STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING **01** B. WING _____	**11/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	**1931 LAKEWOOD ROAD** **TOMS RIVER, NJ 08755**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/08/2021 and Complete Care at Green Acres 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 Occupancies. Complete Care at Green Acres is a three (3) story, Type II Fire Resistant building that was built in January 1988. The facility is divided into 14 smoke zones.	K 000		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes	K 351		2/3/22

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

Electronically Signed | 11/25/2021

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K 351	Continued From page 1 closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, interview and review of facility provided documentation on 11/08/2021, it was determined that the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. Reference #1: N.J.A.C. 5:23 -Uniform Construction Code, Special detailed requirements based on use and occupancy section 407 group I-2, [F] 407.5 Automatic sprinkler system. Smoke compartments containing patient sleeping units shall be equipped throughout with an automatic fire sprinkler system in accordance with Section 903.3.1.1. The smoke compartment shall be equipped with approved quick-response or residential sprinklers in accordance with section 903.3.2. This deficient practice was evidenced by the following: On 11/08/2021 at 8:30 AM, during entrance conference with the facility, the surveyor requested the Licensed Nursing Home Administrator (LNHA) and Maintenance Supervisor (MS) to provide a copy of the facility	K 351	This plan of correction is the facility's credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. 1. All facility residents have the potential to be affected by this deficient practice. All closet doors in resident room bathrooms [redacted] and #[redacted] were immediately removed. 2. All facility maintenance personnel shall be educated regarding this standard and the requirement that clothes closets in resident sleeping rooms be equipped with an automatic sprinkler system in accordance with N.J.A.C 5:23 □ Uniform Construction Code. 3. All remaining partition material in resident room bathrooms [redacted] shall be removed to eliminate any obstruction to the adjacent sprinkler. 4. The facility Maintenance Director or designee shall complete monthly audits of	

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K 351	Continued From page 2 lay-out which identified the various rooms in the facility. During a tour of the building in the presence of the LNHA and MS, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location: 1. At 11:03 AM, inside Resident room [redacted] bathroom, the surveyor observed a 17 inch deep by 22-inch-wide closet with no evidence of fire sprinkler protection. At this time the surveyor asked the LNHA if they saw a fire sprinkler inside the closet. The LNHA looked up and around inside the closet and stated "no." 2. At 11:11 AM, inside Resident room [redacted] bathroom, the surveyor observed a 17 inch deep by 22-inch-wide closet with no evidence of fire sprinkler protection. At this time the surveyor asked the LNHA if they saw a fire sprinkler inside the closet. The LNHA looked inside the closet and stated "no." At approximately 2:00 PM, the surveyor requested the MS to provide a list of Resident rooms that have closets in the bathrooms with no fire sprinkler protection. At 2:10 PM, the MS provided a list with the following Resident room numbers identified with closets in the bathrooms with no fire sprinkler protection: #[redacted]. A review of the facility provided lay-out identified that there were 15 Residential sleeping rooms in that smoke compartment.	K 351	all patient units for the duration of 90 days to determine compliance in this Uniform Construction Code. The facility Maintenance Director shall provide all findings to the facility Quality Assessment and Assurance Committee on a quarterly basis.	

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K 351	Continued From page 3 The facility's LNHA was informed of these findings during the Life Safety Code survey exit conference at 2:21 PM on 11/8/2021. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 11/08/2021, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 10 smoke barrier doors and was evidenced by the following: At 8:54 AM, the surveyor toured the building with	K 374	This plan of correction is the facility's credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because	12/23/21

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K 374	Continued From page 4 the facility's Maintenance Supervisor (MS). Along the tour, the surveyor observed and tested ten (10) sets of double smoke doors in the corridors. At 9:58 AM, when manual testing of the facility's smoke barrier door next to Resident room [redacted] revealed it was not resistant to the transfer of smoke with an observed gap greater than 3/4 of inch from floor to bottom of the door. At this time, the surveyor used a construction tape measure and recorded 1-1/2 inch gap along the bottom edge. The facility's Licensed Nursing Home Administrator was informed of these findings during the Life Safety Code survey exit conference at 2:21 PM on 11/8/2021. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374	it is required by the provision of Federal and State law. 1. All facility residents have the potential to be affected by this deficiency. All other smoke barrier doors were immediately inspected and assessed for gaps in the undercut greater than ¿ of an inch. 2. A structural channel on the undercut of the fire door measuring at least one inch in height was installed. 3. All-facility maintenance personnel shall be in serviced by the facility Administrator regarding this requirement. The facility Administrator or designee shall conduct monthly inspections on all facility smoke barrier doors to determine compliance or necessity for corrective action. These inspections shall be conducted for a duration 90 days and bimonthly thereafter. 4. All findings shall be presented to the facility Quality Assessment and Assurance Committee on a quarterly basis. All findings shall be assessed for compliance and/or corrective action and shall be incorporated into the facility QAPI program as needed.	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover.	K 912		12/16/21

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K 912	Continued From page 5 If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 11/08/2021, it was determined that the facility failed to ensure that 2 of 14 electrical outlets located next to a water source were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: At 8:54 AM, during the building tour in the presence of the facility Maintenance Supervisor (MS), the surveyor conducted an inspection inside nine (9) resident bathrooms, four (4) Resident shower rooms and common areas on three (3) floors. The surveyor observed duplex electrical outlets and GFCI outlets located (within 4 feet of a sink) in wet locations. At the time of the observations, the surveyor asked the MS, were the duplex outlets connected to GFCI outlets or a GFCI breaker. The MS responded, "Yes." When the surveyor used a GFCI tester to de-energize the outlets, two (2) duplex electrical outlets had not de-energize, as required by code in the following locations: 1. At 9:07 AM, one duplex electrical outlet 37 inches to the right of a sink in the third floor serving/dining area when tested had not de-energize as required.	K 912	This plan of correction is the facility's credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. 1. All facility residents have the potential to be affected by this deficient practice. The two duplex electrical outlets lacking connection to a CGFI outlet, were immediately repaired and a CGFI outlet installed. All electrical outlets located within four feet of a water source were re assessed to determine that they are equipped with CGFI protection. 2. All facility maintenance personnel shall be re-educated regarding this standard and the requirement that all electrical outlets within four feet of a water source always be maintained with CGFI protection. 3. The facility Maintenance Director or designee shall complete weekly audits for a total of 90 days and once a month thereafter to ensure that all facility CGFI electrical outlets located within four feet of a water source are maintained with CGFI protection. 4. The facility Maintenance Director shall	

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K 912	Continued From page 6 2. At 9:12 AM, one duplex electrical outlet two (2) feet to the right of the third floor shower bathroom sink when tested had not de-energize as required. The facility's Licensed Nursing Home Administrator was informed of these findings during the Life Safety Code survey exit conference at 2:21 PM on 11/8/2021. NJAC 8:39 -31.2 (e) NFPA 99	K 912	provide all findings to the facility Quality Assessment and Assurance Committee on a quarterly basis. All findings shall be assessed for compliance and/or improvement and shall be incorporated into the facility QAPI program as appropriate.	