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 _____	03/09/2022

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 000	INITIAL COMMENTS Survey Date: 03/09/22 Census: 62 Sample: 21 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete a quarterly Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, for 3 of 21 residents (Residents #5, #7 and #14) reviewed for resident assessments. This deficient practice was evidenced by the following: 1). The surveyor reviewed the MDS information for Resident #5, contained within the electronic medical record. Further review revealed that the most recent MDS record for the referenced resident was created on [redacted], with an	F 638	1. Resident #5, #7, and #14 had their quarterly MDS completed and transmitted by MDS coordinator. 2. All residents have the potential to be affected 3. MDS coordinator or designee will run and audit the OBRA assessment tracking report bi-monthly and MDS tracker report weekly to ensure timely completion and submission of all MDS assessments. 4. Director of nursing or MDS coordinator will report MDS assessments scheduled and completed each month for 3 months to QAPI committee.	4/4/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/2022

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F 638	Continued From page 1	F 638		

Assessment Reference Date (ARD, the end date for the observation period) of [NJ Exec Order 26.4]. The surveyor observed the Quarterly MDS was not completed.

2). The surveyor reviewed the MDS information for Resident #7, contained within the electronic medical record. Further review revealed that the most recent MDS record for the referenced resident was created on [NJ Exec Order 26.4b], with an ARD of [NJ Exec Order 26.4b], and was signed on [NJ Exec Order 26.4].

3). The surveyor reviewed the MDS information for Resident #14, contained within the electronic medical record. Further review revealed that the most recent MDS record for the referenced resident was created on [NJ Exec Order 26.4b] with an ARD date of [NJ Exec Order 26.4], and was signed on [NJ Exec Order 26.4].

During an interview with the surveyor on 03/07/22 at 10:35 AM, the Continuing Care Administrator (CCA) stated that the MDS Coordinator (MDS-C) was on leave until [NJ Exec Order 26.4b1]. The CCA further stated that an acting MDS-C was completing the MDS assessments in her absence.

During an interview with the surveyor on 03/08/22 at 11:09 AM, the acting MDS-C stated that she was covering for an absent staff member, who ordinarily serves in the referenced capacity and has been doing so since [NJ Exec Order 26.4b].

During the same date and time, the acting MDS-C stated that the most recent Quarterly MDS for Resident #7 was completed on [NJ Exec Order 26.4b] and acknowledged that an additional Quarterly MDS should have been completed in [NJ Exec Order 26.4b1]. She also stated that the most recent

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F 638	Continued From page 2	F 638		

Quarterly MDS for Resident #14 was dated [redacted] and acknowledged that an additional Quarterly MDS should have been completed in [redacted]

During an interview with the surveyor on 03/08/22 at 12:20 PM, the Registered Nurse/Clinical Manager (RN/CM) stated the most recent Quarterly MDS for Resident #7 was completed around [redacted] and acknowledged that an additional Quarterly MDS should have been completed in [redacted]. She also stated that the most recent Quarterly MDS for Resident #14 was completed around [redacted] and acknowledged that an additional Quarterly MDS should have been completed in [redacted]

During an interview with the surveyor and team on 03/08/22 at 1:53 PM, the Director of Nursing (DON) stated that MDS assessments should be completed on resident admission, annually, at any time that a significant change in health or status occurs for a resident, and in the absence of such events, on a quarterly basis. The DON acknowledged that the MDS Quarterly assessments should have been completed for both Resident #7 and Resident #14 prior to [redacted].

During an interview with the survey team and administrative staff on 03/09/21 at 10:51 AM, the DON further acknowledged that an additional Quarterly MDS assessment was missed for Resident #5. The CCA stated that Resident #5 had been coded incorrectly in the MDS tracking system and the Quarterly MDS assessment should have been completed. The CCA reiterated that the Quarterly MDS assessments for Residents #7 and #14 should have both been

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F 638	Continued From page 3 completed prior to [redacted]. She further stated that the acting MDS-C scanned the wrong nursing unit (floor), causing some of the residents to be missed for timely MDS completion. Finally, she stated that it would be her expectation for assessments to be completed as they are due. During the same date and time, the DON stated it would be her expectation for MDS assessment tracking to occur more than once per month, so that potential issues such as those discovered are detected sooner. A review of the facility's policy titled, "MDS Completion and Management" revealed the policy had an origin date of April 2005 and a current version date of June 2021. The policy revealed a need for a quarterly MDS to be completed by the team on each resident within skilled nursing. In addition, it revealed that the MDS Coordinator or designee maintains the schedule for MDS completion within the electronic medical record and schedules subsequent assessments. NJAC 8.39 - 11.1	F 638		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		4/4/22

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F 690	Continued From page 4 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure that an NJ Exec Order 26.4b1 [redacted] was stored in a way to prevent the NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 3 residents reviewed for the use of NJ Exec Order 26.4b1 [redacted] (Resident #8) and was evidenced by the following: According to the Admission Record, Resident #8 had diagnoses that included, but were not limited	F 690	1. Resident #4 had NJ Exec Order 26.4b1 [redacted] replaced and NJ Exec Order 26.4b1. All other residents with NJ Exec Order 26.4b1 [redacted] will checked to ensure compliance with NJ Exec Order 26.4b1 2. All residents that require catheters have the potential to be affected. 3. All nursing staff re-educated on catheter care as per Erickson policy 4. Clinical manager/designee will conduct weekly audits of all residents that require a catheter to ensure staff are compliant with policy and infection control practices as it pertains to catheters. Findings will be	

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F 690	Continued From page 5 to: NJ Exec Order 26.4b1 [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed the resident had a Brief Interview for Mental Status of [redacted], which indicated that the resident was NJ Exec Order 26.4b1. Further review of the MDS revealed the resident was [redacted], had an NJ Exec Order 26.4b1, was [redacted] and required extensive assistance of two staff for [redacted]. On 03/04/22 at 9:57 AM, the surveyor observed Resident #4's [redacted] and [redacted] was stored in a NJ Exec Order 26.4b1 [redacted]. The surveyor observed that the NJ Exec Order 26.4b1 [redacted] and did not have [redacted] applied. On 03/08/22 at 12:29 PM, the surveyor observed Resident #4's NJ Exec Order 26.4b1 [redacted]. The surveyor observed that the NJ Exec Order 26.4b1 was open and did not have a [redacted] applied. The surveyor further observed a NJ Exec Order 26.4b1 stored inside a gray bin next to the [redacted] During an interview with the surveyor on 03/08/22 at 12:47 PM, the Care Associate (CA) assigned to Resident #8, stated the resident was [redacted], had an NJ Exec Order 26.4b1 and required total assist with care. The CA further stated the resident [redacted] when out of bed and that the [redacted] was reattached when the resident returned back to bed. The CA added that the NJ Exec Order 26.4b1 [redacted] and	F 690	reported monthly to QAPI committee.	

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F 690		F 690		

Continued From page 6

NJ Exec Order 26.4b1 in the resident's bathroom when not in use.

During an interview with the surveyor on 03/08/22 at 12:58 PM, the Clinical Manager (CM) stated Resident #8 required total assist with care and that staff were responsible for making sure the resident's NJ Exec Order 26.4b1. The CM further stated the resident changed into a NJ Exec Order 26 when out of bed and that staff was supposed to NJ Exec Order 26.4b1 in the resident's bathroom. At that time, the CM accompanied the surveyor to the resident's room to observe the resident's NJ Exec Order 26.4b1. The CM confirmed the surveyor's findings and stated the resident's NJ Exec Order 26.4b1 was probably not NJ Exec Order 26 because there was NJ Exec O in the grey bin stored next to the NJ Exec Order 26.4b1. The CM stated the resident's NJ Exec Order 26.4b1 should have been NJ Exec Order 26 and that NJ Exec Order 26 the NJ Exec Order 26.4b1 was important to NJ Exec Order 26.4b1.

During an interview with the surveyor on 03/09/22 at 10:59 AM, the Director of Nursing (DON) stated she expected staff to NJ Exec Order 26.4b1, make sure it was NJ Exec Order 26.4b1 and NJ Exec Or. The DON added that it was important to NJ Exec Order 26.4b1 to make sur NJ Exec Order 26.4b1 the resident would be using.

A review of the facility's "Urinary Catheters" policy, dated 6/2021, indicated that proper infection control practices regarding catheter care, tubing and collection bag [drainage bag] would be followed at all times.

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F 690	Continued From page 7	F 690		
	NJAC 8:39 - 19.4 (a)(5)			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		4/4/22

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by:
Based on observation, interview, record review, and review of other facility documentation, it was determined that facility staff failed to administer medication in accordance with a physician's orders. This deficient practice was identified in 1 of 3 nurses, on 1 of 2 units (Fourth Floor Nursing Unit) observed during the medication pass.

This deficient practice was evidenced by the following:

On 03/04/22 at 8:47 AM, the surveyor observed the Licensed Practical Nurse (LPN) administer medication to a resident (Resident #43). At that time, the LPN advised the surveyor that he obtained a NJ Exec Order 26.4b1 for Resident #43 of NJ Exec Order 26.4b1 The surveyor observed the LPN prepare various medications for administration to the resident, including but not limited to one tablet of NJ Exec Order 26.4b1 and one tablet NJ Exec Order 26.4b1 The LPN then proceeded to the bedside of the resident, to administer medication to the resident.

The surveyor asked the LPN to return to the cart, so that the two of them could review the medication regimen for Resident #43. The LPN stated that he should have prepared two tablets of NJ Exec Order 26.4b1 for administration to the resident, as per the physician's order. In addition, the LPN stated that he should not have included the tablet of NJ Exec Order 26.4b1 for administration to the resident. He further stated that the resident's NJ Exec Order 26.4b1

1. Potential medication errors were corrected and resident #43 received the proper dosing of medications without any adverse reactions. LPN in question was re-educated on proper medication pass.
2. All residents have the potential to be affected.
3. Staff development cordinator will provide re-education to licensed nursing staff as it pertains to basic medication techniques including review of 5 rights of medication administration.
4.Staff development coordinator or designee will complete 4 medication observations per month for 3 months and then quarterly. DON or designee will report findings monthly to QAPI for 3 months and then quarterly thereafter for 1 year.

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F 755	Continued From page 9	F 755		

NJ Exec Order 26.4b1 and the physician's order indicated that the medication should be held for a NJ Exec Order 26.4b1

During this time, the LPN acknowledged that two medication errors occurred. He added one tablet of NJ Exec Order 26.4b1 to the resident's medication for administration and removed the tablet of NJ Exec Order 26.4b1 from the resident's medication for administration.

A review of the admission Face Sheet for Resident #43 revealed a diagnosis that included but was not limited to NJ Exec Order 26.4b1

A review of the Physician Order Form for March NJ Exec Or revealed orders that included but were not limited to the following for Resident #43: NJ Exec Order 26.4b1, two tablets orally for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, one tablet orally for NJ Exec Order 26.4b1 which included a note to hold for NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) for Resident #43 revealed the LPN's initials on the referenced orders for the morning of NJ Exec Order 26.4b. In addition, it was noted that the NJ Exec Order 26.4b1 was not administered to the resident, due to a vital sign NJ Exec Order 26.4b1 being out of range.

During an interview with the surveyor, the survey team, and administrative staff on 03/04/2022 at 1:07 PM, the Director of Nursing (DON) stated that it would be her expectation for nursing staff to administer medication as ordered by the

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physician, including adherence with parameters and doses that comprised the order. The DON and Continuing Care Administrator (CCA) acknowledged the referenced errors, stated they understood the concerns of the survey team, and had no additional questions regarding the matters presented to them.

A review of the facility's policy titled, "Medication Administration, Receipt, Storage, & Disposal" revealed an origination date of April 2005 and a version date of June 2021. Further review of the policy revealed that it was necessary for designated staff to administer medication correctly, including the right dose. The policy did not address administering medication in accordance with any parameters, a numerical or other measurable factor that provides a condition or guidance in which further action or inaction may occur.

NJAC 8:39 - 29.2(d)

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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 interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. This was evident for 7 of 14 day shifts reviewed and was evidenced by the following: Findings include: 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	S 560	1. Administrator reviewed staffing schedules to ensure facility was meeting NJ certified nursing ratio requirement. 2. All residents have the potential to be affected. 3. Staffing coordinator re-educated on NJ staffing requirements as it pertains to 1:8 certified nursing aide requirement on the 7-3 shift. Staffing coordinator will notify administrator or DON each time this staffing requirement is in jeopardy of being met. 4. Administrator/designee will review staffing schedules daily for 2 weeks and then weekly for 6 months. Findings will be reported monthly to QAPI for 6 months.	4/4/22

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

Electronically Signed | 03/18/22

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S 560	Continued From page 1	S 560		

established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:

One 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.

As per the "Nurse Staffing Report" completed by the facility for the weeks of 02/13/22-02/19/22 and 02/20/22-02/26/22, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift are documented below:

- 02/13/22 had 6 CNAs for 64 residents on the day shift, required 8 CNAs.
- 02/14/22 had 6 CNAs for 64 residents on the day shift, required 8 CNAs.
- 02/15/22 had 6 CNAs for 64 residents on the day shift, required 8 CNAs.
- 02/17/22 had 7 CNAs for 64 residents on the day shift, required 8 CNAs.
- 02/20/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs.
- 02/21/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs.
- 02/23/22 had 6 CNAs for 63 residents on the day shift, required 8 CNAs.

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 _____	03/09/2022

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 560	Continued From page 2 The surveyor interviewed the Staffing Coordinator (SC) and the Assistant Administrator on 03/09/22 at 9:30 AM. The SC stated that the facility used permanent, full-time CNAs to staff the 4th and 5th floors and the number of staff depends on the unit census. The Assistant Administrator stated that we schedule four to five CNAs for the day and evening shifts and supplement the CNA staffing to include nurses who work as CNAs on the evening shifts. The staffing depends on the census of each unit and the acuity of the residents. The surveyor interviewed the Continuing Care Administrator and the Assistant Administrator on 03/09/22 at 9:48 AM. The Administrator stated that the facility utilized three agencies to supplement CNA staffing and for the evening shift, the facility used a combination of Nurses and CNAs. The facility also offered bonuses to staff to pick up open shifts. The Assistant Administrator indicated that the 1st, 2nd and 3rd floors of the building housed assisted living residents. CNA staff, who worked on the assisted living floors, were rotated to the 4th and 5th floors to cover when staff called out. NJAC 8:39-5.1(a)	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	5/25/2022

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 F0638 Reg. # 483.20(c) LSC	Correction Completed 04/04/2022	ID Prefix F0690 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 04/04/2022	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 04/04/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/9/2022	☐ 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)
Q3VL3S		5/25/2022

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 04/04/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/9/2022	☐ 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 _____	**03/09/2022**

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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/03/2022 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 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/03/22, in the presence of facility management, it was determined that the facility failed a.) to ensure that battery back up emergency lights function properly when tested, and b.) to provide a battery backup emergency light above the emergency	K 291	1. Seabrook's electrician installed a battery back up emergency lighting for transfer switch on 3/18/22 2. No residents were directly affected by this. 3. Maintenance supervisor or designee	4/4/22

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

Electronically Signed | 03/18/2022

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 _____	**03/09/2022**

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 291	Continued From page 1 generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was observed in 2 of 2 rooms reviewed for emergency back up lighting and was evidenced by the following: During tour of the building starting at 10:15 AM, with the facility's Maintenance Supervisor (MS), the surveyor observed the following, 1. At 1:45 PM an inspection inside the main electrical room, where the nursing home generator transfer switch is located, was performed. The surveyor observed no evidence of a battery back up emergency light. The surveyor asked the MS if there was a battery back up emergency light for the transfer switch. The MS said, "No." 2. At 1:47 PM, an inspection in the room where the emergency generator was located was performed. During a test of the battery back up emergency light in the room was performed, and the light did not function properly. This findings were verified by the facility's MS at the time of inspection. The surveyor informed the Continuing Care Administrator of the deficiency at the Life Safety Code exit conference on 03/03/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	will test battery back up emergency light for transfer switch weekly for 3 months. 4. Maintenance supervisor will report results monthly to QAPI team for 3 months.	
K 324 SS=E	Cooking Facilities	K 324		4/4/22

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 _____	**03/09/2022**

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 324	Continued From page 2 CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation on 03/03/22, in the presence of facility management, it was determined that the facility failed to inspect the range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. The deficient practice was evidenced by the following:	K 324	1. During annual survey it was noted by the life safety inspector that Seabrook had missed a semi annual inspection of the facility range-hood fire suppression system for May 2021. Facility had the November 2021 inspection and is scheduled for inspection on 5/12/2022 and 11/10/2022. 2. No residents were directly affected by	

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 _____	**03/09/2022**

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 324	Continued From page 3 During the survey entrance at 9:45 AM, a request was made to the Continuing Care Administrator (CCA) and Maintenance Supervisor (MS) to provide all mandatory inspections from 01/01/21 to 03/03/22 for review. Review of the facility's range-hood fire suppression system inspections for the previous 14 months identified the system had one semi-annual inspection on 11/11/21. The surveyor interviewed the CCA and SO on 03/03/22 at 3:23 PM. The surveyor asked the facility to provide the previous inspection for the range-hood system. The SO provided an inspection that was conducted on 11/04/20. The surveyor asked if there were any inspections between 11/04/20 and 11/11/20. The SO said, "No." The surveyor informed the CCA of the deficiency at the Life Safety Code exit conference on 03/03/22. NJAC 8:39-31.2(e) NFPA 99	K 324	this. 3. Security supervisor or designee will schedule all semi annual inspections. Completion of all inspections and repairs will be documented and maintained by security office to ensure compliance. 4. Security supervisor/designee will submit scheduled and completed semi annual inspections monthly to QAPI team for 1 year.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		4/4/22

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 _____	**03/09/2022**

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 521	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/03/22, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 4 of 11 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During tour starting at 10:15 AM, in the presence of the facility's Maintenance Supervisor (MS), an inspection inside of eleven (11) resident bathrooms was performed. The inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 4 of 11 resident bathrooms in the following locations: 1. At 11:56 AM, inside resident room #G-506's bathroom, the exhaust system did not function properly when tested. At this time, the surveyor informed the MS that the exhaust system did not function properly. 2. At 12:01 PM, inside resident room #G-504's bathroom, the exhaust system did not function properly when tested. 3. At 12:05 PM, inside resident room #G-503's bathroom, the exhaust system did not function	K 521	1. The 4 rooms identified during the initial tour were immediately repaired by the facility maintenance team. 2. All residents have the potential to be affected. 3. Maintenance supervisor or designee will complete exhaust testing in 5 resident bathrooms per week for 3 months. 4. Maintenance supervisor will report findings to QAPI team monthly for 3 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 _____	**03/09/2022**

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 521	Continued From page 5 properly when tested. 4. At 1:25 PM, inside resident room #G-402's bathroom, the exhaust system did not function properly when tested. The surveyor observed that the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The MS confirmed the findings at the time of the observations. The surveyor informed the Continuing Care Administrator of the deficiency at the Life Safety Code exit conference on 03/03/22. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		

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	5/25/2022 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0291	Correction Completed 04/04/2022	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 04/04/2022	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 04/04/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/9/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO