STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315105	A. BUILDING **01** B. WING _____	**08/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	**2050 SIXTH AVE** **NEPTUNE CITY, NJ 07753**

(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 LIFE SAFETY CODE 101:2012 THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R.	K 000		
K 345 SS=E	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 observations and interview on 08/15/19, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to maintain the fire alarm system in accordance with NFPA 72. This deficient practice was evidenced by the following:	K 345	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws require it.	9/12/19

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

Electronically Signed | 09/12/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315105	A. BUILDING **01** B. WING _____	**08/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	**2050 SIXTH AVE** **NEPTUNE CITY, NJ 07753**

(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 1 On 08/15/19 at 11:40 AM, the surveyor observed, in the old physical therapy room located across from occupied resident rooms [redacted], that two of two smoke detectors were wrapped with blue-painters tape. The room was currently being renovated and unoccupied at the time of the observation. The tape applied to the two smoke detectors would delay the device from activating the fire alarm system in that room in the event of a smoke or fire condition. An interview was conducted with the Maintenance Director and Regional Plant Operations Director at the time of the observation. The Maintenance Director and Regional Plant Operations Director both acknowledged that the two smoke detectors were taped due to a current renovation of the room, and that the tape should have been removed at the end of the work day. The Administrator was notified of the deficiency at exit. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	K345 E The blue-painters tape was removed from the two smoke detectors noted in the Statement of Deficiencies on 8/15/19 by the Director of Maintenance and integrity of the smoke detectors were confirmed. All residents have the potential to be affected by this practice. Director of Maintenance/designee inspected all smoke detectors in the facility to ensure that they are not covered and that there was nothing else to potentially delay the device from activating the fire alarm system in that room in the event of a smoke or fire condition. No issues were noted. The Administrator/ Designee provided in-service education to the renovation project manager on maintaining maintain the fire alarm system in accordance with NFPA 72, including the need to remove any covering from the smoke detector when the area is unoccupied and ensure that nothing could potentially delay the device from activating the fire alarm system in the event of a smoke or fire condition . A new system was implemented whereas the Maintenance Director/ designee will check any renovation area at the end of each workday to ensure that any covering has been removed from the smoke detector and that nothing could potentially delay the device from activating the fire alarm system in the event of a smoke or fire condition. The Administrator/Designee will perform a weekly audit on the renovation area to assure that all smoke detectors are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315105	A. BUILDING **01** B. WING _____	**08/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	**2050 SIXTH AVE** **NEPTUNE CITY, NJ 07753**

(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 2	K 345	uncovered when not being occupied. The Administrator/Designee will review the results of the audits, including actions taken for any identified issues, at the monthly Quality Assure Performance Improvement meeting. The audits will continue for a period of at least three months or until the Quality Improvement Performance Improvement Committee has identified substantial compliance.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315105	A. Building 01 - MAIN BUILDING 01 B. Wing	9/16/2019

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

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 K0345	Correction Completed 09/16/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/22/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO