad dressings in the dry storage room were immediately	

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	315490	A. BUILDING _____ B. WING _____	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEDICAL CENTER TCU	99 ROUTE 37 WEST TOMS RIVER, NJ 08755

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F 812	Continued From page 3 sticky. The ASHD immediately replaced the dirty can opener along with its tabletop holder, which was also visibly soiled. 8. The wire rack on the conveyer toaster was soiled with "baked on food debris" according to the ASHD. 9. The rack of "clean" cutting boards contained two that were visibly soiled with food particles. Five additional cutting boards had black stains on their surfaces. The ASHD stated that the black stains resulted from pots resting on them. The ASHD also stated that he would replace all of the cutting boards. 10. There was a large trash can and lid that were heavily soiled. The ASHD stated that the can was used for soiled linen but, "it needs to be cleaned." 11. There was one ice scoop resting on a black plastic surface on a shelf on the side of the ice machine. There was a second scoop held in a non-draining container on the wall next to the machine. The clear plastic container was visibly soiled with dust and debris. 12. The rack holding clean pots and steam table pans was visibly soiled and greasy and sticky to the touch. The ASHD agreed that it felt sticky. On 9/9/2021 at 10:43 AM, in the presence of the ASHD and the Administrative Director for Ancillary Services, the surveyor observed the following: In the dry storage room, the ASHD explained the codes that were stamped on the bottles of dressing and mayonnaise corresponded to a production date. He stated that the Kraft	F 812	discarded. These items included: o Sysco Feta Cheese dressing; undetermined expiration date. o Creamy French Dressing; produced in 2019 o Four gallons of Honey Mustard Dressing; undetermined expiration date " The Equipment Cleaning directions will be updated to ensure practice matches policy. This procedure will be converted to a policy, which will then be inclusive of a date. " The weekend cleaning assignment sheets have been updated to include the two-compartment plastic dolly, the plate lowerators, and the plastic dish dollies. The weekend dietary supervisor ensure the cleaning assignments are completed and the patient service manager crosschecks and signs off that cleaning was completed as assigned. " The Administrative Director of Hospitality Services (ADHS) or designee will conduct a weekly food expiration audit ; all food items will be checked for dating prior to use. Any expired items will be discarded immediately. " The Administrative Director of Hospitality Services (ADHS) or designee will conduct a weekly sanitation audit to include the can opener, toaster, clean pot rack, and cutting boards. " All dietary staff members will be educated on the distributor-dating codes	

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F 812	Continued From page 4 dressings were good for 180 days from the production date. The bottles of Kraft mayonnaise were within their 180-day shelf-life. The ASHD stated that the dressing produced by Sysco had a shelf life of 240 days and then he added, "I did not know that." Neither the ASHD nor the surveyor were able to read the code printed on the bottle of the Sysco Feta Cheese dressing, therefore an expiration date could not be determined. The codes indicated that the gallon of Creamy French dressing was produced in 2019. The ASHD stated that "would be expired. I don't use those. I didn't know how to read the codes until today, so those would be expired." The ASHD acknowledged that four gallons of Honey Mustard dressing were also expired. He stated that the facility had not used those gallons of dressing since they closed the salad bar before the Covid -19 pandemic. After surveyor inquiry, the ASHD stated they had one employee to stock shelves who came in twice a week on delivery days. He also stated that most equipment in the kitchen was cleaned on the weekends. A review of the facility's "Food Labeling and Dating" policy dated approved 3/19/2021, included: "Bulk condiments and dressings will be dated on the date on which they were opened and discarded after 30 days or 1 month." The policy did not include labeling and dating of foods upon delivery or when taken out of the original case and placed on a storeroom shelf. A review of the facility's undated "Cleaning Procedures for Kitchen Equipment" policy	F 812	and the additional equipment added to the weekend cleaning schedule. " The Administrative Director of Hospitality Services (ADHS) or designee will monitor expirations on a weekly basis utilizing a standardized audit. " The Administrative Director of Hospitality Services or designee will tour the kitchen on a weekly basis to complete a standardized audit of the kitchen environment, having a special focus on the cleanliness of all areas and ensuring compliance. " The Food Service Director or designee will report all findings monthly to the Licensure & Accreditation Committee and then the data will be sent to the TCU QAPI Committee quarterly for review. Auditing will continue until three(3) continuous months of 100% compliance is achieved.	

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F 812	Continued From page 5	F 812		

included the following procedures:

"Conveyor Toaster...Using a damp cloth wipe the wire conveyor from the outside to the center...Clean the crumb tray, wire feeder rack, and the return chute with mild soap and warm water...Rinse when clean."

"Can Opener...Scrub shank, paying special attention to blade and moving parts. Use sanitizing solution and brush or run through dish machine...Inspect blade and replace if notched...Scrub base plate (attached to table)."

"Tray Carts, Dish Carts, Utility Carts...After each meal to...Wash inside; rinse... allow to air dry...Weekly...Follow steps 1-3 above or take to cart wash area (and) wash wheels and castors with sanitizing solution."

"Cabinets and Drawer...Weekly...Use a mild detergent and water...Rinse shelves and drawers with a clean sponge and dry."

A review of the facility's "Main Kitchen: Saturday Cleaning Sheet" and "Sunday Cleaning Schedule" indicated that the following items had been cleaned on 9/4 and 9/5/2021:

garbage cans, lowerators, all carts and racks, dish dollies, toaster and the pot shelves.

A review of the facility's monthly "Safety and Sanitation Inspection" dated 9/2/2021, reflected the following:

"Lowerators clean and in good repair." This section had the following comment written beside

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F 812	Continued From page 6 it: "Need (unintelligible word) cleaning when not hot." "Cutting boards clean and allowed to air dry." This area was not checked at all. "Freezers: Foods are properly wrapped and labeled and dated." This area was checked "Yes." "Food Preparation Area: Toaster" was checked as clean. "Pot Room: Walls, racks and floors are clean." This section was checked "Yes." NJAC 8:39 17.2 (g)	F 812		

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	656100	A. BUILDING: _____ B. WING _____	09/20/2021

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COMMUNITY MEDICAL CENTER TCU	99 ROUTE 37 WEST TOMS RIVER, NJ 08755

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S 000	Initial Comments THE FACILITY WAS 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 14 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	o The current staffing grid for the TCU was reviewed and revised by the Director of Nursing to ensure it met the standards of the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. o The Director of Nursing revised the TCU staffing plan to include the use of direct care workers which is a nurse or other qualified employee that is signed into work as a C.N.A and is performing C.N.A duties only. 3 The TCU nursing staff was educated	10/6/21

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

Electronically Signed | 10/07/21

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," 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 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 8/22/21 to 8/28/21 and 8/29/21 to 9/4/21, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift; half of all staff on the evening shift to be CNAs as documented below: 8/22/21 had 2 CNAs for 20 residents on the day shift (Must be no more than 8 residents to each CNA). 8/22/21 had 2 CNAs out of 5 total staff on the evening shift (CNAs must be at least half of all staff). 8/23/21 had 2 CNAs for 20 residents on the day shift. 8/23/21 had 2 CNAs out of 5 total staff on the evening shift.	S 560	on the revised staffing grid, the revised staffing plan and the standards of the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. The education emphasized: o The need to ensure if a nurse or another qualified employee is utilized to fulfill the requirements of this mandate, that person is now working as a direct care staff member and therefore is performing C.N.A duties only. o The need to ensure that half of the staff members present on the evening shift are C.N.A.s. 4 The Director of Nursing or designee will review the TCU nurse staffing on a daily basis to ensure the standards of the required minimum direct care staff to resident ratios as mandated by the State of New Jersey is being met. Any non-compliance with this mandate will result in disciplinary action up to and including termination. The Director of Nursing or designee will report all findings at the quarterly QAPI Committee Meeting.	

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S 560	Continued From page 2 8/24/21 had 2 CNAs for 20 residents on the day shift. 8/24/21 had 2 CNAs out of 5 total staff on the evening shift. 8/25/21 had 2 CNAs for 19 residents on the day shift. 8/25/21 had 2 CNAs out of 5 total staff on the evening shift. 8/26/21 had 2 CNAs for 19 residents on the day shift. 8/26/21 had 2 CNAs out of 5 total staff on the evening shift. 8/29/21 had 1 CNA for 11 residents on the day shift. 8/29/21 had 1 CNA out of 3 total staff on the evening shift. 8/31/21 had 1 CNA for 9 residents on the day shift. 8/31/21 had 1 CNA out of 3 total staff on the evening shift. On 9/10/21 at 09:57 AM the surveyor interviewed the Director of Nursing (DON) and the Manager of Quality Resource Services (MQRS) regarding staffing. The DON acknowledged that the facility was aware of the number of CNAs required, but did not always have the required number of CNAs. The nurses helped the CNAs, but they also performed other nursing duties like medication pass. 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
315490 Y1	A. Building B. Wing Y2	11/30/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEDICAL CENTER TCU	99 ROUTE 37 WEST 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 F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 10/15/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 9/20/2021	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
656100		11/30/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEDICAL CENTER TCU	99 ROUTE 37 WEST TOMS RIVER, NJ 08755

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/06/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/20/2021	☐ 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
	315490	A. BUILDING **01** B. WING _____	**09/20/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEDICAL CENTER TCU	**99 ROUTE 37 WEST** **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
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		
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 09/20/21was found to be incompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Community Medical Center (TCU unit) is a 3-building that was built in 80's, It is composed of Type I protected. The facility TCU unit is divided into 5- smoke zones. 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 25 certified beds. At the time of the survey the census was 11.	K 000		

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

Electronically Signed | 10/07/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 The generator does approximately 50 % of the building.	K 000		