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 _____	C 01/31/2024

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		
F 000	INITIAL COMMENTS Complaint #: NJ164226 Survey Date: 1/31/24 Census: 18 Sample: 8 + 2 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.	F 812		2/14/24

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

Electronically Signed | 02/14/2024

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F 812	Continued From page 1 §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 and interview it was determined that the facility failed to: a.) maintain sanitation in cooking areas in a safe consistent manner; b.) label, date, and store potentially hazardous foods appropriately to prevent food borne illness; c.)maintain multiuse food-contact surface cutting board in a manner to prevent microbial growth; and d.) maintain kitchen equipment in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 1/26/24 at 11:05 AM, the surveyor in the presence of the Administrative Director Hospitality Services (ADHS) and Quality Coordinator (QC), toured the kitchen and observed the following: 1. On a preparation table, one large light blue cutting board that was deeply pitted and discolored black. The ADHS confirmed the facility should not be using that cutting board. 2. On a rack, two small light blue, two large tan, one large red, and one large yellow cutting boards all pitted and discolored black. The ADHS acknowledged the cutting boards needed to be changed; that bacteria could grow in the grooves. 3. On a drying rack adjacent to the pot washing room, four full six-inch pans, three four-inch plastic pans, and three large plastic full lids all wet nested (stacked on top of each other while still	F 812	I. 1. The one large light blue cutting board found on the preparation table was immediately discarded and replaced. 2. The two small light blue, two large tan, one large red and one large yellow cutting boards found on a rack were immediately discarded and replaced. 3. The four full six inch pans, three four inch plastic pans and three large plastic lids found nested on the drying rack were immediately removed from the rack, cleaned and were properly placed back on the drying rack, ensuring no items were nested or stacked together. 4. The three six inch full deep pans with yellowish debris were immediately removed from the rack, cleaned and were properly placed back on the drying rack, ensuring no items were nested or stacked together. 5. The one half gallon of fat free milk dated 2/8/24, one opened half gallon of fat free lactose milk with a manufacturer□s expiration date of 2/14/24, one opened gallon of 2% milk with an expiration date of 1/31/24 and the two quart containers of heavy cream with an expiration date of 2/14/24 all without an opened on date identified in the reach-in nourishment refrigerator RU 56 were immediately discarded. The tray that was holding the milk containers as well as portioned containers of milk that had the white liquid	

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F 812	Continued From page 2 wet). The ADHS stated that wet nesting could harbor bacterial growth. 4. On a drying rack adjacent to the pot washing room, three six-inch full deep pans with a yellowish debris caked on. The ADHS confirmed the pans should not have debris on it. 5. In reach-in nourishment refrigerator RU 56, the surveyor observed the following: one half-gallon of fat-free milk dated expired 2/8/24, was opened with no date of when opened. The ADHS stated it was facility policy to use the manufacturer's expiration date on all products even after opened. One opened half-gallon fat-free lactose milk with a manufacturer's expiration date of 2/14/24, there was no date of when opened; the packaging indicated to use within seven days of opening. One opened gallon of 2% milk with an expiration date of 1/31/24, with no date of when opened. Two quart containers of heavy cream with an expiration date of 2/14/24, opened with no date of when opened. The packaging indicated to use within seven days of opening. The tray that held the milk containers as well as portioned containers of milk had a white liquid puddle. The ADHS acknowledged the tray should not have spilled liquid on it. 6. On the spice rack, one opened forty-eight ounce lemon juice with no date of when opened. The packaging indicated to refrigerate after opening. The ADHS confirmed it should have been refrigerated. 7. In the cook's preparation area, one large yellow cutting board that was deeply pitted and discolored black.	F 812	puddle was immediately cleaned. 6. The one forty-eight ounce lemon juice without an opened on date found on the spice rack not refrigerated was immediately discarded. 7. The one large yellow cutting board found in the cook□s prep area was immediately discarded and replaced. 8. The white cutting board found on the steam table was immediately discarded and replaced. 9. The sixteen vanilla and ten chocolate health shakes that were thawed and found without a use by date in reach-in refrigerator RU 63 were immediately discarded. II. All TCU patients, staff and visitors can be effected by the failure to ensure food procurement, storage and service are conducted in a sanitary manner. All of the cutting boards in use throughout the kitchen area were inspected for pitting and discoloration. No other cutting boards were identified as pitted or discolored. All of the items present on drying racks were inspected to ensure there was no nesting present. No other items were identified as nested or stacked. All of the refrigerators present throughout the kitchen were inspected for items that were opened without an opened on date and thawed that did not have a use by/discard date. No other items were identified. All trays present in the refrigerators were inspected to ensure they were free from spills and clean. No other trays were identified. The spice rack was inspected for any	

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F 812	Continued From page 3 8. The steam table contained a white cutting board that was deeply pitted and discolored black/yellow/reddish colors. 9. In the reach-in refrigerator RU 63, sixteen vanilla and ten chocolate health shakes that were thawed. The packaging indicated to use within fourteen days of thawed. There was no date when the health shakes were thawed or when to use by. The ADHS acknowledged the health shakes were thawed and only had a fourteen day period they could be served within. On 1/31/24 at 11:09 AM, the ADHS in the presence of the Licensed Nursing Home Administrator (LNHA), Manager Quality Resource Services, and survey team acknowledged the above findings. The ADHS stated milk should be used within seven days of opening. A review of the facility's "Food Labeling and Dating" policy dated 5/27/22, included health shakes will be postdated for fourteen days and discarded on the expiration date... A review of the facility's "Dietary Department Safety and Sanitation" policy dated 5/22/22, included the Nutrition and Food Service Department will comply with all State, Federal and Local Health Codes; sanitary food handling procedures will be practiced in the preparation, storage and serving of food according to Dietary Department policies...clean pots and pans will be stored in a manner to promote air drying of equipment and prevent wet nesting of pots and pans... A review of the facility's "Food and Nutrition Equipment" policy dated 5/23/22, included cutting	F 812	other items that required an opened on/use by date and refrigeration. No other items were identified. III.The current sanitation audit was revised to include inspection of all cutting boards in use throughout the facility. All employees involved in completing the sanitation audit have been educated on the revised sanitation audit and the need to remove any cutting boards that are identified as being discolored or pitted; All drying racks will be inspected daily to ensure items present are properly placed and not nested. All food service employees were educated on the proper way to place items on the drying rack to ensure there is no nesting present; The Food Dating policy was revised to include the need to have a opened on or use by/discard date on all food items that have been opened and/or thawed. All food service employees have been educated on the revised policy. IV. The Administrative Director of Hospitality Services will conduct a Quality Assurance audit daily for 120 days (3 months). The Quality Resource Services Manager and the Safety Director will conduct a weekly Quality Assurance audit for 120 days (3months) to validate that daily auditing is occurring. For any non-compliance that is identified, the Fair and Just Culture algorithm will be utilized to determine the best action to consider which includes but is not limited to coaching the non-complaint individual(s), increased supervision of the non-complaint individual(s), disciplinary action or termination. The Quality	

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F 812	Continued From page 4 boards...all cutting boards wear out over time. After cutting boards become excessively worn or develop hard-to-clean grooves, they should be discarded... NJAC 8:39-17.2(g)	F 812	Resource Services Manager will report findings at the quarterly Quality Assurance Performance Improvement meeting.	

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	656100	A. BUILDING: _____ B. WING _____	C 01/31/2024

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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 2 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 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	I. The Administrator reviewed the current staffing grid and plan for the TCU to ensure it met the standards of the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. II. All TCU patients and staff can be effected by not meeting the standards of the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. The Administrator ensured the TCU staffing plan includes 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. III. The TCU nursing employees were	2/14/24

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

Electronically Signed | 02/14/24

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S 560	Continued From page 1 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. During entrance conference on 1/26/24 at 9:30 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the facility's Administration Staff informed the surveyor that the facility was good with staffing. 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 1/7/24 to 1/13/24 and 1/14/24 to 1/20/24, which revealed the staffing to resident ratios that did not meet the minimum requirement of total staff on the evening shift as documented below: 1/12/24 had 2.5 CNAs to 5.5 total staff on the evening shift, required at least 3 CNAs. 1/13/24 had 2.5 CNAs to 5.5 total staff on the evening shift, required at least 3 CNAs. NJAC 8:39-5.1(a)	S 560	educated on the staffing grid and plan which includes 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 and the need to ensure that half of the staff members present on the evening shift are working as C.N.A.s. IV. The TCU Director of Nursing or designee will review the TCU nurse staffing on a daily basis for 120 days (3 months) 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. For any non-compliance with this mandate that is identified, the Fair and Just Culture algorithm will be utilized to determine the best action to consider which includes but is not limited to coaching the non-complaint individual(s), increased supervision of the non-complaint individual(s), disciplinary action or termination. The Director of Nursing will report findings at the quarterly Quality Assurance Performance Improvement meeting.	

New Jersey Department of Health

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315490	A. Building B. Wing	2/28/2024

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 02/14/2024	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
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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	
1/31/2024	☐ 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
656100 (Y1)	A. Building B. Wing (Y2)	2/28/2024 (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 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 02/14/2024	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	
1/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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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 1/30/24 and Community Medical Center (TCU unit) was found to be non-compliance 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 has 25 certified beds. The Emergency Generator does approximately 50% of the building.	K 000		
K 291 SS=D	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 1/30/24 in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light above the emergency generator's transfer switch location, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice identified for 1 of 1 emergency transfer switch observed, and was evidenced by the	K 291	I. The Manager of Plant Operations ordered and ensured installation of the appropriate battery backup emergency light. II. All TCU residents, staff and visitors could be effected by the lack of appropriate battery backup emergency light. The Manager of Plant Operations inspected all systems that support the TCU to ensure there was battery backup	2/14/24

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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
K 291	Continued From page 1 following: On 1/30/24 at approximately 9:30 AM, during the survey entrance, a request was made to the Licensed Nursing Home Administrator (LNHA) and the Fire and Safety Director (FSD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. The surveyor also asked if the facility had an emergency generator, in which the FSD responded, yes there was an emergency generator. Starting on 1/30/24 at approximately 9:35 AM, in the presence of the facility's Manager of Plant Operations (MPO) and FSD, a tour of the building was conducted. At approximately 10:10 AM, an inspection inside the basement level Mechanical Room area where the Emergency Generator's Automatic Transfer Switch (ATS) #12 (ATS #12 serves emergency power to the Transitional Care Unit) was located. The surveyor observed no evidence of a battery back-up emergency light in the area. At this time the surveyor asked the MPO and FSD if ATS #12 had a battery back-up emergency light, and the MPO responded, no. The MPO and FSD confirmed the finding at the time of observation. On 1/30/24 during the survey exit at approximately 1:50 PM, the surveyor informed the LNHA of the Life Safety Code finding. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	emergency light available where required. No other areas were identified as needing battery backup emergency power. III. The Plant Operations Manager will include inspection of areas needing battery backup emergency light in the Environment of Care (EOC) rounds to ensure it is present where required. The Plant Operations Manager has added the battery backup emergency light to the inventory on the preventative maintenance (PM) schedule. The PM schedule for the battery backup emergency light is a 30-second check that will occur monthly, and a 90-minute check that occurs annually. In the event of a non-functioning light, the employee conducting the PM will escalate to the Plant Operations manager, place a repair work order, and replace/repair the light as needed. All PM schedules are kept in the PM log book for review and reference. IV. The Plant Operations Manager will audit the PM schedules weekly for 120 days (3 months). If it is identified that any non-compliance with the PM schedule is identified, the Fair and Just Culture algorithm will be utilized to determine the best action which could include but is not limited to coaching, increased supervision of the individual(s), disciplinary action or termination. The Plant Operations Manager will present any findings at the quarterly Quality Assurance Performance Improvement meeting.	

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 _____	**01/31/2024**

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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K 293	Continued From page 2	K 293		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation on 1/30/24, in the presence of facility management, it was determined that the facility failed to provide two (2) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was identified in 2 of 3 exit areas, and was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction	K 293	I. The Manager of Plant Operations ordered and ensured installation of the exit signs above the corridor control double door by the Staff Lounge and by the Pantry/Dining room. II. All TCU residents, staff and visitors could be effected by the lack of clearly identified, illuminated exit sign to all exit access paths that reach an exit discharge door. The Manager of Plant Operations inspected all exit access paths that reach an exit discharge door to ensure a clearly identified, illuminated exit sign was present. No other areas where found to be without to a clearly identified illuminated exit sign. III. The Plant Operations Manager will include inspection of exit access paths that reach an exit discharge door in the Environment of Care (EOC) rounds to ensure a clearly identified illuminated exit sign is present. The Plant Operations Manager has added the exit sign(s) to the inventory on the preventative maintenance (PM) schedule. The PM	2/14/24

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	315490	A. BUILDING **01** B. WING _____	**01/31/2024**

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K 293	Continued From page 3 Code 5:23: International Building Code, Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge."... Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign."... On 1/30/24 at approximately 9:30 AM, during the survey entrance, a request was made to the Licensed Nursing Home Administrator (LNHA) and Fire and Safety Director (FSD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the Transitional Care Unit (TCU) section of the facility. The surveyor also asked, how many resident sleeping rooms were on the TCU, and the LNHA responded there were thirteen resident sleeping rooms on the unit. A review of the facility provided lay-out identified the TCU was located on the third-floor section of a hospital. There were three designated exit stairwells out of the TCU that residents, staff and visitors could use to exit the TCU in the event of	K 293	schedule for the exit signs is a monthly visual check. In the event of a non-illuminated exit sign, the employee conducting the PM will escalate to the Plant Operations manager, place a repair work order, and replace/repair the sign as needed. IV. The Plant Operations Manager will audit the PM schedules weekly for 120 days (3 months). If it is identified that any non-compliance with the PM schedule is identified, the Fair and Just Culture algorithm will be utilized to determine the best action which could include but is not limited to coaching, increased supervision of the individual(s), disciplinary action or termination. The Plant Operations Manager will present any findings at the quarterly Quality Assurance Performance Improvement meeting.	

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	315490	A. BUILDING **01** B. WING _____	**01/31/2024**

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K 293	Continued From page 4 an emergency. On 1/30/24 starting at approximately 9:35 AM, in the presence of the facility's Manager of Plant Operations (MPO) and FSD, a tour of the building was conducted. Along the TCU tour, the surveyor observed the following areas that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit: 1. At approximately 10:31 AM, the surveyor observed no evidence of an illuminate exit sign above the corridor control double doors, next to the Staff Lounge. 2. At approximately 10:39 AM, the surveyor observed no evidence of an illuminate exit sign above the corridor control double doors, next to the Pantry/Dining room. The MPO and FSD confirmed the findings at the time of observations. On 1/30/24 during the survey exit at approximately 1:50 PM, the surveyor informed the LNHA of the Life Safety Code findings. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315490	A. Building 01 - MAIN UNIT B. Wing	2/28/2024

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 Reg. # NFPA 101 LSC K0291	Correction Completed 02/14/2024	ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 02/14/2024	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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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	
1/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO