STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 11/13/23 through 11/16/23 Survey Census: 81 Sample Size: 21 Supplemental Residents: 8 A deficiency was related to Intake ID NJ156270 at F684. No deficiencies were issued related to Complaint Intakes NJ156320, NJ160840, NJ161385, NJ161801, NJ162548, NJ163178, NJ163999, NJ167173, and NJ167580.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		12/31/23

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

Electronically Signed | 12/11/2023

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F 609	Continued From page 1 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, documentation review, and policy review, the facility failed to ensure an allegation of abuse was reported to the State Agency for one of four residents (Resident (R) 79) reviewed for abuse. Findings include: Review of R79 admission "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ ex order 26.4b1, located in the "MDS" tab of the electronic medical record (EMR), revealed R79 had a "Brief Interview for Mental Status" score of NJ ex order 26.4b1 indicating she was cognitively intact; an NJ ex order 26.4b1 [redacted]. Per the NJ ex order 26.4b1, NJ ex order 26.4b1 [redacted]. Review of R79's "Admission Record," located in the EMR "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 from the hospital with a primary diagnosis of NJ ex order 26.4b1,	F 609	1. Residents affected by deficient practice: Facility failed to ensure an allegation of Abuse was reported to the New Jersey Department of Health. Resident #79 was affected by this deficient practice. The allegation regarding Resident #79 was called in to the Department of Health on November 14, 2023 2. Identifying other Residents who could be affected by the deficient practice: All residents with incidents have the potential to be affected. The DON reviewed other incidents from the previous month to identify if there were other incidents that should have been reported to DOH and none was identified. 3. Measures or systemic changes to ensure that the deficiencies will not recur:	

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F 609	Continued From page 2 left side and diagnosis of NJ ex order 26.4b1 [redacted] During an interview on 11/14/23 at 8:36 AM, R79 was asked if staff treated her with dignity and respect and if she had ever been abused. R79 stated the staff take good care of her for the most part; however Certified Nursing Assistant (CNA) 6 put her over bed table over her and lifted the bed up while the table was positioned over her and hurt her chest. R79 stated it happened in the first week she was here, and she told a staff person but could not remember the name of the person she told. R79 stated the aide did not apologize. During an interview on 11/14/23 at 9:30 AM, the Administrator was asked if he had a report related to the resident making an allegation of an aide pushing a table into her chest. At 2:46 PM a letter from R79's insurance company dated 11/02/23 was provided. The letter was addressed to the Administrator and stated the member (R79) made a complaint with the insurance company. The letter stated the member alleged she was injured when an employee "slammed" her food tray into her already NJ ex order 26.4b1 On 11/14/23 at 2:55 PM the letter from the insurance company was reviewed with the Administrator and the Director of Nursing (DON). They stated they became aware of the allegation when they received the letter from the insurance company on NJ ex order 26.4b1. They both stated they did not report it to the State Survey Agency because they talked to R79 and CNA6 and they each stated CNA6 placed her food tray over her and then lifted the head of the bed and her chest	F 609	The facility□s policies and Procedures on Accident/ Incident Reporting and Abuse was reviewed with Administrator / DON/All staff. Emphasis on reportable events according to the long-term regulations, NJ DOH Guidelines , reportable grid and the facility policy. All staff educated on the facility□s incident/accident policy and procedure. Emphasis on reportable grid incidents/accidents and the prompt reporting to NJDOH to be done by the Administrator/DON or the designee as per regulation guidelines. 4. Monitoring the continued effectiveness of the systemic change: The DON/IP/Designee will conduct audits of all Reportable Events and the following of the policy and procedures. Audits will be completed weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 609	Continued From page 3 came into contact with the overbed table and therefore they felt it was not an incident of abuse and did not report it. During an interview on 11/14/23 at 3:18 PM, Licensed Practical Nurse (LPN) 4 stated she was the day shift unit manager on the unit R79 resided on. LPN4 stated R79 told her about the incident a few days after it occurred, however she could not remember the date. LPN4 stated the resident told her CNA6 "NJ ex order 26.4b1 ." LPN4 stated she did tell the DON and they started checking on her more often and having two people go in to care for her. LPN4 stated she could not remember the date she told the DON nor the date the R79 told her. The facility policy titled "Abuse, Neglect, and Misappropriation" with a last date revised of May 2021 stated the following: All allegations of abuse, neglect, exploitation, or mistreatment are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events did not involve abuse to the Administrator and the other officials including the State Survey Agency. The policy also stated the facility will have evidence of a thorough investigation and prevent further abuse or neglect while the investigation is in progress and the results of the investigation will be reported to the State Survey Agency within 5 working days of the incident. NJAC-8:39-9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation	F 610		12/31/23

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F 610	Continued From page 4 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, documentation review, and policy review, the facility failed to ensure an allegation of abuse was thoroughly investigated and failed to prevent further abuse/neglect while the investigation was in progress for one resident of four residents (Resident (R) 79) reviewed for abuse. Findings include: Review of R79's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located in the "MDS" tab of the electronic medical record (EMR), revealed R79 had a "Brief Interview for Mental Status NJ ex order 26.4b1 [redacted]	F 610	1. Residents affected by deficient practice: Facility failed to ensure an allegation of abuse was thoroughly investigated and failed to prevent abuse /neglect while the investigation was in progress. An investigation was initiated on November 14, 2023, and the facility concluded that the alleged abuse was unsubstantiated. 2. Identifying other Residents who could be affected by the deficient practice: All residents have the potential to be affected. All incident reports for the last 30 days were reviewed to ensure any	

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F 610	Continued From page 5 NJ ex order 26.4b1 [redacted] Review of R79's "Admission Record," located in the EMR "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 from the NJ ex order 26.4b1 [redacted] During an interview on 11/14/23 at 8:36 AM, R79 was asked if staff treated her with dignity and respect and if she had ever been abused. R79 stated the staff take good care of her for the most part; however Certified Nursing Assistant (CNA) 6 put her over bed table over her and lifted the bed up while the table was positioned over her and hurt her chest. R79 stated it happened in the first week she was here, and she told a staff person but could not remember the name of the person she told. She stated the aide did not apologize. R79 was upset over the incident. R79 stated she had not seen CNA6 since the incident. During an interview on 11/14/23 at 9:30 AM, the Administrator was asked if he had a report related to the resident making an allegation of an aide pushing a table into her chest. At 2:46 PM a letter from R79's insurance company dated NJ ex order 26.4b1 was provided. The letter was addressed to the Administrator and stated the member (R79) made a complaint with the insurance company. The letter stated the member alleged NJ ex order 26.4b1 [redacted]	F 610	reportable event that meets the state and federal regulations has been reported and an investigation initiated and none were identified. DON/designee will review 24-hour reports and/or progress notes for any documentation that may indicate an allegation of abuse and investigation will be initiated. 3. Measures or systemic changes to ensure that the deficiencies will not recur: The facility□s policies and procedures on Accident/ Incident Reporting and Abuse was reviewed with Administrator / DON/All staff. Emphasis on the reporting and investigating events according to the long-term regulations, NJ DOH Guidelines/ Reportable Grid and the facility policy. With prompt reporting to NJDOH to be done by the Administrator/DON or the designee as per regulation guidelines. 4. Monitoring the continued effectiveness of the systemic change: The DON/IP/Designee will conduct audits of all Reportable Events and the following of the policy and procedures on reporting and investigating reportable events. Audits will be completed weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 610	Continued From page 6	F 610		

On 11/14/23 at 2:55 PM the letter from the insurance company was reviewed with the Administrator and the Director of Nursing (DON). They stated they became aware of the incident on NJ ex order 26.4b1 when the letter arrived. They both stated they only interviewed the alleged perpetrator and the resident because when they talked to the resident and CNA6 they each stated CNA6 placed her food tray over her and then lifted the head of the bed and her chest came into contact with the overbed table and therefore they felt it was not an incident of abuse. Review of the documents provided revealed the only interview statement in the investigation file was from CNA6. The investigation did not include any interviews with R79 or other residents, or other staff. Review of CNA6's time sheets, provided by the facility, revealed she continued working in the facility with no additional interventions.

During an interview on 11/14/23 at 3:18 PM, Licensed Practical Nurse (LPN) 4 stated she was the day shift unit manager on the unit R79 resided on. LPN4 stated R79 told her about the incident a few days after it occurred, however she could not remember the date. LPN4 stated R79 told her CNA6 NJ ex order 26.4b1 LPN4 stated she did tell the DON and they started checking on her more often and having two people go in to care for her. LPN4 stated she could not remember the date she told the DON nor the date the R79 told her. When asked if she checked R79 for bruising or injuries, she stated she did, and R79 NJ ex order 26.4b1 however she did not document it in her medical record. When asked if she further asked R79 about what happened she stated she did not because R79 was visibly upset over the situation, and she did

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F 610	Continued From page 7 not want to further upset her. The facility policy titled "Abuse, Neglect, and Misappropriation" with a last date revised of 05/2021 stated the following: When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. The policy stated the resident involved should be interviewed; interview all witnesses; interview residents in adjoining rooms and staff members. All statements should be timed and dated. NJAC-8:39-4.1(a)5, NJAC-8:39-9.4(f), NJAC-8:39-27.1(a)	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		12/31/23

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F 656	Continued From page 8 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop comprehensive care plans according to resident needed care areas for three of twenty-one residents sampled (Resident (R) 18 and R36). Findings include: 1. Record review of R18's "Face Sheet" located in the electronic medical record (EMR) under the	F 656	1. Residents affected by deficient practice: The facility failed to develop and implement comprehensive care plans according to the needed care areas. Resident #18 and resident #36 were affected. The DON reviewed residents #18 and #36 medical record and implemented	

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F 656	Continued From page 9 "Profile" tab revealed an admission date of NJ ex order 26.4b1 and NJ ex order 26.4b1 Record review for R18's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date of NJ ex order 26.4b1 revealed a Brief Interview for Mental Status (BIMS)" score of NJ ex of 15, indicating NJ ex order Record review of R18's EMR "Orders" revealed current physician's orders for NJ ex order 26.4b1 Record review for R18 revealed in the EMR "Care Plans" tab, that R18 did not have a care plan focus category for NJ ex order 26.4b1. 2. Record review of R36's "Face Sheet" located in the EMR under the "Profile" tab revealed an admission date of NJ ex order 26.4b1 and diagnoses NJ ex order 26.4b1 Record review for R36's admission "MDS" with an ARD of NJ ex order 26.4b1 reveals a NJ ex order 26.4b1 out of 15, indicating NJ ex order 26.4b1. The "Care Area Assessment Summary" of the "MDS," indicated NJ ex order 26.4b1 During observation and interview on NJ ex order 26.4b1 at 9:28 AM, R36 was sitting in her room near her bed. R36 NJ ex order 26.4b1 but stated she was	F 656	NJ Ex.Order 26.4(b)(1) Care plans. 2. Identifying other Residents who could be affected by the deficient practice: Residents that require Psychotropic Medication and Behavior Care plans have the potential to be affected. 3. Measures or systemic changes to ensure that the deficiencies will not recur: The facility□s policies and Procedures on Comprehensive Care plan and was reviewed with DON all licensed nursing staff. Emphasis on initiating and updating comprehensive care plans. 4. Monitoring the continued effectiveness of the systemic change: The DON/Unit Manger/Designee will conduct audits of four residents that require Psychotropic Medication and Behavior Care plans. Audits will be completed weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 656	Continued From page 10 okay and asked that surveyor come back later. During observation and interview on 11/15/23 at 10:47 AM, R36 was in her room in the dark with her blinds closed. R36 appeared [NJ Ex.Order 26] and stated she was NJ ex order 26.4b1 [redacted] R36 admitted to feeling sad and sated her mom passed away about this time of year. Record review of R36's care plan, located in the EMR in the tab labeled "Care Plans," revealed that R36 did not have a care plan focus category for Behavioral/Emotional/Mood. During an interview on 11/16/23 at 8:59 AM, LPN4/Unit Manager, revealed she was responsible for the nursing part of the care plans, implementing new focus areas for care plans, and updating those areas. LPN4/unit manager revealed the importance and purpose of the care plan was to implement and track changes of care needs for the residents. LPN4 confirmed that R18's care plan did not address her [NJ Ex.Order 26.4(b)(1)] [redacted] and R36's care plan did not address [NJ Ex.Order 26] and should have. NJAC-8:39-11.2(e)1,2 NJAC-8:39-27.1(a)	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		12/31/23

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F 684	Continued From page 11 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and policy review, the facility staff failed to administer medications timely to two of four residents (Resident (R)136 and R69) out of a total sample of 21 residents. Findings include: 1. Review of R136's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of NJ ex order 26.4b1 with medical diagnoses that included but not limited to NJ ex order 26.4b1 Review of R136's "Orders" located in the EMR under the "Orders" tab, revealed physician orders for the following medications: NJ ex order 26.4b1 [redacted]	F 684	1. Residents affected by deficient practice: The facility failed to ensure medication was administered timely. Residents #69 and #136 were affected by this deficient practice. 2. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. 3. What corrective action will be accomplished for those residents affected by the deficient practice: All facility Nurses re-educated on Administrating medication policy with an emphasis on the importance of medication being administered in accordance with the orders, including any required time frame. The education of all existing nurse staff immediate and will be ongoing with all new hires. 4. Measures or systemic changes to ensure that the deficiencies will not recur: The DON/Unit Manger/Designee will conduct compliance audits of 4 residents medication administration times. The	

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F 684	Continued From page 12 Review of R136's "Medication Administration Audit Report," that was provided by the facility, NJ ex order 26.4b1 [redacted]	F 684	duration of all audits will occur weekly X4 and then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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F 684	Continued From page 13 Scheduled for 07/15/22 at 1:00 PM. Given on 07/15/22 at 4:47 PM. Interviewed the Director of Nursing (DON) on 11/16/23 at 4:13 PM. The DON confirmed that these medications were given outside of the hour that the medications were scheduled to be administered. 2. Review of R69's undated "Admission Record," located in the EMR under the "Profile" tab, revealed an admission date of [redacted] with medical diagnoses that included but not limited to [redacted] Review of R69's "Orders" located in the EMR under the "Order" tab, revealed physician orders fo [redacted] Review of R69's "Medication Administration Audit Report," that was provided by the facility, revealed the following: [redacted]	F 684		

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F 684	Continued From page 14 capsule by mouth two times a day for mood NJ ex order 26.4b1 [redacted] Interviewed the DON on 11/16/23 at 4:13 PM. The DON confirmed that these medications were given outside of the hour that the medications were scheduled to be administered. Review of the facility policy titled "Administering Medications" with revision date of 2023 stated, " ...Medications must be administered within one (l) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) ..." NJAC-8:39-29.2(d)	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observations, the facility implemented oxygen	F 695	1. Residents affected by deficient practice:	12/31/23

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F 695	Continued From page 15 therapy without physician's orders for one of one resident (Resident (R) R20) reviewed for NJ ex order 26.4 [redacted] Findings include: Observation on 11/14/23 at 10:09 AM, revealed R20 in bed, NJ ex order 26.4b1 [redacted] R20 NJ ex order 26.4b1 [redacted]. R20 stated she NJ ex order 26.4b1 [redacted] Observation on 11/15/23 at 8:43 AM revealed R20 in bed, alert with NJ ex order 26.4b1 [redacted] Observation on 11/16/23 at 9:20AM revealed R20 in bed resting quietly, NJ ex order 26.4b1 [redacted] Observation on 11/16/23 at 9:20 AM with Licensed Practical Nurse (LPN) 4, observed R20 NJ ex order 26.4b1 [redacted] Review of R20's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of NJ ex order 26.4b1 [redacted] with diagnosis of NJ ex order 26.4b1 [redacted] Review of R20's EMR, under the "Orders Tab"	F 695	The facility implemented NJ Ex.Order 26.4(b)(1) [redacted] without a physician order. Resident #20 was affected by this deficient practice. The DON reviewed residents #20 medical record new orders received from MD and initiated for use of NJ Ex.Order 26.4 [redacted]. 2. Identifying other Residents who could be affected by the deficient practice: Residents that require oxygen therapy could be affected by this deficient practice. 3. Measures or systemic changes to ensure that the deficiencies will not recur: The facility□s policies and Procedures on Physician Order were reviewed with DON and all licensed nursing staff. Emphasis on initiating and recording orders for oxygen, specifying the rate of flow, route and diagnosis for use. 4. Monitoring the continued effectiveness of the systemic change: The DON/Unit Manger/Designee will conduct audits of all residents that require Oxygen Therapy. Audits will be completed weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 695	Continued From page 16 revealed no orders for oxygen therapy. Review of R20's care plan under the "care Plan" tab in the EMR did not reveal any use for [NJ Ex.Order 26.4(b)(1)] During an interview on 11/16/23 at 9:20 AM, LPN4 confirmed R20 did not have orders for [NJ Ex.Order 26.4(b)(1)] in her physical chart or the EMR. During an interview on 11/16/23 at 10:00AM, Registered Nurse (RN) 1, who was identified as the RN that completed the admission on R20, revealed and confirmed R20 did not have orders for [NJ Ex.Order 26.4(b)(1)]. NJAC-8:39-29.2(d)	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		12/31/23

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F 812	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to serve food in a sanitary manner as evidenced by one employee not washing his hands and changing his gloves after they became contaminated. This had the potential to affect 80 of the 81 facility residents who consumed food from the facility kitchen. Findings include: On 11/15/23 at 11:07 AM, Cook1 was observed at the steam table placing soup in bowls when a metal steam table divider fell on the floor. Cook1 picked the metal steam table divider up and placed it on the shelf just below the serving counter of the steam table. Without changing his gloves and washing his hands he touched the oven door handle and removed a pan of baked beans out of the oven and touched the thermometer and took the temperature of the beans. Cook1 placed the pan of beans back into the oven and obtained a clean wiping cloth and wiped off the counter and then touched the trash can lid and lifted it up and threw the wiping cloth in the trash. After Cook1 touched the lid of the trash can, he touched the thermometer and took the temperature of the soup and placed six bowls on the counter touching each bowl. Using a ladle Cook1 put soup in the bowls and put the bowls on a pan and placed them in the food warmer. Cook1 obtained another wiping cloth and wiped the counter off and then touched the trash can lid with the same gloves on to throw away the wiping cloth. Cook1 removed additional food items from the oven and while wiping the thermometer with an alcohol wipe the wipe fell to the floor. Cook1 picked it up from the floor and placed it in his	F 812	1. Residents affected by deficient practice: The facility failed to serve food in a sanitary manner as evidenced by one employee not performing proper hand hygiene. Cook # 1 was immediately provided an in-service on Proper food handling and handwashing. 2. Identifying other Residents who could be affected by the deficient practice: All Residents have the potential to be affected when food is not handled or stored in a safe and sanitary manner. 3. Measures or systemic changes to ensure that the deficiencies will not recur: The Food Service Director in-serviced all dietary staff on Proper food handling and handwashing. The Facility□s Policies on Safe Food Handling and Handwashing were reviewed by the Administrator and Regional Dietary Director and no changes were made. 4. Monitoring the continued effectiveness of the systemic change: The Food Service Director/designee will observe the Kitchen staff handling food and washing their hands three times a week for four weeks and once a week for the next two months and document their	

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F 812	Continued From page 18 pocket and continued taking the temperature of the food items and placing the pans on the steam table. At 11:27 AM, Cook1 was questioned about if he had changed his gloves after picking items up from the floor and after touching the trash can lid and he pointed at a box of gloves laying on a food cart but did not give an answer. At 11:30 AM, Cook1 was observed to take off his gloves and wash his hands however he touched the top of the trash can to throw the paper towel away and then took a pair of disposable gloves out of the box of gloves that was hanging on the wall over the hand sink touching the outside of the gloves. Cook1 began serving and at 11:35 AM he removed his gloves, touched the top of the trash can to throw them away and without washing his hands he reached into the box of clean gloves and touching the outside of the gloves took them out of the box. At 11:35 AM, the Corporate Support Specialist was present in the kitchen watching the tray line and she verified Cook1 contaminated his hands throwing the gloves away and then obtained a clean pair of gloves touching the outside of the gloves. the Corporate Support Specialist stated Cook1 should have washed his hands after touching the trash can lid and throwing his soiled gloves away. The facility policy's titled "Hand Washing Policy" with a revised date of October 2022 stated staff were to wash their hands after touching trash and contaminated objects. NJAC-8:39-17.(g) NJAC-8:39-19.4(a) NJAC-8:39-19.7(d)	F 812	findings on an Audit tool. The Food Service Director will report on her findings to the Administrator at Quarterly QA meetings x 3.	

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This deficient practice was evidence by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	S 560	1. Residents affected by deficient practice: Facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersy. The facility continues to recruit new staff and use agency staff to meet staffing standards. 2. Identifying other Residents who could be affected by the deficient practice: All residents have the possibility to be affected. 3. Measures or systemic changes to	12/31/23

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

Electronically Signed | 12/11/23

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S 560	Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 07/17/2022 to 07/30/2022, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -07/17/22 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -07/18/22 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs. -07/20/22 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -07/23/22 had 6 CNAs for 76 residents on the day shift, required at least 9 CNAs. -07/24/22 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs. -07/25/22 had 7 CNAs for 78 residents on the day shift, required at least 10 CNAs. -07/26/22 had 7 CNAs for 78 residents on the day shift, required at least 10 CNAs. -07/27/22 had 6 CNAs for 78 residents on the day shift, required at least 10 CNAs. -07/28/22 had 7 CNAs for 81 residents on the day	S 560	ensure that the deficiencies will not recur: The facility has put in place the following: a. Increased wage rates for CNA□s and nurses b. Attendance bonuses c. Recruitment sign on bonuses for new staff d. The facility has started an employee morale/recruitment and retention committee. e. Employee of the month program f. Employee Rewards) Program g. Indeed, job openings advertisement h. Facility monthly appreciation celebrations i. Have reached out to prior employees to see if they will come back. j. The facility will monitor the staffing ratios in QAPI reporting for 3 months. 4. Monitoring the continued effectiveness of the systemic change: DON/ Designee will audit schedule daily to proactively secure staff. Results of audits will be submitted to QAPI monthly x 3 to ensure compliance and reassessed for further action. All findings will be reported quarterly to the QAPI committee.	

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S 560	Continued From page 2	S 560		

shift, required at least 10 CNAs.
-07/29/22 had 7 CNAs for 81 residents on the day shift, required at least 10 CNAs.
-07/30/22 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs.

2. For the 2 weeks of Complaint staffing from 01/08/2023 to 01/21/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows:

-01/08/23 had 6 CNAs for 87 residents on the day shift, required at least 11 CNAs.
-01/10/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-01/11/23 had 4 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-01/12/23 had 5 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-01/13/23 had 5 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-01/14/23 had 7 CNAs for 86 residents on the day shift, required at least 11 CNAs.

-01/15/23 had 6 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-01/15/23 had 3 CNAs to 8 total staff on the evening shift, required at least 4 CNAs.
-01/16/23 had 5 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-01/17/23 had 6 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-01/18/23 had 6 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-01/19/23 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs.
-01/20/23 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs.
-01/21/23 had 7 CNAs for 80 residents on the day

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S 560	Continued From page 3 shift, required at least 10 CNAs. 3. For the 4 weeks of Complaint staffing from 02/05/2023 to 03/04/2023, the facility was deficient in CNA staffing for residents on 22 of 28 day shifts and deficient in CNAs to total staff on 1 of 28 evening shifts as follows: -02/05/23 had 6 CNAs for 78 residents on the day shift, required at least 10 CNAs. -02/07/23 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -02/09/23 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs. -02/11/23 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -02/12/23 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -02/14/23 had 6 CNAs for 76 residents on the day shift, required at least 9 CNAs. -02/15/23 had 6 CNAs for 75 residents on the day shift, required at least 9 CNAs. -02/16/23 had 8 CNAs for 75 residents on the day shift, required at least 9 CNAs. -02/18/23 had 5 CNAs for 75 residents on the day shift, required at least 9 CNAs. -02/19/23 had 5 CNAs for 75 residents on the day shift, required at least 9 CNAs. -02/21/23 had 6 CNAs for 75 residents on the day shift, required at least 9 CNAs. -02/22/23 had 6 CNAs for 75 residents on the day shift, required at least 9 CNAs. -02/23/23 had 7 CNAs for 77 residents on the day shift, required at least 10 CNAs. -02/24/23 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -02/25/23 had 7 CNAs for 77 residents on the day shift, required at least 10 CNAs.	S 560		

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S 560	Continued From page 4 -02/26/23 had 7 CNAs for 77 residents on the day shift, required at least 10 CNAs. -02/26/23 had 3 CNAs to 9 total staff on the evening shift, required at least 4 CNAs. -02/27/23 had 7 CNAs for 78 residents on the day shift, required at least 10 CNAs. -02/28/23 had 6 CNAs for 78 residents on the day shift, required at least 10 CNAs. -03/01/23 had 5 CNAs for 76 residents on the day shift, required at least 9 CNAs. -03/02/23 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -03/03/23 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs. -03/04/23 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs. 4. For the 2 weeks of staffing prior to survey from 10/29/2023 to 11/11/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -10/29/23 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -11/01/23 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -11/08/23 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. -11/09/23 had 8 CNAs for 78 residents on the day shift, required at least 10 CNAs. -11/10/23 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. -11/11/23 had 8 CNAs for 80 residents on the day shift, required at least 10 CNAs.	S 560		

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)
315284	A. Building B. Wing	12/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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 F0684 Reg. # 483.25 LSC	Correction Completed 12/31/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON
11/16/2023

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061318		12/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/31/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/16/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING **02** B. WING _____	**11/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE** **LONG BRANCH, NJ 07740**

(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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 11/14/2023. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/14/23 and 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. Complete Care at Monmouth is a two-story building with basement that was built in 1990's. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator does approximately 40 % of the building as per the Maintenance Director. The current occupied beds are 80 of 120.	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	K 271		12/31/23

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

Electronically Signed | 12/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING **02** B. WING _____	**11/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE** **LONG BRANCH, NJ 07740**

(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 271	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the exterior stair handrail was installed correctly in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.2.2.4.4.2. This deficient practice had the potential to affect 27 residents who resided at the facility. Findings include: An observation on 11/14/23 at 11:57 AM revealed the bottom of the exterior ramp handrail and guard were rusted and broken and not secured to the concrete. Continued observation revealed the top of the exterior ramp handrail was broken and was not secured to the wall. An observation on 11/14/23 at 12:07 PM revealed the exterior ramp handrail near the nurses' station was loose and was not secured to the wall. During interviews at the time of the observations, the Maintenance Director verified the handrail at the exterior ramp was rusted and broken away from the concrete. The Maintenance Director also confirmed the handrail near the nurses' station was not secured to the wall. NJAC 8:39-31.2(e)	K 271	1. 1. The rusted and broken section of the exterior handrail was replaced and the new handrail was properly secured to the concrete. The top of the exterior handrail was properly secured to the wall. The exterior ramp handrail near the nurses station was properly secured to the wall. 2. All residents who use the outside area can be at risk of the incorrectly installed railings. 3. Checking for loose and rusted railings will be added and assigned to the Maintenance Director weekly rounds on Tels Building maintenance software. The Maintenance Director or designee will be responsible for completing and signing off on weekly rounds. The checklist will be audited monthly by the Administrator for 3 months. 4. The Director of Maintenance or designee will report on the status of weekly rounds to the Administrator at Quarterly QA meeting x 3.	
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	K 345		12/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING **02** B. WING _____	**11/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE** **LONG BRANCH, NJ 07740**

(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 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 record review, the facility failed to ensure smoke detection sensitivity testing of the smoke detectors were completed every alternate year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 80 residents who resided at the facility. Findings include: A review of the facility's binder for the 2023 calendar year, provided by the Maintenance Director, revealed the "Inspection and Testing Reports," dated 07/07/23 had no reference to a smoke detection sensitivity test. An observation of the facility smoke detectors on 11/14/23 from 11:30 AM to 3:30 PM with the Maintenance Director and the Regional Maintenance Director revealed smoke detectors were in the corridors at the smoke barriers, in all sleeping rooms, and other concealed areas throughout the building. During an interview at the time of the observations, the Maintenance Director, and Regional Maintenance Director both confirmed the smoke sensitivity testing was not completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e)	K 345	1. Sensitivity testing of all Smoke Detectors was done on November 27, 2023. 2. All residents can be at risk from failure to adequately test and maintain the Fire Alarm system. 3. The sensitivity testing was added to the TELS Building Maintenance software to alert the Maintenance Director to insure the task is completed timely every alternate year. The Maintenance Director or designee will be responsible to communicate with the appropriate vendor to schedule all maintenance and testing. 4. The Director of Maintenance or designee will report to the Administrator on the status of all Fire Alarm tests and inspections at Quarterly QA Meeting x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING **02** B. WING _____	**11/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE** **LONG BRANCH, NJ 07740**

(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 3 NFPA 70, 72	K 345		
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) 8.5.2.2. This deficient practice had the potential to affect all 80 residents who resided at the facility. Findings include: An observation on 11/14/23 at 2:20 PM of the	K 362	1. The penetration in the Smoke Barrier located on wing 100 was repaired with fire retardant caulk on November 20, 2023. 2. All residents are considered at risk due to penetration in smoke compartment barriers. 3. The Maintenance Director or designee will follow behind all work done in the Facility that has the possibility of penetration of Smoke Barriers to insure no penetrations exist or are repaired	12/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING **02** B. WING _____	**11/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE** **LONG BRANCH, NJ 07740**

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K 362	Continued From page 4 smoke barrier located in the 100-wing above the smoke barrier doors, adjacent to the nurses' station, revealed a one-inch by one-inch hole, with two low voltage wires going through it which penetrated the smoke barrier. Continued observation revealed the smoke barrier was not protected by a system or material capable of restricting the transfer of smoke. During an interview at the time of the observation, the Maintenance Director, and the Regional Maintenance Director both confirmed the penetrations in the smoke barrier was not protected by a system or material capable of restricting the transfer of smoke. NJAC 8:39-31.1(c), 31.2(e)	K 362	immediately if they are found. 4. The Director of Maintenance or designee will report to the Administrator on the status of all work done in the Facility that may have created new penetrations in any Smoke Barrier at Quarterly QA Meeting x 3.	

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
315284 Y1	A. Building 02 - MONMOUTH CARE CENTER B. Wing Y2	12/31/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0271	Correction Completed 12/31/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 12/31/2023	ID Prefix Reg. # NFPA 101 LSC K0362	Correction Completed 12/31/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 11/16/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO