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	315469	A. BUILDING _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, NJ 07753

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E 000	Initial Comments Survey: 08/31/23 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		
F 000	INITIAL COMMENTS Survey Date: 08/31/2023 Census: 74 Sample: 18 + 7 = 25 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		9/29/23

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

Electronically Signed | 09/26/2023

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F 758	Continued From page 1 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined that the facility failed to ensure the facility policy was followed to identify and adequately monitor target behaviors for residents receiving	F 758	1. Resident #27 and #33 had target behaviors identified, documented in a monthly summary and added to the residents care plan. 2. All residents that received psychoactive	

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F 758	Continued From page 2 NJ Exec Order 26.4b1 for 2 of 2 residents (Residents #27 and #33) reviewed for use of NJ Exec Order 26.4b1 use. The deficient practice was evidenced by the following: 1. On 08/22/23 at 10:05 AM during the initial tour, the surveyor observed Resident #27 sitting in the room and a visitor was at the bedside. The surveyor knocked on the door and was prompted by the visitor to enter the room. The surveyor explained the purpose of the visit to both the resident and the visitor. The visitor identified himself as the resident's representative and agreed to engage in a conversation with the surveyor at a later time. On 08/23/23 at 9:15 AM, the surveyor observed Resident #27 in the dining room area eating breakfast. On 08/25/23 at 7:45 AM, the surveyor observed Resident #27 asleep in bed. The resident representative was observed in the room. The surveyor observed two NJ Exec Order 26.4b1 on each side of the bed. An interview with the representative revealed that Resident #27 could be NJ Exec Order 26.4b1 with care givers. He stated that Resident #27 was recently hospitalized for NJ Exec Order 26.4b1 and the visitor further stated that they were looking forward to taking the resident home. On 08/25/23 at 10:15 AM, the surveyor reviewed Resident #27 medical record. The Admission Face Sheet (an admission summary) reflected that Resident #27 was admitted to the facility with diagnoses which included, but were not limited to, NJ Exec Order 26.4b1	F 758	medications have the potential to be affected. An audit was preformed on all other residents that received psychoactive medication for compliance 3. All nursing staff re-educated on psychoactive medication policy with a focus on daily ADL documentation, completing monthly summaries, identifying target behaviors and updating resident care plans. 4.Clinical manager/designee will conduct daily audits of documentation for residents receiving psychoactive medications for 2 weeks and then 3 times a week for 4 months. Clinical manager/designee will report results monthly to QAPI for 6 months and the reevaluate	

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NJ Exec Order 26.4b1 [redacted]

The admission Minimum Data Set (MDS) with an assessment reference date of NJ Exec Order 26.4, revealed that Resident #27 scored NJ E[redacted] out of 15 on the Brief Interview for Mental Status (BIMS) which was indicative of a NJ Exec Order 26.4b1.

The Comprehensive Care Plan (CP) initiated NJ Exec Order 26.4b indicated under Cognitive Patterns, Mood, and Expressions #13 Goal(s) the following:
NJ Exec Order 26.4b1 [redacted]

The CP for Resident #27 did not address all behaviors exhibited by the resident.

Resident #27 had physician's orders for the following NJ Exec Order 26.4b1 medications:
NJ Exec Order 26.4b1 [redacted] tablet daily for NJ Exec Order 26.4b1.
1(tab) Tablet Oral every day for NJ Exec Order 26.4b1.

NJ Exec Order 26.4b1 [redacted], delayed release (2 caps) Capsule every twelve hours.

NJ Exec Order 26.4b1 [redacted] tablet 1 tablet as needed every

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F 758	Continued From page 4 8 hours as needed for [redacted] The psychiatry Progress Note dated [redacted], indicated the following: Patient reevaluated for NJ Exec Order 26.4b1. Nursing staff continue to report increased in [redacted], NJ Exec Order 26.4b1, [redacted]. On examination, patient [referring to Resident #27] was [redacted]. Thought process is [redacted]. Patient is likely to benefit from NJ Exec Order 26.4b1 Plan: 1. Always consider supportive and individualized non-pharmacological interventions. Treat medical issues. Encourage participation in activities, social engagement as tolerated and as possible for psychosocial well-being. 1. Add NJ Exec Order 26.4b1 every 12 hours as needed for [redacted] Continue will all current treatments, Benefit greater than risks. Resident #27 had diagnosis of [redacted] was recently admitted with [redacted] and the [redacted] and causing him/her to be [redacted] On 08/29/23 at 8:57 AM, during an interview with the Clinical Coordinator Registered Nurse (CC/RN), she stated that Resident #27 had episodes of NJ Exec Order 26.4b1, [redacted] and [redacted]. The NJ Exec Order 26.4b1 was prescribed during the resident hospitalization for [redacted] and NJ Exec Order 26.4b1. The CC/RN further stated on 08/29/23 at 10:30 AM, that if the resident displayed target behaviors, they would be included in the nurses notes and then	F 758		

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summarized monthly. The surveyor requested the monthly summary notes regarding the NJ Exec Order 26.4b1 and behaviors, and the facility was unable to provide.

On 08/29/23 at 11:37 AM, during an interview with the the CC/RN and the Assistant Director of Nursing (ADON) both revealed that resident documentation was completed by exception. The ADON stated that the Certified Nursing Assistant (CNA) would ask questions from the Action and Expression Touch Screen, then document their answers and then report the information to the nurse. The nurse would then enter their documentation in the monthly summary. The surveyor requested the Action and Expressions Form for review.

The surveyor reviewed the medical record and the following behaviors were entered in the progress notes for Resident #27:

NJ Exec Order 26.4b1 07:05 AM, NJ Exec Order 26.4b1.

NJ Exec Order 26.4b1 3:49 PM, NJ Exec Order 26.4b1 during lunch, NJ Exec Order 26.4b1

NJ Exec Order 26.4b1 06:19 AM, NJ Exec Order 26.4b1

NJ Exec Order 26.4b1 04:39 PM, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1

NJ Exec Order 26.4b1 2:35 PM, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1.

NJ Exec Order 26.4b1 7:50 PM, NJ Exec Order 26.4b1.

On 08/30/23 at 12:27 PM, during a pre-exit conference with the administrative staff, the Director of Nursing (DON) stated that target behaviors for NJ Exec Order 26.4b1 were documented on the Activities of Daily Living Flow Sheet (ADLs) Form Action and Expression Touch

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Screen and she would provide the documentation in the morning.

On 08/31/23 at 8:27 AM, the ADON in the presence of the survey team, stated that the CNA's failed to document the behavior on the ADLs Touch Screen Action and Expression. The ADON provided the CNA's documentation for the resident which documented, "No behavior".

On 08/31/23 at 9:30 AM, when the nurses notes were reviewed, along with the documentation from the Actions and Expressions Touch Screen provided by the facility for the corresponding time periods NJ Exec Order 26.4b1, the CNAs documentation did not include any behavior entries for the number of behavior incidents reportedly displayed and were documented in the medical record.

2. Resident #33 was admitted to the facility with diagnoses which included, but was not limited to NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.

On 08/22/23 at 10:30 AM, the surveyor observed Resident #33 in the room and the resident was NJ Exec Order 26.4b1.

On 08/24/23 at 11:30 AM, the surveyor reviewed the medical record which revealed that Resident #33 was prescribed the following NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 at bedtime for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 every one day for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 tablet, 1 tablet twice daily for NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1 daily for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 as needed at bedtime for NJ Exec Order 26.4b1.

On 08/28/23 at 11:30 AM, the surveyor interviewed the resident regarding the prescribed medications. Resident #33 informed the surveyor that he/she could not recall all the medications prescribed, however he/she had been diagnosed with NJ Exec Order 26.4b1 a long time ago.

The Quarterly Minimum Data Set (MDS) dated NJ Exec Order 26.4b revealed that Resident #33 was able to NJ Exec Order 26.4b1 Resident #33 scored NJ Ex out of 15 on the Brief Interview for Mental Status (BIMS) indicative of NJ Exec Order 26.4b1

The Comprehensive Care Plan (CP) dated NJ Exec Order 26.4b which did not include a focus area for behavior.

On 08/28/23 at 11:30 AM, the surveyor interviewed the CC/RN regarding the above medications and the target behavior that was identified and what was being monitored. The CC/RN could not identify the target behaviors for the above medications. When inquired regarding if the resident's behavior had been monitored and documented, the CC/RN stated that the behaviors were documented on the monthly summary.

On 08/29/23 at 11:30 AM, the surveyor then requested the monthly summaries for review. The CC/RN could not provide the monthly summaries. A review of the nurses notes failed to identify the target behaviors that were being monitored.

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A review of the psychiatry consultation dated NJ Exec Order 26.4b indicated the following:
Client was referred to [name redacted- crisis response program for the elderly] due to become NJ Exec Order 26.4b and NJ Exec Order 26.4 in response to being informed by staff that he/she is being transferred to a new psychiatric Nurse Practitioner.
Progress notes were reviewed and there was no documentation regarding the resident exhibiting NJ Exec Order 26.4b1. The following recommendations were suggested on the psychiatry consultation from [name redacted- crisis response program for the elderly].
1. Have client participate in a NJ Exec Order 26.4b1 as a means of helping to NJ Exec Order 26.4b1 and providing NJ Exec Order 26.4b1 to encourage NJ Exec Order 26.4b1, [name redacted- crisis response program for the elderly] recommend staff training on: NJ Exec Order 26.4b1 and Identifying Potential Triggers to behaviors (Assessment tool used to gather information that should evolve into a behavior implementation plan). The same recommendations were again documented on NJ Exec Order 26.4.

When interviewed on 08/29/23 at 11:00 AM, the CC/RN confirmed that monthly summaries to monitor behaviors for Resident #33 were not being completed. The target behaviors were not identified or documented. The Patient Care associate [CNA] could not comment on the behavior. Upon inquiry the staff that were assigned to Resident #33 stated that the resident was attention seeking and would lower him/herself on the floor to get staff into the room. The staff did not state that the resident had been NJ Exec Order 26.4b1. The behavior was not

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captured on the ADL's Touch Screen Action and Expression. The CNA's indicated in their documentation that the resident did not exhibit any behaviors.

On 08/30/23 at 12:33 PM, the DON stated that the CNA's documented the behavior on the computer, reported the behaviors to nursing and then the nurse would complete the monthly summary.

On 08/31/23 at 8:27 AM, the ADON in the presence of the survey team, stated that the CNA's failed to document the behavior on the ADLs Touch Screen Action and Expression for both residents Resident #27 and #33. The ADON provided the CNA's documentation which revealed all documented, "No behavior".

On 08/31/23 at 9:30 AM, during a pre-exit conference held with the administrator and the DON, the DON confirmed that target behaviors were not identified or documented.

A review of the facility policy titled, "Psychoactive Medications" dated 05/2003 last updated 06/2021, revealed the following :
Psychoactive medication therapy shall be used only when it is necessary to achieve specific treatment goals. Once treatment goals have been achieved, residents on psychoactive medications will receive gradual dose reductions and behavioral interventions, as clinically indicated, in an effort to discontinue these medications.
Procedure:
All psychoactive medication orders will contain supporting documentation to define specific goals of treatment. The minimum documentation required includes a specific diagnosis or

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F 758	Continued From page 10 condition, if known, or a specific target behavior. Any medication used to manage the behavior will include provider documentation of target symptoms or behaviors in the clinical record and the documentation will be sufficient to demonstrate that said behaviors are : a. Violent or dangerous to self or others. b. Extremely disturbing to the resident or other staff. c. Interfere significantly with care delivery causing adverse outcomes. N.J.A.C. 8:39-27.1(a)	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		9/29/23

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F 880	Continued From page 11 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review it was determined that the facility failed to follow their Handwashing/Hand Hygiene policy and perform hand hygiene during a lunch meal observation. This deficient practice was observed on 1 of 2 resident units and was evidenced by the following: On 08/22/23 at 11:55 AM, during the observation of the lunch meal in the main dining area on the fourth-floor unit, a Certified Nurse Aide (CNA) #1 was observed without performing hand hygiene as follows: 11:55 AM before and after delivering a lunch tray to Resident #1. 11:59 AM before and after delivering a lunch tray to Resident #2. 12:04 PM before delivering a lunch tray to Resident #3, and then required a second tray and was taken away. 12:07 PM CNA # 1 reached into her scrub top pocket, answered her cell phone, put the phone back into her pocket and then delivered a tray to Resident #3. 12:09 PM CNA #1 dropped a pen out of her pocket and then picked it up off of the ground. CNA #1 then delivered a lunch tray to Resident # 4. 12:11 PM before and after delivering lunch tray to Resident #5. 12:13 PM before and after delivering lunch tray to Resident #6. 12:14 PM before and after delivering a cup and	F 880	1. CNA #1 was re-educated on infection control as it pertains to hand washing, meal service and cell phone policy. Hand washing competency was completed 2. All residents have the potential to be affected 3. Certified nursing aides that serve in the 4th floor dining room will be re-educated on hand washing, meal service and cell phone policy. 4. Clinical manager/designee will observe 5 meal services in the dining room per week for 4 weeks and than 5 meal services a month for 3 months to ensure infection control compliance. Clinical manager/designee will report results monthly to QAPI for 4 months and then reevaluate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, 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
F 880	Continued From page 13	F 880		

drink to Resident #7.
12:16 PM before and after delivering lunch tray to Resident #8.
12:19 PM CNA #1 walked away from the dining area into another room to talk on her cell phone, and then returned to continue with meal delivery without first performing hand hygiene.
12:21 PM CNA #1 exited the dining room and then returned the cell phone into her pocket.

On 08/22/23 at 12:23 PM, during an interview with the surveyor, CNA #1 stated she was supposed to use hand hygiene between passing each residents meal tray. "You caught me, we were just hectic." CNA #1 also stated that the cell phone in her pocket was also dirty and hand hygiene needed to be performed after using her cell phone or reaching into her scrub pocket, which she acknowledged was a dirty environment.

On 08/22/23 at 12:25 PM, during an interview with the surveyor, the Licensed Practical Nurse # 1 (LPN #1) explained her job duty was to oversee meals making sure the residents were safe and not choking. LPN #1 also stated that hand hygiene must be performed before and after delivering food to prevent the spread of germs.

On 08/22/23 at 12:37 PM, the Director of Nursing (DON) stated the process for the lunch meal was that dietary and nursing were present for assisting, and the nursing staff would bring in hand wipes for the residents and also assist with feeding. The DON stated, staff "should perform hand hygiene in between residents for infection control." She further stated that any items in scrub pockets were considered dirty and hand hygiene should be completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315469	A. BUILDING _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, 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
F 880	Continued From page 14 A review of the facility provided, "Handwashing/Hand Hygiene" policy dated 5/2019 included but not limited to: Purpose to prevent the spread of potentially infectious organism to residents/patients, staff, and visitors. Definition hand hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis. When to perform some form of hand hygiene (at a minimum) -After touching a resident/patient's immediate environment -Hand washing is required anytime you are handling food -When handling food, hands must be washed. Alcohol based sanitizers can not be substituted. NJAC 8:39-19.4(a); 27.1(a)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Q3VL3S	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, 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) COMPLETE DATE
S 000	Initial Comments The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 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 provisions of 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 observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 4 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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,	S 560	1. No residents affected 2. The community realizes all residents have the potential to be affected. The administrator/designee has reviewed the daily staffing sheets for the next 2 weeks to validate that the community will meet the minimum staffing requirements for certified nursing assistants 3. The administrator/designee will re-educate staffing coordinator and clinical leadership regarding the required direct care staff to resident ratio. The community has job postings and advertised for all open certified nurse aide positions. Administrator/designee will pursue securing direct care staffing services from	9/29/23

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

Electronically Signed | 09/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Q3VL3S	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, NJ 07753

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S 560	Continued From page 1 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 2/01/21: 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. The surveyor requested staffing for the weeks of 08/06/23 through 08/12/23 and 08/13/23 through 08/19/23. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -08/10/23 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs. -08/14/23 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -08/16/23 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. -08/17/23 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs.	S 560	staffing agencieis. Staffing coordinator/designee will utilize floating staff from our Assisted Living with short notice vacancies. 4. The Administrator/designee will review the certified nurse aide staffing and resident census to ensure compliance with the required direct care staffing ratios daily for 1 month and then weekly for 3 months. Administrator/designee will report findings monthly to QAPI for 4 months and reevaluate for continued oberservation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Q3VL3S	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, NJ 07753

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S 560	Continued From page 2 On 08/25/23 at 10:28 AM, the interim staffing coordinator stated at times the facility will use flex staff [per diem] for call outs. On 08/29/23 at 9:14 AM, a Licensed Practical Nurse (LPN) stated that call outs usually happen on the weekends. On 08/29/23 at 09:25 AM, a CNA stated that weekends and holidays the facility was always short.	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)
315469	A. Building B. Wing	10/3/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, 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 F0758 Reg. # 483.45(c)(3)(e)(1)-(5) LSC	Correction Completed 09/29/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 09/29/2023	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	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	
8/31/2023	☐ 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 (Y2)	DATE OF REVISIT (Y3)
Q3VL3S	A. Building B. Wing	10/3/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, NJ 07753

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 09/29/2023	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 8/31/2023	☐ 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
	315469	A. BUILDING **01** B. WING _____	**08/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, 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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/23/2023 and 08/24/2023 and Continuing Care at Seabrook 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. Continuing Care at Seabrook is a Five (5) story, Type I Fire Resistant building that was built in January 1999. The facility is divided into 6 smoke zones.	K 000		
K 321 SS=D	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	K 321		9/29/23

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

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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
	315469	A. BUILDING **01** B. WING _____	**08/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, NJ 07753**

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K 321	Continued From page 1 Separation N/A 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 review of facility provided documentation on 08/23/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas 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 evidenced by the following: On 08/23/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Maintenance Supervisor (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a five-story building with the Basement, fourth (4th.) and fifth (5th.) floors were for the Nursing Facility. Starting at approximately 8:57 AM on 08/23/2023 in the presence of the facility MS a tour of the	K 321	1. Door closure on medical records door was installed and tested for function on 8/23/23 2. All residents have the potential to be affected 3. General services/maintenance staff re-educated on hazardous area door requirements and protocols. 4. Maintenance supervisor/designee will audit the medical record door weekly for 4 weeks and then monthly for 3 months to ensure door closure is functioning properly. Maintenance supervisor will report results monthly to QAPI for 4 months	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, NJ 07753**

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K 321	Continued From page 2 building was conducted. During the building tour the of the facility the surveyor observed the following hazardous area that failed to have smoke resisting doors, 1) At approximately 9:28 AM, an inspection inside the basement level Medical Records room was performed. The surveyor observed that the corridor door leading into the Medical Records room had no means to self- The surveyor observed multiple combustible medical records in the room. The Medical Records room was larger then 50 square feet. With this corridor door not closing into its frame all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted in the area identified to pass the Medical Records room is the primary and/ or secondary egress route in the event of a fire. The MS confirmed the finding at the time of observations. On 08/24/2023 at approximately 12:56 PM during the survey exit , the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
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	K 345		9/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315469	A. BUILDING **01** B. WING _____	**08/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, NJ 07753**

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K 345	Continued From page 3 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 interview and review of facility provided documentation on 08/23/2023 and 08/24/2023, it was determined that the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. The is evidence by the following: On 08/23/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Maintenance Supervisor (MS) to provide to provide all mandatory inspections from January 1, 2022 through August 22, 2023 and to provide a copy of the last Smoke Detector Sensitivity testing. Later at approximately 11:55 AM a review of the facility provided mandatory inspections was performed. The surveyor reviewed the following Fire Alarm and Detection system inspections, - 04/11/2023 inspection. - 02/07/2023 inspection. - 10/27/2022 inspection. - 04/07/2022 inspection. This review of the testing reports revealed no reference to a smoke detection sensitivity testing.	K 345	1. Community vendor completed smoke detector sensitivity testing on 8/24/23. Community scheduled next test with vendor to be conducted August 2025 2. All residents have the potential to be affected 3. Maintenance staff re-educated on smoke detector testing policy 4. Maintenance supervisor/designee will audit communities red books weekly for 4 weeks and then monthly for 3 months to ensure all necessary testing has been completed. Maintenance supervisor will report findings monthly to QAPI for 4 months	

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K 345	Continued From page 4 At approximately 1:30 PM a request was made to the MS to place a call to the facility fire alarm and detection inspection vendor and request a copy of the last Sensitivity testing of the smoke detectors. On 08/24/2023 (day two of survey) at 10:39 AM, during an interview with the MS, handed the surveyor an email and said that the Fire Alarm Vendor will be on-site today. A review of the facility provided Fire Alarm Vendor's email reads in part: "Per our conversation, we will have a Tech onsite today to retrieve the sensitivity report for you, I will update you once he is heading over to you." Later at approximately 12:25 PM an interview with the Fire Alarm vendor's Tech was conducted. The surveyor asked the Tech. if he had the last sensitivity resting of the smoke detectors. The Tech said, no I am doing the sensitivity testing now. The facility has not performed a sensitivity test of the smoke detectors. The MS confirmed the smoke detector sensitivity testing had not been performed. On 08/24/2023 at approximately 12:56 PM during the survey exit , the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.1 (c), -31.2 (e) NFPA 70, 72.	K 345		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K 351		9/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315469	A. BUILDING **01** B. WING _____	**08/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, 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 351	Continued From page 5 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 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 observation and review of facility provided documentation on 08/23/2023 and 08/24/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, 2) Failed to provide fire sprinkler coverage to all areas of the facility as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition The deficient practice is evidenced by the following, On 08/23/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Maintenance Supervisor (MS) to provide a copy of the facility lay-out which	K 351	1. Community vendor installed sprinklers in stairwell #2 lower landing on 9/19/2023. Kitchen walk in refrigerator repaired 9/21/23 and ceiling tile in medical office replaced 8/24/23 2. All residents have the potential to be affected 3. General services/maintenance staff re-educated on sprinkler installation and CMS/ NFPA regulation for fire sprinkler coverage 4. Maintenance supervisor/designee will audit weekly for 4 months all areas in the building that require fire sprinkler coverage to ensure compliance. Maintenance supervisor will report findings monthly to QAPI for 4 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315469	A. BUILDING **01** B. WING _____	**08/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, 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 351	Continued From page 6 identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a five-story building with the Basement, fourth (4th.) and fifth (5th.) floors that are the Nursing Facility floors of the building. Starting at approximately 8:57 AM on 08/23/2023 in the presence of the facility MS a tour of the building was conducted. Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 08/23/2023 in the basement level: 1) At approximately 9:01 AM, the surveyor observed inside the Kitchens walk-in refrigerator one sprinkler missing an escheon cap. This left an approximately 1/2 inch gap in the ceiling. With the missing escheon cap, in the event of a fire this would allow the heat to by-pass the fire sprinkler and take longer to activate. 2) At approximately 9:27 AM, the surveyor observed inside the Medical Records department that the ceiling grid was missing one (1) 2 feet by 4 feet ceiling tile. With the missing ceiling tile, in the event of a fire this would allow the heat to by-pass the fire sprinkler and take longer to activate. 3) At approximately 9:55 AM, the surveyor observed no evidence of fire sprinkler coverage inside the 19'-6" by 9" stairwell #2 lower landing. At this time a request was made to the MS, do you see a fire sprinkler in the lower landing area. The MS said, no. The facility failed to provide fire sprinkler	K 351		

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CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, NJ 07753**

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K 351	Continued From page 7 coverage to all areas in the facility. The MS confirmed the finding at the time of observations. On 08/24/2023 at approximately 12:56 PM during the survey exit , the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=F	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 review of facility documentation on 08/23/2023 and 08/24/2023 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 20 of 20 portable fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be	K 355	1. Basement level on 8/24/23 One "Wet Chemical" fire extinguisher in the Main Kitchen, last annually inspected October 2022 was checked and dated, One "Wet Chemical" fire extinguisher in the Main Kitchen, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher in the Main Kitchen, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher in the boiler room was last annually inspected April 2023 was checked and dated, One "ABC" type fire extinguisher near the Medical Records department was last annually inspected April 2023 was checked and dated, One	9/29/23

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K 355	Continued From page 8 inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following, On 08/23/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Maintenance Supervisor (MS) to provide to provide a copy of the facility lay-put which identifies the various rooms and common areas for the Nursing facility. A review of the facility provided lay-out identified the building is a 5 story building with the 5th. and 4th. floors are Skilled Nursing floors with the basement level is common areas to the Skilled Nursing facility part of the building. Starting at approximately 8:54 AM on 08/23/2023 and continued on 08/24/2023 in the presence of the facility's MS a tour of the facility was conducted. During the two day building tour the surveyor	K 355	"ABC" type fire extinguisher in the Dining area, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher near the Commercial Laundry room, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher inside the Commercial Laundry room, last annually inspected October 2022 was checked and dated, One (1) "ABC" type fire extinguisher Facility Identification (FI) number, # RG-OB, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher FI # RG-acility Identification (FI) number, RG-OA, last annually inspected October 2022 was checked and dated On the 5th. floor, One "ABC" type fire extinguisher in the corridor near Resident laundry room, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher in the corridor near Resident room #531, last annually inspected October 2022 was checked and dated, one "ABC" type fire extinguisher in the corridor near the Dining room, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher in the corridor near Resident room #514, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher in the corridor near Resident room #507, last annually inspected October 2022 was checked and dated. On 8/25/23 4th. floor, One "ABC" type fire extinguisher in the corridor near Resident room #407, last annually inspected October 2022 was checked and dated, One "ABC" type fire	

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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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 9 observed and inspected twenty (20) portable fire extinguishers in various locations. The surveyor observed eighteen (18) portable fire extinguishers were last annually inspected in October 2022 and two (2) were last annually inspected April 2023 with the surveyor observing the following issues that were identified: On 08/23/2023: Basement level, 1) One (1) "Wet Chemical" fire extinguisher in the Main Kitchen, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 2) One (1) "Wet Chemical" fire extinguisher in the Main Kitchen, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 3) One (1) "ABC" type fire extinguisher in the Main Kitchen, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 4) One (1) "ABC" type fire extinguisher in the boiler room was last annually inspected April 2023. There was no evidence of monthly visual examination performed and documented for May, June and July 2023. 5) One (1) "ABC" type fire extinguisher near the	K 355	extinguisher in the corridor near Resident room #414, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher in the corridor near the Dining room, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher in the corridor near Residents laundry room, last annually inspected October 2022 was checked and dated, One "ABC" type fire extinguisher in the corridor near Resident room #431, last annually inspected October 2022 was checked and dated. 2. All residents have the potential to be affected 3. Security and maintenance team will be re-educated on policy for checking and dating fire extinguishers. 4. Security team will audit all fire extinguishers weekly for 4 weeks and then monthly for 3 months to ensure compliance. Maintenance supervisor/designee will report results monthly to QAPI for 4 months	

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K 355	Continued From page 10 Medical Records department was last annually inspected April 2023. There was no evidence of monthly visual examination performed and documented for May, June and July 2023. 6) One (1) "ABC" type fire extinguisher in the Dining area, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 7) One (1) "ABC" type fire extinguisher near the Commercial Laundry room, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 8) One (1) "ABC" type fire extinguisher inside the Commercial Laundry room, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 9) One (1) "ABC" type fire extinguisher Facility Identification (FI) number, # RG-OB, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 10) One (1) "ABC" type fire extinguisher FI # RG-acility Identification (FI) number, RG-OA, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for	K 355		

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K 355	Continued From page 11 November 2022. On the 5th. floor, 11) One (1) "ABC" type fire extinguisher in the corridor near Resident,s laundry room, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 12) One (1) "ABC" type fire extinguisher in the corridor near Resident room #531, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 13) One (1) "ABC" type fire extinguisher in the corridor near the Dining room, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 14) One (1) "ABC" type fire extinguisher in the corridor near Resident room #514, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 15) One (1) "ABC" type fire extinguisher in the corridor near Resident room #507, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. On 08/24/2023:	K 355		

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K 355	Continued From page 12 4th. floor, 16) One (1) "ABC" type fire extinguisher in the corridor near Resident room #407, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 17) One (1) "ABC" type fire extinguisher in the corridor near Resident room #414, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 18) One (1) "ABC" type fire extinguisher in the corridor near the Dining room, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 19) One (1) "ABC" type fire extinguisher in the corridor near Resident,s laundry room, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. 20) One (1) "ABC" type fire extinguisher in the corridor near Resident room #431, last annually inspected October 2022. There was no evidence of monthly visual examination performed and documented for November 2022. The MS confirmed the finding at the time of observations.	K 355		

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K 355	Continued From page 13 On 08/24/2023 at approximately 12:56 PM during the survey exit , the surveyor informed the Administrator of the deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
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 and review of facility provided documentation on 08/23/2023 and 08/24/2023 in the presence of facility management, 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 4 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition,	K 374	1. Door identified near resident room #410 was repaired and tested for function on 8/23/23. 2. All residents have the potential to be affected 3. General services/maintenance staff re-educated on smoke barrier doors policy. 4. Maintenance supervisor/designee will audit smoke barrier doors weekly for 4 weeks and then monthly for 3 months to ensure proper closure. Maintenance	9/29/23

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K 374	Continued From page 14 - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 08/23/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Maintenance Supervisor (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a five-story building with the Basement, fourth (4th.) and fifth (5th.) floors that are the Nursing Facility floors of the building. There are three (3) smoke compartments on the 4th. floor and three (3) smoke compartments on the 5th. floor with a total of four (4) sets of double corridor smoke doors . Starting at approximately 8:57 AM on 08/23/2023 and continued on 08/24/2023 in the presence of the facility MS a tour of the building was conducted. Along the two (2) day tour the surveyor performed a closure test of four (4) sets of double smoke doors in the corridors with the following results, On 08/24/2023: 1) At approximately 9:52 AM, during a closure test of the 4th. floor double smoke doors in the corridor near to Resident room #410 when the doors were release from the magnetic hold open device and allowed to self close into their frame, one door did not close into it's frame. The surveyor observed and measure an approximately 1-1/8 inch gap along the meeting	K 374	supervisor will report results monthly to QAPI for 4 months	

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K 374	Continued From page 15 edges. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The MS confirmed the finding at the time of observations. On 08/24/2023 at approximately 12:56 PM during the survey exit , the surveyor informed the Administrator of the deficiency. NJAC. 8:39-31.1(c), 31.2(e)	K 374		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 08/23/2023 and 08/24/2023, in the presence of facility management, it was determined that the facility failed to ensure that 3 of 17 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following:	K 911	1.Two Electrical outlets inside the 5th floor resident spa room one duplex outlet located 5'-4" to the left of the sink and one GFCI outlet located 13 inches from the left of the sink were replaced and tested for function on 8/24/23. 1 Duplex electrical outlet in the 4th floor soiled utility located 33 inches to the right of the sink was replaced and tested for function on 8/24/23	9/29/23

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K 911	Continued From page 16 Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 08/23/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Maintenance Supervisor (MS) to provide a copy of the facility lay-out which identifies the various rooms and common areas in the facility. A review of the facility provided lay-out identified the facility is a five-story building with the Basement, fourth (4th.) and fifth (5th.) floors are part of the Nursing facility. There are 82 Residential sleeping rooms. Starting at approximately 8:57 AM on 08/23/2023 in the presence of the facility MS a tour of the building was conducted.	K 911	2. All residents have the potential to be affected 3. General services/maintenance staff re-educated on GFCI protection and protocol. 4. Maintenance supervisor/designee will test 3 random GFCI outlets per week for 4 weeks and then monthly for 3 months to ensure compliance. Maintenance supervisor will report results monthly to QAPI for 4 months	

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	315469	A. BUILDING **01** B. WING _____	**08/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, 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 911	Continued From page 17 During the two (2) day tour of the facility, the surveyor observed and tested seventeen (17) electrical outlets in wet (with-in 6 feet of a sink) locations that failed to de-energize when tested in the following locations, On 08/23/2023: 1. At approximately 10:28 AM, inside the 5th. floor Residents Spa room, one Duplex electrical outlet located five feet four inches (5'-4") to the left of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 2. At approximately 10:56 AM, inside the the 5th. floor Resident Spa bathroom, one GFCI electrical outlet located thirteen (13) inches to the left of the sink, when tested with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. On 08/24/2023: 3. At approximately 9:50 AM, inside the the 4th. floor Soiled Utility room, one Duplex electrical outlet located thirty-three (33) inches to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The MS confirmed the findings at the time of observations. On 08/24/2023 at approximately 12:56 PM during the survey exit , the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		9/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315469	A. BUILDING **01** B. WING _____	**08/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, 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 918	Continued From page 18 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 observation and interview on 08/23/2023 in the presence of the facility	K 918	1. Community vendor completed wiring and install of remote manual stop station	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315469	A. BUILDING **01** B. WING _____	**08/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD** **TINTON FALLS, 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 918	Continued From page 19 management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 08/23/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Maintenance Supervisor (MS) if the facility had an Emergency Generator. The MS told the surveyor, yes we have one Caterpillar 300KW Diesel Emergency Generator. On 08/23/2023 during the building tour at approximately 9:12 AM, an inspection inside the boiler room where the 300 KW emergency generator was located was performed. The surveyor observed the emergency stop button was located on the control panel on the generator. At this time the surveyor asked the MS, Do you have a remote emergency stop button for the generator. The MS said, no. The MS confirmed the finding at the time of inspection. On 08/24/2023 at approximately 12:56 PM during the survey exit , the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	for generator completed 9/22/23. 2. All residents have the potential to be affected 3. General services/maintenance staff re-educated on generator requirements and protocols. 4. Maintenance supervisor/designee will check remote manual stop button placement weekly during generator load testing for 4 weeks and then monthly for 3 months. Maintenance supervisor will report findings monthly to QAPI for 4 months	

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
315469 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	09/29/2023	LSC K0345	09/29/2023	LSC K0351	09/29/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	09/29/2023	LSC K0374	09/29/2023	LSC K0911	09/29/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	09/29/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
8/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO