STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ___	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/15/23 and 9/18/23, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Manahawkin H&R Center is a 2- building with a partial basement, that was built in 80's, It is composed of Type I (fire resistant) construction. The facility is divided into 10 smoke zones. The inside diesel generator does approximately 65 % of the building. *It was noted that the facility once had a fire pump system. The system is currently supported by city pressure. *The building was recently taken over by a different company.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		11/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 10/04/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 222	Continued From page 1 only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(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 222	Continued From page 2	K 222		

ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS
Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.
18.2.2.2.4, 19.2.2.2.4
This REQUIREMENT is not met as evidenced by:
Based on observation and interview on 9/18/23, in the presence of Maintenance Director (MD) and Regional Plant Operations Director (RPOD), A). it was determined that the facility failed to ensure that the 15-second delayed egress feature on 2 of 6 exit discharge doors (with this feature) observed would activate when tested. B). it was determined that the facility failed to ensure that egress doors equipped with a delayed 15-second egress feature were labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." This deficient practice was evidenced for 6 of 6 egress doors by the following in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6.

A-1. At 11:11 AM, the surveyor, RPOD and MD observed that the egress door by resident room 237 had a delayed egress system installed on the door. The delayed egress system was activated, but did not function on the first activation when tested by the RPOD. The door was provided with a key pad that opened the door, and according to the Maintenance Director, the fire alarm would open the door when activated.

A-2. At 11:55 AM, the surveyor, RPOD and MD

K222
Specific Concerns
The required 15 second delayed egress feature on the exit doors by 237 and 138 has been installed
and the appropriate signage has been placed on the doors by 136, 139, 236,239, and both units by the dining rooms.

Identification of Similar Concerns
All residents have the potential to be affected by this deficient practice. The Maintenance Director or designee will review 100% of all exit doors to determine if any other exit doors requiring the delayed egress feature as well as corresponding signage is present. If not, any additional issues will be corrected as required.

Systemic Changes
The Maintenance Director will be inserviced on these requirements and monthly rounds will be conducted by the Maintenance Director or designee to ensure the 15 second egress feature is functioning and signage is in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 222	Continued From page 3 observed that the egress door by resident room 138 had a delayed egress system installed on the door. The delayed egress system was activated, but did not function when tested by the RPOD.The door was provided with a key pad that opened the door, and according to the Maintenance Director, the fire alarm would open the door when activated. The RPOD and MD both confirmed the above findings during the observations. B). During the building tour from 9:15 AM, to 1:30 PM, the Surveyor, Regional Plant Operations Director and Maintenance Director observed 6 of 6 egress doors. The doors were equipped with a delayed 15-second egress feature, but were not labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door locations were as follows: Floor #2 West by resident room 239 Floor #2 East by resident room 236 Floor #2 center by resident dining room Floor #1 West by resident room 139 Floor #1 East by resident room 136 Floor #1 center by resident dining room The MD and RPOD both confirmed the findings during the observations. The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference on 9/18/23.The Administrator was at a meeting during the LSC exit. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1,	K 222	Monitoring The Maintenance Director or designee will submit a report to the facility□s monthly QAPI Committee for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 222	Continued From page 4 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C 2. At 12:38 PM, the Surveyor and Maintenance staff member observed the egress doors by resident room 113. The doors indicated that they were equipped with a delayed 15-second egress feature which was labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door's egress feature did not function. The door was provided with a key pad that opened the door, and according to the Maintenance staff member, the fire alarm would open the door when activated.	K 222		
K 321 SS=F	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	K 321		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ____	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 321	Continued From page 5 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 9/15/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 10 of 15 hazardous storage room doors observed and was evidenced by the following: 1). At 12:28 PM, the surveyor observed on floor #1, that the exit/egress corridor lead to the facility kitchen. The set of wooden doors from the corridor to the kitchen were observed to have no fire rating labels. 2). At 12:34 PM, the surveyor observed in the basement that the chemical storage room gray door did not have a fire rating label. 3). At 12:51 PM, the surveyor observed the gray door to the laundry room from dirty to clean, did	K 321	K321 Specific Concerns The facility has placed the required fire rating labels on the following doors: wooden door from the corridor to the kitchen, basement grey chemical storage room door, grey door to biohazard room,dietary storage room grey door,elevator room grey door. Additionally, the facility has repaired the laundry room, dietary storage room and activities doors so that they latch, the striker plate on the resident storage room door has been installed, and the laundry and recreation room door key pads have been repaired. The cord was removed from the general storage room door. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. The Maintenance Director or designated designee will do a 100% review of all fire doors to ensure they all are properly labeled with the fire rating, have closures, latch properly, have striker plates, and are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 321	Continued From page 6 not latch when released from the auto magnetic releasing device. 4). At 12:55 PM, the surveyor observed the gray door to the Biohazard room did not have a fire rating label. 5). At 1:13 PM, the surveyor observed the resident storage room door frame was missing a striker plate. 6). At 1:15 PM, the surveyor observed the activities door did not latch into its frame. 7). At 1:20 PM, the surveyor observed that the general storage room was tied open with a black cord, no staff was observed in the area. 8). At 1:22 PM, the surveyor observed that the dietary storage room gray door would not latch into its frame and did not have a fire rating label. 9). At 1:36 PM, the surveyor observed that the elevator room gray door, did not have a fire rating label. 10). At 1:41 PM, the surveyor observed that the laundry and recreation room doors had a push pad to install a code so the door opens, the RPOD and MD could not open the door due to the batteries being dead, the MD indicated he could not find the key to bypass the key pad. The RPOD and MD both confirmed the findings during the observations. The RPOD was informed of the findings at the Life Safety exit conference on 9/18/23. The Administrator was at a meeting during the LSC	K 321	not propped open. Additional identified concerns will be corrected. Systemic Changes The Maintenance Director will be inserviced on these requirements and the Housekeeping and Maintenance staff will be inserviced on not tying/propping fire doors. Monthly rounds will be conducted by the Maintenance Director or designee on all fire doors. Monitoring The Maintenance Director or designee will submit a report to the facility□s monthly QAPI Committee for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ___	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 321	Continued From page 7 exit. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review, on 9/18/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance	K 324	K324 Specific Concerns	11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 324

Continued From page 8

Director (MD), A). it was determined that the facility failed to ensure that 1 of 1 kitchen ansul system inspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10. B). it was determined that the facility failed to ensure that a smoke detector was installed less than 20 ft from the cooktop or range.

The deficient practice was evidenced for 1 of 1 monthly inspection tags by the following:

A). At 12:45 PM, the surveyor, RPOD and MD observed in the facility kitchen, that the ansul system inspection tag, located at the activation pull station was annually inspected: 3/23, but the monthly inspection tag was only filled out for the month of September 12, 2023.

The MD and RPOD both confirmed that the ansul system must be inspected monthly and the date signed off on the tag.

B). At 12:50 PM, the surveyor, RPOD, MD and Dietary Director observed in the facility kitchen that no smoke detector's was located less than 20 ft. from the cooktop or range.

The Dietary and Maintenance Director indicated that they were unaware of this requirement and both confirmed no smoke detectors were observed in the kitchen.

The Regional Plant Operations Director was informed of the finding at the Life Safety Code exit conference on 9/18/23.The (new) Administrator was at a meeting during the LSC exit.

NJAC 8:39-31.2(e)

K 324

The ansul system tag has been signed for October 2023 and a smoke detector has been installed as required by the cooktop/range.

Identification of Similar Concerns
All residents have the potential to be affected by this deficient practice. The Maintenance Director or designee will conduct 100% rounds on all fire extinguishers to ensure they are signed for October. A review of the kitchen will also be conducted to ensure no other smoke detectors are missing where required.

Systemic Changes
The Maintenance Director will be inserviced on these requirements and the Maintenance Director or designee will also conduct monthly rounds to ensure all fire extinguishers are signed.

Monitoring
The Maintenance Director or designee will submit a report to the facility�s monthly QAPI Committee for the next 3 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ___	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 324	Continued From page 9 NFPA 96 and NFPA 10. NFPA 101 2012 edition 19.3.2.5, 19.3.2.5.3 (12)	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 9/15/23, in the presence of the (new) Maintenance Director (MD), it was determined that the facility failed to ensure smoke detection sensitivity testing were completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The deficient practice was identified for 2 of 2 semi annual inspection reports provided and was evidenced by the following: At 10:00 AM, the surveyor reviewed all related fire alarm documentation provided by the MD, from the fire alarm vendor to determine if the sensitivity test was performed. The reports provided did not indicate any information on the testing of the smoke detectors for sensitivity. An interview was conducted with the MD, during document review, he was not sure if the required sensitivity test for the facility smoke detectors	K 345	K345 Specific Concerns Sensitivity testing has been conducted on all smoke detectors as required by this regulation. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. A 100% review of all smoke detectors will be conducted by the facility□s fire system contractor to ensure all detectors are sensitivity tested as required. Systemic Changes The Maintenance Director will be inserviced on this requirement and the Maintenance Director and Administrator will ensure all smoke detectors are sensitivity tested as required.	11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ___	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 345	Continued From page 10 were performed. The MD further stated he would contact the facility fire alarm vendor to see if the sensitivity test was performed, but at the LSC exit no further documentation was provided. The Regional Plant Operations Director was informed of the findings at the Life Safety Code Exit conference on 9/18/23. The (new) Administrator was at a meeting during the LSC exit. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	Monitoring The Maintenance Director or designee will submit a report to the facility s monthly QAPI Committee for the next 3 months.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ 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:	K 353		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 353	Continued From page 11 Based on surveyor observation and interview on 9/15/23, in the presence of the Maintenance Director (MD), A). it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. B). it was determined that the facility failed to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated as evidenced by the following: in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. TThis deficient practice was identified for and evidenced by the following: A-1). At 12:41 PM, the surveyor and MD observed in the laundry room that 1 of 1 fire sprinkler heads behind the commercial clothes dryers were loaded with green oxidation and lint. A-2). At 12:45 PM, the surveyor and MD observed 3 of 3 fire sprinkler heads with a coating of lint in front of the dryers. A-3). At 1:32 PM, the surveyor and MD observed 1 of 1 fire sprinkler cabinets. The red cabinet was observed to have extra fire sprinkler heads, but did not have the required wrench to change the sprinkler heads in the event of an activation. B-1). At 12:47 PM, the surveyor and MD observed in the 1st floor nurse station closet that an 24" x 18" ceiling tile was missing. B-2). At 1:10 PM, the surveyor and MD observed in the activities room that (2) two 2' x 4' drop ceiling tiles were missing.	K 353	K353 Specific Concerns The sprinkler heads behind and in front of the dryers have been cleaned, an appropriate wrench to change sprinkler heads has been obtained, and ceiling tiles in the 1st floor nurses station closet and activities have been replaced. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. The Maintenance Director or designee will conduct 100% rounds of all sprinkler heads in the basement to identify any additional ones needing cleaning as well as 100% facility rounds on missing ceiling tiles that need replacing. Systemic Changes The Maintenance Director will be inserviced on this requirement and the Maintenance Director or designee will also conduct monthly rounds on the basement sprinkler heads and all missing ceiling tiles. Monitoring The Maintenance Director or designee will submit a report to the facility�s monthly QAPI Committee for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(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 353	Continued From page 12 An interview was conducted with the MD during the observation's, where he confirmed that the above findings. The Regional Plant Operations Director was informed of the finding's at the Life Safety Code exit conference on 9/18/23. The (new) Administrator was at a meeting at the time of the LSC exit. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and an interview on 9/18/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to perform and document on the tag attached to the fire extinguisher a full monthly visual examination for 2 of 15 fire extinguishers observed by the following: 1). At 10:00 AM, the surveyor and MD observed that the fire extinguisher identified as # 12 was annually inspected from the facility vendor December 2022, but the monthly inspection tag was only filled out for September 9/12/23, leaving the previous months blank.	K 355	K355 Specific Concerns Fire extinguisher #12 has been signed for October 2023 and the extinguisher by room 253 has been inspected as required. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. The Maintenance Director or designee will conduct 100% rounds on all fire extinguishers to ensure they are signed monthly and have been inspected	11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 13 2), At 10:13 AM, the surveyor and MD observed that the fire extinguisher by resident room 253, did not have any inspection tag, indicating it has not been annually inspected. The MD stated and confirmed the above findings during the observations. The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference on 9/18/23.The Administrator was at a meeting during the LSC exit. NJAC 8:39-31.2(e) NFPA 10, Standard for Portable Fire Extinguishers.19.3.5.12, NFPA 10	K 355	annually. Systemic Changes The Maintenance Director will be inserviced on this requirement and the Maintenance Director or designee will conduct monthly rounds to ensure all fire extinguishers are signed and inspected annually. Monitoring The Maintenance Director or designee will submit a report to the facility□s monthly QAPI Committee for the next 3 months.	
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 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	K 363		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 363	Continued From page 14 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 9/18/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to 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 19 of 60 resident room (RR) doors observed and was evidenced by the following: During the building tour on 9/18/23 from 9:15 AM to 1:45 PM, the surveyor in the presence of the	K 363	K363 Specific Concerns The doors to resident rooms 251, 245, 243, 241, 239, 238, 229, 228, 227, 222, 157, 153, 146, 138, 134, 130, 125, 123 and 122 have been repaired or replaced so they meet this standard. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. The Maintenance Director or designee will review 100% of all resident room doors to ensure they meet this standard and can properly resist the passage of smoke. Any additional noted concerns will be corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 363	Continued From page 15 RPOD and MD toured the facility and observed the following compromised RR doors: RR # 251 door will not latch into its frame. RR # 245 loose door hardware RR # 243 top of the door not alligned with the top of the frame, approximately 1/2" opening. RR # 241 top of the door not alligned with the top of the frame, approximately 1/2" opening. RR # 239 top of the door not alligned with the top of the frame, approximately 1/2" opening. RR # 238 door rubs into its frame. RR # 229 loose hardware RR # 228 door rubs into its frame RR # 227 loose hardware RR # 222 door will not latch properly RR # 157 top of door is warped 1/4" opening when closed RR # 153 top of door is warped 1/4" opening when closed RR # 146 door has no latch RR # 138 door will not latch RR # 134 loose hardware interior and warped door top RR # 130 door will not latch properly 1/2" opening RR # 125 door warped will not latch RR # 123 top of the door not alligned with the top of the frame, approximately 1/2" opening. RR # 122 door gets stuck into its frame At the time of observations, the surveyor interviewed the RPOD and MD, who both confirmed the above findings. The RPOD was informed of the findings at the Life Safety Code exit conference on 9/18/23. The Administrator was at a meeting during the LSC exit.	K 363	Systemic Changes The Maintenance Director will be inserviced on these requirements and the Maintenance Director or designee will conduct monthly rounds on all resident room doors. Monitoring The Maintenance Director or designee will submit a report to the facility□s monthly QAPI Committee for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING ___	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(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 363	Continued From page 16 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 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/18/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), A), it was determined that the facility failed to ensure resident bathroom ventilation systems were adequately maintained and operating in optimal condition, in accordance with the National Fire Protection Association (NFPA) 90 A. B. B). it was determined that PTAC (packaged termial air conditioners) units were not kept in optimal condition.This deficient practice was identified for 7 of 50 resident room bathrooms vents observed and 6 of 30 PTAC units observed and was evidenced by the following: A). From 9:55 AM, to 12:50 PM, during a tour of the building, the surveyor, RPOD and MD, toured the facility and observed that the ventilation in resident rooms: 255, 251, 249, 247, 246, 240, & 222, did not function when the MD applied a	K 521	K521 Specific Concerns The bathroom ventilation system in rooms 255, 251, 249, 247, 246, 240 and 222 have been repaired. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. The Maintenance Director or designee will review 100% of all resident room bathroom ventilation systems to ensure they are functioning properly and any additional noted concerns will be corrected. Systemic Changes The Maintenance Director will be inserviced on these requirements and the	11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 521	Continued From page 17 piece of single-ply toilet tissue paper across the upper ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. An interview was conducted with the MD during the observations, and he confirmed the findings. He stated currently the facility did not have a ventilation inspection log or operating check list to provide. B). From 9:55 AM, to 12:50 PM, the surveyor, RPOD and MD observed PTAC units with clogged and dirty filters in the following resident rooms: Resident Room # 122, 142, 155, 232, 246, & 257 The RPOD and MD confirmed the findings during the observations. The MD stated he did not have a PTAC cleaning log or documented schedule at this time. The RPOD was informed of the findings at the Life Safety Code exit conference on 9/18/23. The Administrator was at a meeting during the LSC exit. NFPA 90 A Standard for the installation of ventilating systems NFPA 101-2012 -19.5.2.1 section 9.2.1 and 9.2.2 NJAC 8:39-31.2(e)	K 521	Maintenance Director or designee will conduct monthly rounds on all resident room bathroom ventilation systems to ensure proper operation. Monitoring The Maintenance Director or designee will submit a report to the facility□s monthly QAPI Committee for the next 3 months.	
K 531 SS=F	Elevators CFR(s): NFPA 101	K 531		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ____________	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 531	Continued From page 18 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/18/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to maintain elevator emergency communication for 2 of 2 passenger elevator telephones tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: At 9:56 AM, the surveyor had the Maintenance Director conduct a test of the emergency communication telephone system in the (2) facility passenger elevators. The emergency telephone's did function when the button was activated, the MD indicated a communication	K 531	K531 Specific Changes The emergency communication system has been repaired on both elevators. Identification of Similar Concderns All residents have the potential to be affected by this deficient practice. The facility only has 2 elevators and both emergency communication systems have been checked. Systemic Changes The Maintenance Director will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 531	Continued From page 19 issue between the telephone vendor and the elevator company were the issue. The Regional Plant Operations Director was informed of the finding's at the Life Safety Code exit conference on 9/18/23. The (new) Administrator was at a meeting during the LSC exit. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	inserviced on these requirements and the Maintenance Director or designee will check both elevator emergency communication systems on a monthly basis to ensure proper operation. Monitoring The Maintenance Director or designee will submit a report to the facility□s monthly QAPI Committee for the next 3 months.	
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 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	K 741		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 741	Continued From page 20 permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/15/23 and 9/18/23, in the presence of the Surveyor, Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. The practice of dumping cigarette butts and ash into trash cans with other combustibles, increases the risk of fire to facility occupants. This deficient practice was evidenced for 1 of 1 smoking areas observed and was evidenced by the following: 1). On 9/15/23 at 1:14 PM, the surveyor and MD observed in the occupied (12 residents) smoking courtyard on floor #1 that 50 plus cigarettes were observed in dry debris around the outer area of the enclosed smoking fence. A combustible Glade black plastic garbage can next to the building was filled with 40 plus cigarette butts and combustible cups, paper and cigarette boxes. The area was observed to have four oasis style ashtrays. The smoking area was not provided with an approved self-closing covered metal container's for the disposal of cigarette butts and ashes in the area. The MD confirmed the findings during the observations. 2). On 9/18/23 at 12:30 PM, the surveyor, RPOD and MD observed in the koi-pond outside courtyard, that a plastic garbage can was filled with 30 plus cigeratte butts along with	K 741	K741 Specific Concerns In the residents smoking area, the cigarette butts were cleaned up and a metal container has been purchased for proper disposal of cigarette butts. Butts were also removed from the non-smoking courtyard. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. The facility only has 2 outside areas the residents can access. Systemic Changes The Maintenance Director will be inserviced on the requirement to have metal containers for cigarette disposal in the resident smoking courtyard and a metal container will be purchased. Smoking Monitors who are present in the smoking area, will be inserviced on the importance of ensuring cigarette butts are properly disposed of and keeping the surrounding area clean. The facility□s Smoking Policy has recently been revised indicating that Smoking Policy infractions, including smoking in non-smoking areas, will result in a resident being designated as a Supervised Smoker. All in-house and newly admitted residents will be made aware of the revised policy. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 741	Continued From page 21 combustible paper, cups and misc items. It was noted this area was not a designated smoking area. The MD confirmed the finding during the observation. The Regional Plant Operations Director was informed of the finding's at the Life Safety Code exit conference on 9/18/23.The Administrator was at a meeting during the LSC exit. NJAC 8:39-31.2(e)	K 741	Administrator will also conduct weekly rounds in both courtyard areas. Monitoring The Administrator will submit a report to the facility□s monthly QAPI Committee for the next 3 months.	
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 area tested, and results. 6.3.4 (NFPA 99)	K 914		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 914	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 9/18/23, in the presence of the facility's Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 60 of 60 resident rooms observed by the following: From approximately 10:30 AM to 1:30 PM, the surveyor, RPOD and MD, observed that resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The RPOD and MD, confirmed that the facility had non-hospital outlets installed in resident rooms, but could not provide any documentation or logs indicating the annual inspection was conducted. The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference on 9/18/23.The (new) Administrator was at a meeting during the LSC exit. NJAC 8:39-31.2(e) NFPA 99	K 914	K914 Specific Concerns The facility has tested all resident room outlets for proper grounding, polarity and blade tension and any outlets that did not meet this regulation requirement have been repaired/replaced. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. 100% of all resident room outlets will be checked for proper grounding, polarity and blade tension and any outlets that do not meet this regulation requirement will be repaired/replaced. Systemic Changes The Maintenance Director will be inserviced on this requirements and the Maintenance Director or designee will conduct an annual audit of all resident room outlets for proper grounding, polarity and blade tension. Monitoring The Maintenance Director or designee will submit a report to the facility�s monthly QAPI Committee for the next 3 months.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 918	Continued From page 23 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility documents on 9/15/23 and 9/18/23, in the presence of the Regional Plant Operations	K 918	K918 Specific Concerns	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 918	Continued From page 24 Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to certify, what systems were on the generator in the event it was activated as per NFPA 99. On 9/15/23 at 11:25 AM, the Maintenance Director was asked to provide a document indicating what electrical systems were on the facility generator. The MD indicated he was not completely sure and he could not provide any docummentation indicating so at this time. The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference on 9/18/23.The (new) Administrator was at a meeting during the LSC exit. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918	The facility has determined what electrical systems are on the emergency generator per NFPA 99 and all major systems are on generator power. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. The facility will review 100% of key operating systems to determine which ones are tied into the emergency generator and add any key systems that are not. Systemic Changes The Maintenance Director will be inserviced on this requirements and the Maintenance Director will coordinate with the generator contractor as needed to identify which key operating systems are tied into the emergency generator and add any key systems that are not. Monitoring The Maintenance Director or designee will submit a report to the facility□s monthly QAPI Committee for the next 3 months.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal	K 920		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 920	Continued From page 25 electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/15/23 and 9/18/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was identified for three 10 of 15 areas observed and was evidenced by the following: 1). On 9/15/23 at 12:22 PM, the surveyor and MD, observed in the physical therapy room that a	K 920	K920 Specific Concerns All power strips and extension cords in the therapy room, laundry folding room, maintenance shop, boiler room, DON□s office, unit manager's office, nurse break room, and activities room have been removed. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. A 100% review of all areas in the facility will be reviewed and any extension cords or power strips being used in violation of this requirement will be removed. Systemic Changes The Maintenance Director and all Department Heads will be inserviced on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING ______	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 920	Continued From page 26 microwave was plugged into a white multi-outlet power strip, the white power strip was then plugged into another black multi-outlet power strip (daisy chained). The black power strip was then plugged into the duplex wall outlet. 2). On 9/15/23 at 12:54 PM, the surveyor and MD, observed in the laundry folding room that a box fan was plugged into a 25' black extension cord, the extension cord was then plugged into a black multi-outlet power strip. the power strip was then plugged into the duplex wall outlet. 3). On 9/15/23 at 1:01 PM, the surveyor and MD, observed in the maintenance shop that a bug light was plugged into an extenstion cord that was attached to the fire sprinkler pipe, the extension cord was then plugged into a 12-plug multi-outlet power strip. The power strip was then plugged into a 3-plug adaptor that was plugged into a duplex wall outlet. 4). On 9/15/23 at 1:07 PM, the surveyor and MD observed in the maintenance shop that a refrigerator was plugged into a green extension cord to an orange extension cord to the duplex wall outlet. 5). On 9/15/23 at 1:17 PM, the surveyor and MD observed in the maintenance shop that a white extension cord was plugged into a brown extension cord to a green extension cord to a orange multi-outlet power strip. The power strip was then plugged into a green multi-outlet power strip that was plugged into a duplex wall outlet. 6). On 9/15/23 at 1:28 PM, the surveyor and MD observed in the boiler room that an unvented 7000 BTU air conditioner was plugged into a	K 920	these requirements and the Maintenance Director or designee will round on all areas of the building on a monthly basis to ensure no power strips or extension cords are used in violation of this regulation. Monitoring The Maintenance Director or designee will submit a report to the facility□s monthly QAPI Committee for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 920	Continued From page 27 white extension cord, then to a multi-outlet power strip. The power strip was then plugged into a duplex wall outlet. The MD confirmed the duplex wall outlet was warm to the touch when observed. 7). On 9/15/23 at 1:48 PM, the surveyor observed in the floor 1 Director of Nurse (DON) office that electronics were plugged into (4) multi-outlet power strips (daisy chained). The power strips were then plugged into a duplex wall outlet that was observed by the MD to be warm to the touch. 8). On 9/18/23 at 11:22 AM, the surveyor, MD and RPOD observed in the unit manager office that a refridgerator was plugged into a yellow extension cord that was plugged into a duplex wall outlet. 9). On 9/18/23 at 11:28 AM, the surveyor, MD and RPOD observed in the nurse break room, behind the nurse station that a refridgerator and microwave were plugged into a multi-outlet power strip. The power strip was then plugged into a duplex wall outlet. 10). On 9/18/23 at 1:10 PM, the surveyor, MD and RPOD observed in the activities room that (4) multi-outlet power strips (daisy chained) were plugged into a refrigerator. The power strips were then plugged into a duplex wall outlet. The findings were verified by the MD at the time of the observations, where he stated and confirmed that extension cords and multi-outlet power strips cannot be plugged into each other (Daisy Chaining) and cannot be plugged into high draw appliances in the facility. The RPOD were informed of the finding's at the Life Safety Code Exit Conference on 9/18/23. The	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 920	Continued From page 28 (new) Administrator was at a meeting during the LSC exit. NJAC 8:39-31.2(e)	K 920		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 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	K 923		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	**09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 923	Continued From page 29 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: Based on observations and interview on 9/15/23 and 9/18/23, in the presence of the Maintenance Director (MD) Regional Plant Operations Director (RPOD), it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 3 of 6 portable oxygen cylinders observed and was evidenced by the following: 1). On 9/15/23 at 12:20 PM, the surveyor and MD, observed in the Physical Therapy equipment closet that 1 of 2 portable oxygen cylinders were observed unsecured standing in the corner of the room. The unsecured cylinder was observed to be at 400 PSI and stored unprotected against tipping, rupture and damage. 2). On 9/18/23 at 10:06 AM, the surveyor, RPOD and MD, observed in the floor-2 medical supply room that 1 of 3 portable oxygen cylinders, were observed unsecured standing in the center of the room. The O2 cylinder was observed to be full. 3). On 9/18/23 at 10:42 AM, the surveyor, RPOD and MD, observed in the floor-2 clean utility room that 1 of 1 portable oxygen cylinders, were observed unsecured standing in the corner of the room. The O2 cylinder was observed to be at 500	K 923	K923 Specific Concerns The oxygen cylinders in the physical therapy room, 2nd floor medical supply room and 2nd floor clean utility room have been secured. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. A 100% review of all areas in the facility will be reviewed to ensure all oxygen cylinders are properly secured. Systemic Changes The Maintenance Director and all Department Heads will be inserviced on these requirements and the Maintenance Director or designee will round on all areas of the building on a monthly basis to ensure oxygen cylinders are properly secured. Monitoring The Maintenance Director or designee will submit a report to the facility's monthly QAPI Committee for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING ______	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST** **MANAHAWKIN, NJ 08050**

(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 923	Continued From page 30 PSI. An interview was conducted with the MD and RPOD, during the observations, they stated that the portable oxygen cylinder's observed, must be secured from tipping, rupture and damage at all times in the facility. The Regional Plant Operations Director was informed of the finding's at the Life Safety Code exit conference on 9/18/23.The (new) Administrator was at a meeting during the LSC exit. NJAC 8:39-31.2(e) NFPA 99	K 923		

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
315206 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	11/13/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

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 K0222	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 11/10/2023
ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 11/10/2023
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0531	Correction Completed 11/10/2023
ID Prefix Reg. # NFPA 101 LSC K0741	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0914	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 11/10/2023
ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0923	Correction Completed 11/10/2023	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	
9/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO