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

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 08/03/2022 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 02			COMPLETED	
		315284	B. WING			09/	09/2019
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT MONMOUTH, LLC			•	229	EET ADDRESS, CITY, STATE, ZIP CODE BATH AVENUE NG BRANCH, NJ 07740		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
K 000	Appendix Z-Emergener Provider and Supplier	quirements for Long Term	K	000			
	LIFE SAFETY CODE	E 101:2012					
K 321 SS=D	the minimum Life Safe surveyed using CMS- Hazardous Areas - Er		K	321			11/8/19
	having 1-hour fire resifire rated doors) or an system in accordance. When the approved a system option is used separated from other partitions and doors in Doors shall be self-clain and permitted to have protective plates that from the bottom of the Describe the floor and	protected by a fire barrier istance rating (with 3/4 hour automatic fire extinguishing with 8.7.1 or 19.3.5.9. utomatic fire extinguishing the areas shall be spaces by smoke resisting accordance with 8.4. posing or automatic-closing an anatomatic or field-applied do not exceed 48 inches edoor.					
	Area Separation N/A a. Boiler and Fuel-Fire b. Laundries (larger the	ed Heater Rooms nan 100 square feet)					

(X2) MULTIPLE CONSTRUCTION

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

Electronically Signed 09/25/2019

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L TOENTIEICATION NITIMBED:		MULTIPLE CONSTRUCTION UILDING 02		(X3) DATE SURVEY COMPLETED	
		315284	B. WING	 	09	/09/2019	
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT MONMOUTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 229 BATH AVENUE LONG BRANCH, NJ 07740		00.0012010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 321	e. Trash Collection R (exceeding 64 gallons f. Combustible Storag (over 50 square feet) g. Laboratories (if cla Hazard - see K322) This REQUIREMENT by: Based on observation 09/03/19, in the present Maintenance Director facility failed to maintenance of the second facility failed f	ns (exceeding 64 gallons) coms s) ge Rooms/Spaces ssified as Severe is not met as evidenced ans and interview on ence of the facility r, it was determined that the ain doors to hazardous e was evidenced by the veyor observed that vacant as turned into a combustible om contained 20-plus large that were made out of a material and shelves. The in 50 square feet in size and osing or automatic-closing	K 32	I. Immediate Correction: A self-closing hydraulic door closer immediately ordered by the Mainten Director for the vacant resident roon numbered. The Maintenance Dimediately checked all areas in the facility over 50 square feet in size word combustible material to ensure door hazardous areas self-close. No oth areas were identified. II. Identification of Other Areas: The Maintenance Director immediate checked all areas in the facility over square feet in size to ensure complewith hazardous areas via NFPA 10 Hazardous Areas -Enclosures (LSC Health Existing). No other areas wite identified. III. Systematic Change: The Safety Officer or Maintenance Director will add Combustible Storate Rooms/Spaces over 50 square feet Preventative Maintenance Monthly Log. Copies will be retained for refeated validation. IV. Quality Assurance Monitoring: The Safety Officer or Maintenance	nance m Director ne vith ors to er ately r 50 liance 1 C 2012 ere age t to the Round		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED		
		315284	B. WING _			09/09/2019		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETION DATE		
K 321	Continued From page	÷ 2	К3		en findings to the erly. The safety Director will also immediately of area - enclosure			