STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING **01** B. WING _____	**08/03/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET** **HOLMDEL, NJ 07733**

(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 07/27/2022 and 07/28/2022 and Bayshore Healthcare Center 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. Bayshore Healthcare Center is a two story, Type II Protected building that was built in January 1968. The facility is divided into 13 smoke zones.	K 000		
K 291 SS=F	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 07/27/2022 and 07/28/2022, in the presence of facility management, it was determined that the facility failed provide a battery backup emergency light above 1 of 3 emergency 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 evidenced by the following: During the survey entrance 07/27/2022 at 8:52 AM, a request was made to the facility's Director	K 291	Battery backup lights will be installed above the one missing emergency generator transfer switch. No individual residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. The other emergency generator, located in the same room, has emergency backup battery lighting installed. The room will be illuminated if the power goes out. The additional backup lighting will ensure all	10/4/22

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

Electronically Signed | 08/29/2022

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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K 291	Continued From page 1 of Plant Operations (DPO) if the facility had an emergency generator. The DPO said, yes there were three (3) here, one (1) was for the Long Term Care, one (1) was for our [redacted] Unit and one (1) was for the Assisted Living building. Based on observation and interview on 07/27/2022 in the presence of facility management, it was determined that the facility failed provide a battery backup. Later during the building tour with the facility Regional Director of Plant Operations (RDPO) and DPO at 1:28 PM, an inspection inside the Boiler room where the three (3) generator transfer switches were located was performed. The surveyor observed three Automatic Transfer Switches (ATS) and that ATS #1 was not equipped with battery back-up emergency lighting independent of the building's electrical system and emergency generator. The surveyor asked the DPO, which emergency generator was connected to ATS #1. The DPO told the surveyor, ATS #1 was for the Long Term Care building. This finding was verified by the facility's RDPO and DPO at the time of inspection. The Administrator was notified of the finding at the Life Safety Code exit conference on 07/28/2022 at 2:37 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	residents receive facility power as quickly as possible in the event of an outage or failure of the transfer switch. There are no other emergency generators missing battery powered emergency transfer switches. A quarterly test of the battery backup lights will be performed by the Director of Maintenance/designee during facility safety rounds on an ongoing basis. Results of the quarterly battery backup light audits will be reported to the Safety Committee monthly for 3 months. The Safety Committee will determine the need for further reports.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure	K 311		9/13/22

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K 311	Continued From page 2 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations on 07/27/2022 in the presence of facility Management, it was determined that the facility failed to ensure that 1 of 10 exit stairwell doors tested were capable of maintaining the two hour fire rated construction. This deficient practice was evidenced by the following, On 07/27/2022 starting at approximately 9:25 AM during the building tour with the Facility's Regional Director of Plant Operations (RDPO) and Director of Plant Operations (DPO), the surveyor performed a closure test of the ten (10) 1-1/2 hour fire rated doors leading into the stairwells, one (1) fire rated door did not positive latch into their frames as required by code to maintain the fire rated construction in the following locations, 1. At 11:10 AM, the surveyor observed on the [redacted] floor stairwell #4 one 1-1/2 hour fire rated door when tested and allowed to self-close 3 times the door did not positive latch into its frame. The surveyor observed this 1-1/2 hour fire rated door handle was stuck in the open position.	K 311	The handle on the stairwell door identified will be replaced by the Director of Maintenance. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. All stairwell doors were audited and positively latched, maintaining the two hour fire rating required. Stair tower doors have been added to the weekly maintenance audits and will be checked weekly by the Director of Maintenance/designee to ensure proper function and positive latching ongoing. Results of the weekly audits will be presented to the Safety Committee monthly for 3 months. The Safety Committee will determine the need for continued reports based on the results of the audits.	

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K 311	Continued From page 3 The stairwell doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The RDPO and DPO confirmed the findings at the time of observations. The Administrator was notified of the finding at the Life Safety Code exit conference on 07/28/2022 at 2:37 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		9/13/22

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K 321	Continued From page 4 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/27/2022, in the presence of Facility Management, it was determined that the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous areas in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in 1 of 11 hazardous storage areas in the facility and was evidenced by the following: On 07/27/2022 during the building tour with the facility's DPO at 9:57 AM, an inspection inside the second floor Staff Training room was performed. The surveyor observed approximately 80 combustible cardboard boxes of various sizes. At this time the surveyor asked the DPO what were all the boxes. The DPO told the surveyor that this room was being used as a storage room to store all the extra Personal Protective Equipment (PPE). The room was over 50 square feet in size and the door did not have a self-closing device installed. This would allow fire, smoke and poisonous gasses to enter into the exit access corridor in the event of a fire. This finding was verified by the facility's DPO at	K 321	A self-closing device has been added to the door by the Director of Maintenance. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. A tour of the facility revealed no additional areas with hazardous materials missing self closing mechanisms. The Director of Maintenance/designee will tour the facility on a monthly basis and observe any areas where hazardous materials are stored to ensure a self closing device is present and functioning. The monthly tours are ongoing. The results of the monthly tours will be presented to the Safety Committee for 3 months. The Safety Committee will determine the need for continued reports based on the results of the tours.	

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K 321	Continued From page 5 the time of inspection. The Administrator was notified of the finding at the Life Safety Code exit conference on 07/28/2022 at 2:37 PM. NJAC 8:39-31.2(e)	K 321		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 07/27 and 28/2022, in the presence of facility management, it was determined that, 1) The facility failed to provide fire alarm notification by audible and visible signals for 2 of 2 enclosed courtyard. 2) The facility failed to install supervised smoke detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6, 9.6.1.8, NFPA 70,	K 341	1.Fire Alarm notification with audio and visual strobes will be installed in the courtyards identified. Supervised smoke detection will be installed in the lobby area identified. No residents were affected by the deficient practice. 2.We have implemented hourly rounding by the maintenance director or designee	10/12/22

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K 341	Continued From page 6 2011 Edition and NFPA 72, 2010 Edition. The deficient practice was evidenced by the following: On 07/27/2022 during the survey entrance at 8:52 AM, a request was made to the facility's Administrator and Director of Plant Operations (DPO) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out of the first floor identified that there are two (2) enclosed courtyards in the facility. On 7/28/2022 (day two of survey) starting at approximately 11:00 AM, a tour of the [redacted] floor of the building in the presence of the facility's Regional Plant Operations Director (RPOD) and DPO was conducted. Along the tour the surveyor observed the following, 1) At 12:09 PM, an inspection inside the enclosed [redacted] performed. The surveyor observed no evidence of an Audio and Visual alarm that is tied into the buildings fire alarm and detection system. At this time the surveyor asked RPOD, do you have an audio and visual alarm in the enclosed courtyard. The RPOD said, no. 2) At 12:24 PM, an inspection inside the enclosed [redacted] was performed. The surveyor observed no evidence of an Audio and Visual alarm that is tied into the buildings fire alarm and detection system. 3) At 1:11 PM, an inspection in the [redacted] area was performed. The surveyor observed no	K 341	during normal business hours and the nursing supervisor or their designee for off shift and weekend rounding. The facility is a smoke free facility and the [redacted] are seldom used in the winter months. A battery operated smoke detector will be installed in the atrium and will be used in conjunction with the hourly rounding as an added safety measure. 3. Rounding by the maintenance director or designee during normal business hours and the nursing supervisor or their designee for off shift and weekend rounding will monitor. 4.The results of the required inspections will be reported to the Safety Committee on a monthly basis for 3 months. The Safety Committee will make recommendations on the need for further audits based on the results. 5. Time limited waiver requested with our projection date of completion 1/10/2024.	

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K 341	Continued From page 7 evidence of a smoke detector in the approximately 12 feet by 12 feet by 5 feet raised high ceiling area. At this time the surveyor asked the DPO do you have a smoke detector in the high ceiling area. The DPO said, no. The RPOD and DPO confirmed the findings at the time of observations. The Administrator was notified of the finding at the Life Safety Code exit conference on 07/28/2022 at 2:37 PM. Fire Safety Hazard. NJAC 8:39 -31.2(a)	K 341		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		10/12/22

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K 351	Continued From page 8 by: Based on observations and interview on 07/27/2022 and 07/28/2022, it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The evidence includes the following, On 07/27/2022 (day one of survey) during the survey entrance at 8:52 AM, a request was made to the facility's Administrator and Director of Plant Operations (DPO) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting at approximately 9:25 AM, in the presence of facility's Regional Director of Plant Operations (RDPO) and DPO a tour of the building was conducted. Along the tour the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location: On 07/27/2022, 1. At 9:35 AM, on the second floor (west end of the building) the surveyor observed inside the Residents shower room by the Tub area one sprinkler head with no evidence of an escheon cap. This left a 1/4 inch gap between the sprinkler head and the ceiling tile. This would allow fire (heat) to by pass and not activate the sprinkler head. 2) At 11:24 AM, on the [redacted] floor (east end of the building) the surveyor observed no evidence	K 351	A sprinkler escheon will be added to the identified sprinkler head in the west side, [redacted] floor tub room. A sprinkler head will be added to the identified east side, 2nd floor shower room. A sprinkler head will be added in the main lobby area identified. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. An audit of the shower rooms and lobby areas revealed no additional areas requiring sprinkler heads or escheons. The Director of Maintenance will ensure the additional sprinkler heads are added to the list of equipment to be inspected and tested on a semi-annual basis as required. The results of the required inspections will be reported to the Safety Committee on a monthly basis for 3 months. The Safety Committee will make recommendations on the need for further audits based on the results.	

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K 351	Continued From page 9 of fire sprinkler protection inside the four (4) feet by eight (8) feet deep shower stall. At this time the surveyor asked the RDPO, do you see a sprinkler inside the shower stall. The RDPO looked inside the shower stall and said, no. On 07/28/2022, 3) At 1:11 PM, An inspection in the main lobby area was performed. The surveyor observed no evidence of a fire sprinkler up inside the approximately 12 feet by 12 feet by 5 feet raised high ceiling area. At this time the surveyor asked the DPO do you have a fire sprinkler in the high part of the ceiling area. The DPO said, no. The RDPO and DPO confirmed the findings at the time of observations. The Administrator was notified of the finding at the Life Safety Code exit conference on 07/28/2022 at 2:37 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation interview and review of facility documentation on 07/27 and 28/2022 in	K 355	The 3 fire extinguishers identified were visually inspected by the Director of	9/13/22

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K 355	Continued From page 10 the presence of facility management, it was determined that the facility failed to: 1) Perform and document on the tag attached to the fire extinguisher a monthly visual examination for 3 of 32 fire extinguishers, as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 7.3 Maintenance. - 7.3.1.1 All Fire Extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. According to NFPA 10- 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded and that records shall be kept on a tag or label attached to the fire extinguishers. During the building tour on 07/27/2022 and continued on 07/28/2022 in the presence of the facility Director of Plant Operations (DPO) the surveyor observed 32 fire extinguishers in various locations that were last annually inspected March 2022 with no evidence of a monthly visual inspection being documented on the tags attached to three (3) fire extinguishers in the following location, 1) At 1:47 PM an inspection inside the Maintenance shop was conducted. The surveyor observed three (3) portable fire extinguishers that	K 355	Maintenance and the inspection was documented. The 3 fire extinguishers were added to the monthly inspection checklist. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. An audit of the premises revealed no additional fire extinguishers that needed to be inspected. On a monthly basis the Director of Maintenance/designee will inspect the premises to ensure all fire extinguishers are visually inspected and included on the list. This will be completed monthly for 3 months. The results of the audits of fire extinguishers will be reviewed and presented by the Director of Maintenance to the Quality Assurance Committee for 3 months. The Committee will determine the need for additional audits moving forward.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 11 were last annually inspected March 2022 with no evidence of a monthly examination being performed and documented on the tags for April, May and June 2022. At this time the surveyor asked the DPO, are these spare fire extinguishers. The DPO said, yes. The findings were verified and confirmed by the DPO during the observations. The surveyor informed the Administrator of the findings at the Life Safety Code exit conference on 07/28/2022 at 2:37 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 364 SS=F	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced	K 364		9/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING **01** B. WING _____	**08/03/2022**

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COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET** **HOLMDEL, NJ 07733**

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K 364	Continued From page 12 by: Based on observations on 07/27/2022, in the presence of facility management it was determined that the facility failed to prohibit transfer grills in corridor walls on resident sleeping units. The deficient practice was evidenced by the following: On 07/27/2022 during the building tour in the presence of the facility's Regional Director of Plant Operations (RDPO) and Director of Plant Operations (DPO) at 10:27 AM, an inspection on the NJ EX Order: 264b1 floor NJ EX Order: 264b1 Unit was performed. The surveyor observed a 17 inch by 17 inch open transfer grill in the corridor wall leading into the NJ EX Order: 264b1 room. The RPOD and DPO confirmed the findings at the time of observations. The Administrator was notified of the finding at the Life Safety Code exit conference on 07/28/2022 at 2:37 PM. NJAC 8:39 -31.2 (e).	K 364	The transfer grill identified will be removed and the wall will be closed with appropriate materials. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. A visual inspection of the facility revealed no additional sleeping units with transfer grills. The Director of Maintenance/designee will conduct monthly rounds and visualize the resident sleeping units to ensure there are no transfer grills present. The results of the monthly rounds will be presented by the Director of Maintenance to the Quality Assurance Committee. Any findings related to transfer grills in resident sleeping areas will be highlighted for 3 months. The Quality Assurance Committee will determine the need for continued audits of transfer grills in resident sleeping areas.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for	K 372		9/13/22

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	315252	A. BUILDING **01** B. WING _____	**08/03/2022**

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K 372	Continued From page 13 smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations on 07/27/2022, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for four (4) of thirteen (13) smoke barrier walls as evidenced by the following: On 07/27/2022 during the survey entrance at 8:52 AM, a request was made to the facility's Administrator and Director of Plant Operations (DPO) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting at approximately 9:25 AM, in the presence of facility's Regional Director of Plant Operations (RDPO) and DPO, a tour of the building was conducted. During the building tour the surveyor observed the following smoke barrier walls failed to maintain the 1/2 hour fire rated construction as required by code in the following locations, On 07/27/2022, 1) At 9:27 AM, the surveyor observed on the [redacted] floor above the ceiling tiles by the corridor double smoke doors, near the two elevators going into the [redacted] of the building had two holes approximately 1" in diameter holes with 1 wire running through the smoke barrier wall. 2) At 10:02 AM, the surveyor observed on the [redacted] floor above the ceiling tiles by the corridor	K 372	Penetrations in the identified smoke barriers will be sealed with a fire barrier by the Director of Maintenance. No residents were affected by the deficient practice. All residents have the potential to be affected by the deficient practice. A visual inspection of the smoke barrier walls did not reveal any additional areas requiring correction. The Director of Maintenance/designee will conduct a visual inspection of the smoke barrier walls on a quarterly basis ongoing. Any penetrations identified will be filled with appropriate fire barriers. The Director of Maintenance or designee will follow any work in the facility with the potential to create penetrations. We will ensure any penetrations are sealed with proper materials. The results of the quarterly inspections will be presented to the Quality Assurance Committee ongoing for 4 quarters. The Quality Assurance Committee will determine the need for continued reporting.	

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K 372	Continued From page 14 double smoke doors, near the In-service training room had an approximately one 2 inch by 2 inch hole with a group of yellow wires and two white cables running through the smoke barrier wall. 3) At 10:48 AM, the surveyor observed on the second floor above the ceiling tiles by the corridor double smoke doors, next to Resident room [redacted] had an approximately one 2 inch by 2 inch hole with a group of yellow wires and 4 white cables running through the smoke barrier wall. 4) At 11:15 AM, the surveyor observed on the second floor above the ceiling tiles by the corridor double smoke doors, near the Janitors closet and soiled utility rooms had an approximately one 3.4 inch by 1 inch hole with a group of yellow wires running through the smoke barrier wall. These penetrations were observed on both sides through the smoke barrier walls, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The RPOD and DPO confirmed the findings at the time of observations. The Administrator was notified of the finding at the Life Safety Code exit conference on 07/28/2022 at 2:37 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)7	K 372		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		10/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 15 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/27/2022 , in the presence of the Regional Plant Operations Director (RPOD) and Director of Plant Operations (DPO), it was determined that the facility failed to ensure a remote manual stop	K 918	The Director of Maintenance will contract with an electrical contractor to install remote manual stop stations for the 2 generators identified. No residents were affected by the deficient practice.	

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K 918	Continued From page 16 station for 2 of 2 Long Term Care Nursing Home emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: During the survey entrance 07/27/2022 at 8:52 AM, a request was made to the facility's Director of Plant Operations (DPO) if the facility had an emergency generator. The DPO said, yes there were three (3) here, one (1) 500 Kilo Watt (KW) emergency generator was for the Long Term Care building, one (1) 60 KW emergency generator was for our Vent Unit and one (1) was for the Assisted Living building. Later during the building tour with the facility's RDPO and DPO, an inspection outside where the emergency generators located was performed. The surveyor observed the following, 1) The 60 KW Diesel emergency generator (Vent Unit) had no evidence of a remote emergency stop button. The surveyor did observe the emergency stop button was located inside the generators metal housing. 2) The 500 KW Diesel emergency generator (Long Term Care Building) had no evidence of a remote emergency stop button. The surveyor observed the emergency stop button was located on the metal housing of the of the emergency generator. The RPOD and DPO confirmed the findings at the time of observations.	K 918	All residents have the potential to be affected by the deficient practice. An audit of the facility revealed no additional missing remote manual stop stations. The Director of Maintenance/designee will include the remote manual stop stations as part of the monthly generator inspection and testing process. The results of the monthly generator inspections and testing will be presented by the Director of Maintenance to the Quality Assurance Committee for 3 months. The need for continued reporting on the remote manual stop stations will be determined by the committee after 3 months.	

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K 918	Continued From page 17 The Administrator was notified of the finding at the Life Safety Code exit conference on 07/28/2022 at 2:37 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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
315252 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/21/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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 K0291	10/04/2022	LSC K0311	09/13/2022	LSC K0321	09/13/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0341	10/12/2022	LSC K0351	10/12/2022	LSC K0355	09/13/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0364	09/13/2022	LSC K0372	09/13/2022	LSC K0918	10/12/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/3/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO