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 _____	C 09/12/2024

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 not 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		
E 006 SS=E	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E 006		10/14/24

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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.

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E 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and a review of the facility's Emergency Preparedness Plan (EPP), it was determined that the facility failed to include a facility-based and community-based risk assessment within the EPP.	E 006	1. No residents directly affected. 2. All residents have the potential to be affected. Community completed hazard risk assessment. 3. Maintenance and administration re-educated on requirements and facility	

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E 006	Continued From page 2 This deficient practice was evidenced by the following: On 9/11/24 at 8:45 AM, the surveyor interviewed the [redacted] who stated the [redacted]) and himself were responsible for the facility's EPP. The [redacted] stated that the plan was reviewed annually, and the facility had reviewed it in March of 2024. At that time, the surveyor reviewed the EPP with the [redacted] and requested to see the facility's facility-based and community-based all-hazards risk assessments. The [redacted] stated that there was no risk assessment, that the facility used an all-hazards approach for their plan. The surveyor observed that the facility had specific emergency procedures that included but not limited to; bomb threat, earthquake, flood, landslide, hazardous spill, hurricane, tornado, wild fire, and snow emergency. The surveyor asked if the facility was at risk for landslides? The [redacted] stated that the facility was not at risk for landslides, that the plan was a universal plan that could be used throughout the country using an all-hazards approach. The [redacted] confirmed that he was unaware of facility-based and community-based all-hazards risk-assessments completed for the facility. On 9/11/24 at 9:05 AM, the surveyor in the presence of the [redacted] asked the [redacted] if the facility had facility-based and community-based all-hazards risk assessments completed. The [redacted] stated that the facility did, and she would provide it to the surveyor.	E 006	policy on all hazard risk assessment. Will schedule next hazard risk assessment September 2025. 4. Maintenance supervisor/designee will audit communities emergency plan quarterly for 4 quarters to ensure all scheduled assessment/ inspections are completed. Results will be reported to Quality assurance/performance improvement committee (QAPI) for 3 months.	

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E 006	Continued From page 3 On 9/11/24 at 1:31 PM, the surveyor in the presence of the survey team, requested from the US FOIA (b)(6) and the US FOIA (b)(6)), a copy of the facility's facility-based and community-based all-hazards risk assessments. On 9/12/24 at 11:22 AM, the surveyor in the presence of the survey team asked the US FOIA (b) the Administrator in Training (AIT #1), and AIT #2 for a copy of the facility's all-hazards risk assessments. No additional information was provided.	E 006		
F 000	INITIAL COMMENTS Complaint #: NJ173031 Survey Date: 9/12/24 Census: 63 Sample: 15 + 2 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 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		10/14/24

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F 883	Continued From page 4 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		

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F 883	Continued From page 5 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that all eligible residents were educated and offered the NJ Exec Order 26.4b1 to prevent incidence of NJ Exec Order 26.4b1 The deficient practice was identified for 2 of 5 residents reviewed for NJ Exec Order 26.4b1 (Resident #23 and Resident #40), and was evidenced by the following: 1. On 9/8/24 at 10:44 AM, during initial tour of the facility, the surveyor observed Resident #40 in the activity room sleeping upright in their wheelchair. On 9/9/24 at 10:27 AM, the surveyor reviewed the medical record for Resident #40. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses included but not limited to; NJ Exec Order 26.4b1 . A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, reflected that the resident had a brief interview for mental status (BIMS) score of NJ out of 15, which indicated a NJ Exec Order 26.4b1 A review the electronic Medical Record (eMR) did	F 883	1. Resident #40 and resident #23 were offered and signed NJ Exec Order 26.4b1 declination form. 2. All residents have the potential to be affected. The Clinical team conducted an audit of all current residents to ensure pneumococcal vaccine was offered, proper consent completed and vaccine given as indicted. Discrepancies addressed promptly. 3. The licensed nurses and clinical leadership re-educated on facility policy for offering, educating and obtaining proper consent for immunizations. The clinical manger/designee will review new admissions in the daily clinical meeting to ensure pneumococcal vaccine was offered and proper consent obtained. 4. Clinical managers/designee will audit 20% of new admissions and long term care resident residents weekly for 4 weeks and then monthly for 2 months to ensure compliance with consent/declination form for pneumococcal vaccine. Results will be submitted to Quality assurance/performance improvement Committee (QAPI) for 3 months	

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F 883	Continued From page 6	F 883		

not include documentation that the resident received or declined the NJ Exec Order 26.4b1 [redacted]

On 9/10/24 at 11:19 AM, the surveyor with the Unit Manager/Registered Nurse (UM/RN #1) reviewed Resident #40's eMR, and UM/RN #1 confirmed there was no documentation that the resident received or declined the NJ Exec Order 26.4b1 [redacted] UM/RN #1 stated that she would follow-up with the US FOIA (b)(6) [redacted] to see if they had any further information. When asked who was responsible for obtaining the NJ Exec Order 26.4b1 [redacted] consent or declination and maintaining the NJ Exec Order 26 [redacted] records, UM/RN #1 stated the JS FO [redacted] and the facility was responsible.

On 9/10/24 at 12:15 PM, the surveyor in the presence of UM/RN #1 and the survey team interviewed the JS FO [redacted] who stated that Resident #40's family NJ Exec Order 26 [redacted] the NJ Exec Order 26.4b1 [redacted], but the facility was "still working on the long-term care process for declinations". When asked if there was any documentation of the NJ Exec Order 26 [redacted] the JS F [redacted] responded that she was "working on that now to get it". The JS F [redacted] confirmed that the declination should have been obtained prior to surveyor inquiry and that the responsibility of maintaining the NJ Exec Order 26 [redacted] records was a collective between herself and the clinical team.

On 9/12/24 at 11:22 AM, the US FOIA (b)(6) [redacted] in the presence of the Administrator in Training (AIT #1), AIT #2, and survey team, acknowledged that the resident's declination for the NJ Exec Order 26.4b1 should have been obtained prior to surveyor inquiry.

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F 883	Continued From page 7	F 883		

2. On 9/8/24 at 10:08 AM, during initial tour of the facility, the surveyor observed Resident #23 in their bedroom lying in bed watching television.

On 9/9/24 at 12:26 PM, the surveyor reviewed the medical record for Resident #23.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses including but not limited to; NJ Exec Order 26.4b1 [redacted]

A review of the most recent quarterly MDS dated NJ Exec Order 26. reflected the resident had a BIMS score of NJ Ex of out of 15, indicating a NJ Exec Order 26.4b1 [redacted]. A review of Section " NJ Exec Order 26 indicated Resident #23's NJ Exec Order 26.4b1 was up to date.

A review of the NJ Exec Order 26 Administration Record revealed that the NJ Exec Order 26.4b1 was administered on NJ Exec Order 26.

A review of the (eMR) did not include documentation that the resident was offered and declined the NJ Exec Order 26.4b1 upon admission.

On 9/10/24, the surveyor requested the "NJ Exec Order 26.4b1 Consent Form" declination form from the US FC

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F 883	Continued From page 8	F 883		

On 9/10/24 at 12:33 PM, the surveyor interviewed the [NJ Exec Order 26.4b1] who stated that the NJ Exec Order 26.4b1 administered on [NJ Exec Order 26.4b1], was the most up to date [NJ Exec Order 26.4b1] for Resident #23. The [US FOIA (b)(6)] stated that the facility was "putting a system into place for the long-term care residents to offer [NJ Exec Order 26.4b1] to the residents upon admission". The [US FOIA (b)(6)] confirmed that the resident was eligible for the [NJ Exec Order 26.4b1], but was not offered. The [US FOIA (b)(6)] was unable to provide any declination documentation.

On 9/12/24 at 11:22 AM, the [US FOIA (b)(6)] in the presence of AIT #1, AIT #2, and the survey team, provided the surveyor with a [NJ Exec Order 26.4b1] Consent Form declination for Resident #23 dated [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] confirmed that the declination should have been obtained prior to surveyor inquiry.

On 9/12/24 at 11:45 AM, the surveyor in the presence of the [US FOIA (b)(6)] AIT #1, AIT #2, and survey team, interviewed the US FOIA (b)(6), who confirmed that Resident #23 should have been offered NJ Exec Order 26.4b1.

A review of the facility's "Infection Prevention and Control Preventing Transmission of Infectious Agents Process: Screening and Vaccinations" policy dated June 2021, included...4. vaccines will be offered to residents and staff when available unless the immunization is medically contraindicated or the resident/staff has already been immunized... 6. the resident, resident representative, or staff member will have the opportunity to accept or refuse a vaccine and may change their decision at any time...documentation of refusal will be completed in the resident's EMR or the employee's health record...8. the resident's medical record and the

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F 883	Continued From page 9 employee's health record will include documentation that indicates [...] if the resident did not receive the vaccine that this was due to medical contraindications or refusal... NJAC 8:39-19.4(i)	F 883		

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S 000	Initial Comments The facility was not in compliance with 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 deficieny 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 interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 1 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	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	10/14/24

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

Electronically Signed | 09/27/24

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: 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. During entrance conference on 9/8/24 at 10:07 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing Acting (DON) how the facility's staff was, and the LNHA stated that staffing was good; that the facility did not use Agency staff. At that time, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 8/25/24 to 8/31/24 and 9/1/24 to 9/7/24. The surveyor reviewed the Nursing Staffing Reports provided by the facility which revealed the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: 8/25/24 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.	S 560	staffing agencies. 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 observation.	
S2120	8:39-31.1(c) Mandatory Physical Environment	S2120		10/14/24

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S2120	Continued From page 2 (c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, P.O. Box 809, Trenton, New Jersey 08625-0809. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined the facility failed to ensure the quarterly local fire inspections were performed in accordance with the New Jersey Uniform Fire Safety Code. This deficient practice had the potential to affect 63 residents, and was evidenced by the following: On 9/10/24 at 10:30 AM, the surveyor reviewed the quarterly local fire inspection reports provided by the facility for the past twelve months, which revealed three of the four quarterly inspections were not completed. The facility was only able to provide an inspection report dated 6/3/24.	S2120	1. No residents directly affected. 2. The community realizes that all residents have the potential to be affected. Quarterly fire inspection scheduled as well as the next 4 Quarterly fire inspections scheduled with communities vendor 3. Maintenance staff re-educated on requirements for local fire inspections as well as facility policy. 4. Maintenance supervisor/designee will audit communities red book quarterly for 4 quarters to ensure required testing has been completed. Results will be submitted to Quality Assurance/performance	

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 _____	C 09/12/2024

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
S2120	Continued From page 3 On 9/11/24 at 10:00 AM, the surveyor interviewed the Facility Manager (FM), who stated that the local Fire Inspector (FI) did not come out to the facility. The FM confirmed that he did not reach out to the local FI to request an inspection, but moving forward he planned to. The FM confirmed the fire inspection report dated 6/3/24, was the only report he had for the past twelve months. On 9/11/24 at 3:08 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), FM, and Maintenance Supervisor of the identified concern during the Life Safety Code exit conference.	S2120	committee (QAPI) quarterly for 4 quarters.	
S2315	8:39-31.6(i)(1-2) Mandatory Physical Environment (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan; or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents.	S2315		10/14/24

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

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S2315	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to meet with municipal and county emergency management officials annually to review and update the emergency evacuation plan. This deficient practice had the potential to affect all residents and was evidenced by the following: On 9/11/24 at 8:45 AM, the surveyor in the presence of the Security Emergency Services (SES), reviewed the facility's Emergency Preparedness Plan (EPP) which was documented as updated March 2024, with the Executive Director of the facility signing reviewed on 2/29/24. The surveyor interviewed the SES who identified the Licensed Nursing Home Administrator (LNHA) and himself as the responsible parties for the facility's EPP, and stated that the facility reviewed the EPP annually. At that time, the surveyor asked for evidence that the EPP was reviewed with the local Office of Emergency Management (OEM). The SES stated that it was not sent to the local OEM, that he was unaware it was a requirement. On 9/12/24 at 11:22 AM, the Director of Nursing (DON) in the presence of the Administrator in Training (AIT #1), AIT #2, and survey team, stated that the facility sent their EPP for the year to the local OEM yesterday.	S2315	1. No residents affected. 2. The community realizes all residents have the potential to be affected. The Emergency Preparedness plan was sent to the local office of Emergency Management on 9/12/2024 for review. Local office of emergency management invited to communities EPP review September 2025 3. Maintenance staff and administration re-educated on requirements for Emergency preparedness plan (EPP) as well as the facility policy. 4. Maintenance supervisor/designee will audit communities EPP quarterly to ensure all requirements are meet. Results will be submitted to QAPI	
S2340	8:39-31.6(n) Mandatory Physical Environment (n) The facility shall maintain at least a three-day	S2340		10/14/24

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 _____	C 09/12/2024

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
S2340	Continued From page 5 supply of food and have access to an alternative supply of water in case of an emergency. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain a three-day minimum emergency food supply. This deficient practice would affect all residents and was evidenced by the following: On 9/11/24 at 9:54 AM, the surveyor in the presence of the food service General Manager (GM), Dining Director (DD), Executive Chef (EC), and Security Emergency Services (SES), observed the facility's emergency three-day food supply inventory compared with the facility's provided menus. The observations were as followed: For lunch on day one and dinner on day three, the facility was to serve chicken salad sandwiches. The surveyor observed no chicken salad. At that time, the EC stated that the facility's vendor could no longer supply canned chicken. For lunch on days two and three, the facility was to serve tuna salad sandwiches. The surveyor observed only one 4.16 pound can of tuna. The surveyor also observed only one gallon of mayonnaise that would be used to prepare both chicken salad and tuna salad, if the facility had the amounts needed on their menu. For dinner on days one and three, the facility was	S2340	1. No residents affected. 2. The community realizes all residents have the potential to be affected. Community posted updated emergency food policy and procured additional supplies to meet the 3 day requirement and comply with facility policy. 3. Dietary staff and managers re-educated on requirement for emergency food supply and on communities new updated policy 4. Dietary manager/designee will audit communities emergency food and water supply monthly. Results will be reported to Quality Assurance Performance committee (QAPI) for 3 months	

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 _____	C 09/12/2024

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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S2340	Continued From page 6	S2340		

to serve peanut butter and jelly sandwiches. The surveyor observed only one five pound container of peanut butter.

For lunch on day one, the facility was to offer juice packed pears. The surveyor observed no pears.

For dinner on day one, the facility was to offer juice packed peaches. The surveyor observed no peaches.

For dinner on days one, two, and three, the facility was to offer three bean salad. The surveyor observed no three bean salad. At that time, the EC stated the facility's vendor could no longer supply.

For lunch on day two, the facility was to offer juice packed fruit cocktail and pickled beets. The surveyor observed no fruit cocktail or beets.

For dinner on day two, the facility was to serve apple sauce. The surveyor observed no apple sauce.

For dinner on day three, the facility was to offer crushed pineapple. The surveyor observed no pineapple.

For evening snack on days one and three, the facility was to offer graham crackers. The surveyor observed no graham crackers. At that time, the EC stated that the facility was substituting the graham crackers for the box of assorted crackers.

The facility planned to offer juices at all three meals and evening snacks on all three days. The surveyor observed no fruit juices. At that time, the

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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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S2340	Continued From page 7 EC stated that the facility's vendor could no longer provide bottled juice. At that time, the surveyor asked the facility if anyone checked their emergency food supply, and the EC stated that the kitchen checked the supply and rotated food out that was going to expire. The EC stated that the menu should have been changed and new items should have been added at the time the facility was unable to obtain the food. The GM, DD, EC, and SES all acknowledged that the facility needed to have a separate three-day emergency food supply that matched the menu. On 9/12/24 at 11:22 AM, the Director of Nursing (DON) in the presence of the Administrator in Training (AIT #1), AIT #2, and survey team, acknowledged that the facility did not maintain their three-day emergency food supply at the time of observation. A review of the facility's "Emergency Procedures - Meal Services" dated revised January 2024, included emergency food supplies for three days are on hand to feed residents and staff...	S2340		

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	10/24/2024

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 E0006 Reg. # 483.73(a)(1)-(2) LSC	Correction Completed 10/14/2024	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
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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
9/12/2024

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

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	10/24/2024

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 F0883 Reg. # 483.80(d)(1)(2) LSC	Correction Completed 10/14/2024	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 9/12/2024	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
Q3VL3S Y1	A. Building B. Wing Y2	10/24/2024 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 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	Correction	ID Prefix S2120	Correction	ID Prefix S2315	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-31.1(c)	Completed	Reg. # 8:39-31.6(i)(1-2)	Completed
LSC	10/14/2024	LSC	10/14/2024	LSC	10/14/2024
ID Prefix S2340	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-31.6(n)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/14/2024	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	
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	
9/12/2024	☐ 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 _____	**09/12/2024**

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 09/10/2024 and 09/11/2024 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. The Skilled Nursing/Nursing facility is on the 4th and 5th floor. The facility had an internal 300 KW diesel powered generator located in the basement. The kitchen, laundry and hot water heaters serving the 4th and 5th floors were located in the basement. The facility had 86 licensed beds, the census was 63 at the time of survey.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm 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	K 345		10/21/24

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

Electronically Signed | 09/27/2024

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 _____	**09/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 1 by: Based on documentation review and interviews on 09/10/24 and 09/11/24 in the presence of the US FOIA (b)(6) and US FOIA (b)(6)), it was determined that the facility failed to a) ensure that sensitivity testing of smoke detectors was conducted each alternate year in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70, and NFPA 72. This deficient practice had the potential to affect 63 residents and was evidenced by the following: A documentation review on 9/10/24, revealed there was no documentation of any sensitivity testing for smoke detectors. In an interview on 09/11/24 at 10:10 AM, the FM provided 2 documents that were not smoke detector sensitivity reports. The US FOIA consulted with their contracted fire alarm service company and the US FOIA stated the fire alarm system auto adjusts sensitivity. The surveyor requested a printed report and documentation from the manufacturer at the time. No further documentation was provided. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 09/11/24 at 03:08 PM. The deficient practice of failure to provide smoke detector sensitivity testing documentation was cited at the previous standard survey on 08/31/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	1. No residents were affected. 2. The community realizes that all residents have the potential to be affected. Smoke detector sensitivity inspection scheduled with community vendor. 3. Maintenance staff re-educated on smoke detector sensitivity testing policy. Next sensitivity test scheduled for June 2025 4. Maintenance supervisor/designee will audit communities red book quarterly for 4 quarters to ensure all required testing has been completed. Discrepancies or missing inspections will be addressed promptly. Results will be reported quarterly to Quality assurance performance committee (QAPI) for 4 quarters	
K 353 SS=F	Sprinkler System - Maintenance and Testing	K 353		10/21/24

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 _____	**09/12/2024**

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 353	Continued From page 2 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 9/10/24 and 9/11/24 in the presence of the US FOIA (b)(6) [redacted] and US FOIA (b)(6) [redacted] it was determined the facility failed to perform a 5-year internal inspection of the wet and dry fire sprinkler systems in accordance with NFPA 101: 2012 edition, Sections 19.3.5.1, 9.7, 9.7.1, 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice had the potential to affect all 63 residents and was evidenced by: A record review on 9/10/24 between 8:08 AM and 2:40 PM, revealed there was no documentation of a 5-year internal sprinkler system inspection provided by the facility. The surveyor informed the FM at the time.	K 353	1. No residents affected. 2. The community realizes all residents have the potential to be affected. 5 year sprinkler inspection completed 10/4/2024 by community vendor 3. Maintenance staff re-educated by facilities supervisor on CMS/NFPA regulation for sprinkler system-maintenance and testing 4. Maintenance supervisor/designee will audit communities red book quarterly for 4 quarters to ensure required fire inspections are complete. Discrepancies and missing inspections will be addressed promptly. Results will be reported by maintenance supervisor/designee to	

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 _____	**09/12/2024**

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 353	Continued From page 3 In an interview on 9/11/24 at 11:25 AM the US FOIA consulted with the fire sprinkler system service contractor and stated that neither the service nor the facility has a 5-year internal inspection report and it is not known when the last internal inspection was performed. The Facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 9/11/24 at 3:08 PM. NJAC 8:39-31.2(e)	K 353	Quality assurance performance committee (QAPI) quarterly for 4 quarters	
K 355 SS=E	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 interview on 9/11/24, in the presence of the US FOIA (b)(6) [redacted] it was a determined that the facility failed to provide the required instructional placards near 2 of 2 Class K portable fire extinguisher, in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition, Section 5.5.5.3(a). This deficient practice had the potential to affect 63 residents and was evidenced by the following: An observation at 11:50 AM of the Kitchen,	K 355	1. No residents were affected. 2. The community realizes all residents have the potential to be affected. Placards were placed above the 2 K-type in the kitchen. 3. Maintenance and kitchen staff re-educated on NFPA regulation as it pertains to portable fire extinguishers by security manager 4. Maintenance supervisor/designee will audit K portable fire extinguishers located in the kitchen during monthly kitchen rounds rounds to ensure compliance. Discrepancies or missing signs will be	10/21/24

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 _____	**09/12/2024**

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 355	Continued From page 4 revealed 2 K-Type fire extinguishers that did not have the required instructional placard indicating the fire protection system must be activated prior to using the fire extinguisher. In an interview at the time of observation, the FM and other facility managers stated they were unaware of the requirement. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference at 3:08 PM. NJAC 8:39-31.2(e) NFPA 10, 96	K 355	addressed promptly. Results will be reported by maintenance supervisor to Quality assurance performance committee (QAPI) monthly for 3 months and then quarterly for 1 quarter.	
K 374 SS=F	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 observation and interview on 09/11/24 in the presence of the US FOIA (b)(6) and US FOIA (b)(6)	K 374	1. No residents affected. 2. The community realizes all residents have the potential to be affected. 4th and	10/21/24

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

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K 374	Continued From page 5 US FOIA (b)(6) it was determined that the facility failed to ensure smoke barrier doors closed into their door frame when released from their hold open devices or close leaving only the minimum clearance necessary for proper operation to resist the passage of smoke for 4 of 6 smoke barrier doors observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3, 19.3.7 to 19.3.7.9, 8.5.4, 8.5.4.1 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect 63 residents and was evidenced by the following: An observation at 12:15 PM, revealed the 5th floor elevator lobby smoke barrier double doors were kept in the closed position and had a 5/16-inch to 1/4-inch gap running vertically from the bottom to the top of the meeting door leaf edges. An observation at 12:30 PM, revealed the 5th floor High Side Wing smoke barrier doors did not close to the frame when released from the hold-open device. One of the double door leaves remained open 1-inch from its proper place in the door frame. An observation at 12:45 PM, revealed the 5th floor Low Side Wing smoke barrier doors did not close to the frame when released from the hold-open device. One of the double door leaves remained open 1-1/4 inch from the door frame. An observation at 12:50 PM, revealed the 4th floor elevator lobby smoke barrier double doors were kept in the closed position and had a 5/16-inch to 1/4-inch gap running vertically from the bottom to the top of the meeting door leaf edges.	K 374	5th floor gaps in the elevators had astragals installed. 5th floor high and low side doors repaired. New latches installed in 4th floor oxygen room and room 421 corridor door. All tested and all functioning properly 3.Maintenance staff re-educated by facilities manager on requirement for smoke barrier doors. 4. Maintenance supervisor/designee will test all smoke barrier doors for gaps and function monthly for 3 months to ensure compliance. Discrepancies will be addressed promptly. Results will be submitted by maintenance supervisor/designee to Quality assurance performance committee (QAPI) monthly for 3 months.	

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K 374	Continued From page 6 An observation at 1:05 PM, revealed the resident room 421 corridor door hit the door frame making it difficult to close. Additionally, the door did not latch when closed into the frame. An observation at 1:22 PM, revealed the door to the 4th floor oxygen room did not latch when open to 90 degrees and released and would not latch when pulled into its frame. The US FOI tested the door a second time with the same result. In an interview at the time of observations, the US FOIA (b)(6) confirmed the findings. Values were measured with a standard tape measure and confirmed by facility staff. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference at 3:08 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 374		
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency	K 531		10/21/24

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K 531	Continued From page 7 personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews on 9/10/24 and 9/11/24 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to test and inspect 2 of 2 elevators annually with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division and/or AHJ in accordance with NFPA 101:2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. This deficient practice had the potential to affect 63 residents and was evidenced by the following: A record review on 9/10/24, revealed the facility had no elevator inspection certificates of compliance/occupancy or reports for 2 of 2 elevator devices: elevators #11 and #12 serving the 4th and 5th floors. No documentation was provided. An observation on 9/11/24 at 12:00 PM of the elevator mechanical room for elevators #11 and #12 revealed the signed off elevator inspection card was not up to date and was last inspected in 2022. No further documentation was provided. In an interview on 9/11/24 between 10:00 and 10:45 AM, the facility's US FOI [redacted] stated he only had what was inspected in the fire alarm inspection	K 531	1. No residents affected. 2. The community realizes all residents have the potential to be affected. Elevator #11 and #12 inspected on 10/15/2024 3. Maintenance staff re-educated by facilities manager on requirement for elevator testing. 4. Maintenance supervisor/designee will audit communities red book quarterly to ensure elevator #11 and #12 inspection are up to date and complete. Discrepancies or missing inspections will be addressed promptly. Results will be reported by maintenance supervisor/designee to Quality assurance/performance committee (QAPI) quarterly for 3 quarters	

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K 531	Continued From page 8 report. No further documentation was provided. The US FOIA (b)(6) and US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 9/11/24 at 3:08 PM. NJAC 8:39-31.2(e)	K 531		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation record review and interview on 09/10/24 and 09/11/2024 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that the fire barrier doors including corridor doors to patient rooms and smoke barrier doors were inspected annually with written record by an individual who could demonstrate knowledge and understanding of the operating components for 6 of 6 smoke barrier	K 761	1. No residents affected. 2. The community realizes all residents have the potential to be affected all Smoke barriers doors had annual inspection June 2024 and monthly inspection October 2024 inspected by in house security team 3. Maintenance staff re-educated on inspection, maintenance and testing of smoke barriers doors by security	10/21/24

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K 761	Continued From page 9 doors in accordance with NFPA 101: 2012 Edition, Section 7.2.1.15, 7.2.1.15.1 to 7.2.1.15.8, 8.3.3.1, 19.7.6 and NFPA 80: 2010 Edition, Section 5.2.1, 5.2.3. This deficient practice had the potential to affect all 63 residents and was evidenced by the following: A document review on 09/10/2024, revealed there were no documented annual fire or smoke door inspections provided by the facility. In an interview on 09/11/2024 at 10:43 AM, the US FOIA consulted with the US FOIA and stated that the facility had no documented inspections of the fire and smoke doors in the last 12 months. Observations during a tour of the 4th and 5th floor on 09/11/2024 between 11:30 AM and 2:09 PM in the presence of the US FOIA and US FOIA revealed there were 3 smoke door assemblies on each floor. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 09/11/2024 at 3:08 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	manager. 4. Maintenance supervisor/designee will inspect 3 random smoke barrier doors monthly for 3 months and then all smoke barrier doors annually. Discrepancies or missed inspections will be addressed promptly. Results will be submitted by maintenance manager or designee monthly for 3 months to Quality assurance performance committee (QAPI)	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		10/21/24

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K 914	Continued From page 10 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review on 9/11/24 in the presence of the US FOIA (b)(6) it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99: 2012 Edition. This deficient practice had the potential to affect 63 resident and was evidenced by: Record review on 9/11/24 at 8:16 AM revealed documentation provided by the U.S. FO of the facility's annual electrical inspection report, dated 4/11/24, from the facility's licensed vendor. The report only documented that an infrared electrical equipment inspection was performed and did not indicated that the rooms with non-hospital grade electrical outlets were annually inspected for grounding, polarity, and blade tension. In an interview on 9/11/24 at 9:35 AM, the US FOIA stated that the facility was not currently	K 914	1. No residents affected. 2. The community realizes that all residents have the potential to be affected. All non hospital grade electrical outlets were tested for grounding, polarity and blade tension 3. Maintenance staff re-educated on the requirement for testing and maintenance of electrical systems for rooms with non hospital grade electrical outlets by facilities supervisor. Maintenance supervisor/designee will test 3 random non hospital grade outlets per week for 4 weeks to ensure proper function 4. Maintenance supervisor/designee will audit communities red book monthly to ensure all non hospital grade outlets have been tested in accordance with the regulation. Discrepancies or missed inspections will be addressed promptly. Results will be submitted monthly by maintenance supervisor/designee to Quality assurance performance	

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K 914	Continued From page 11 conducting the required non-hospital grade outlet testing for grounding, polarity and tension. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 9/11/24 at 3:08 PM. NJAC 8:39-31.2(e) NFPA 99	K 914	committee (QAPI) for 3 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	10/24/2024 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 K0345	10/21/2024	LSC K0353	10/21/2024	LSC K0355	10/21/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	10/21/2024	LSC K0531	10/21/2024	LSC K0761	10/21/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0914	10/21/2024	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	
9/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO