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 _____	**10/19/2023**

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
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 10/10/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/10/23 and 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 Occupancy. Complete Care at Bayshore is a two-story building that was built in 1988. It is composed of Type II protected construction. The facility is divided into 13 - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 129 of 232. .	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings	K 311		11/1/23

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

Electronically Signed | 11/01/2023

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 311	Continued From page 1 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 observation and interview, the facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect 129 residents. Findings include: An observation on 10/10/23 at 2:13 PM revealed one of ten stairway exit doors, located on the second floor adjacent to the activity room, was equipped with panic hardware which violated the listing of the rated fire door assembly. During an interview at the time of observation, the Maintenance Director and Administrator confirmed the stairway exit door was equipped with panic hardware. NJAC 8:39-31.2(e) NFPA 80 .	K 311	1. The fire door hardware identified near the stairway exit door, located on the second floor adjacent to the activity room was replaced with the correct fire-rated door assemblies with approved fire exit hardware. 2. All residents have the potential to be affected by this deficient practice. The remainder of the facility fire doors were assessed to ensure proper hardware was in place with no further non-compliance noted. 3. The Maintenance Director was educated on correct fire-rated door assemblies with approved fire exit hardware to ensure any further corrections to facility fire doors receive proper hardware. 4. The administrator or designee will audit all facility fire doors to ensure the correct fire-rated door assemblies with approved fire exit hardware are in place weekly for four weeks, then monthly for two months. All findings will be reported to the administrator at the facility's monthly QAPI meeting.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		11/1/23

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	315252	A. BUILDING **01** B. WING _____	**10/19/2023**

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 372	Continued From page 2 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 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 and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) Section 8.5.2.2. This deficient practice had the potential to affect 129 residents. Findings include: An observation on 10/10/23 at 3:20 PM revealed the smoke barrier, located in B-wing above the smoke barrier doors adjacent to the office, had a one-inch by one-inch hole with one low voltage wire going through it and was not protected by a system or material capable of restricting the transfer of smoke. An observation on 10/10/23 at 3:24 PM revealed the smoke barrier, located in B-wing above the smoke barrier doors adjacent to the dining room,	K 372	1. The smoke barrier penetrations located in B-wing above the smoke barrier doors adjacent to the office, dining room, and resident room 110 were sealed with material capable of restricting the transfer of smoke. 2. All residents have the potential to be affected by this practice. The remainder of the facility's smoke barrier doors were audited for any further penetrations. No further non-compliance was noted. 3. The Maintenance Director was educated on the importance of ensuring penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke. The Maintenance Director will conduct a full check of any work completed in the facility by an outside vendor to ensure no penetrations are left and the facility remains in compliance. 4. The Maintenance Director or	

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

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K 372	Continued From page 3 had a one-inch by one-inch hole with one low voltage wire going through it and was not protected by a system or material capable of restricting the transfer of smoke. An observation on 10/10/23 at 3:28 PM revealed the smoke barrier, located in B-wing above the smoke barrier doors adjacent to room 110, had a one-inch by one-inch hole with five high voltage wire going through it and was not protected by a system or material capable of restricting the transfer of smoke. During an interview at the time of the observations, the Maintenance Director and the Administrator confirmed the penetrations in the smoke barriers were not protected by a system or material capable of restricting the transfer of smoke. NJAC 8:39-31.1(c). 31.2(e) .	K 372	designee will complete a random audit of all smoke barrier doors to ensure penetration barriers remain intact monthly times 3 months and then quarterly for three months. All findings will be reported at the facility's administrator monthly QAPI meeting.	
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 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	K 914		11/1/23

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	315252	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 914	Continued From page 4 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 document review and interview, the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. This deficient practice had the potential to affect 129 residents. Findings include: Document review of the Fire Safety Folder for 2023, provided by the Maintenance Director, revealed the electrical outlet testing was not completed on the electrical outlets. During an interview at 3:55 PM on 10/10/23, the Administrator confirmed that the electrical outlet testing was not completed on the electrical system. . .	K 914	1. The facility completed the facility electrical outlet testing and ensured proper documentation was in place. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was educated on the importance of completing the facility's electrical system testing. The maintenance department or designee will implement a work order into the facility maintenance calendar to ensure all electrical outlets are inspected yearly. 4. The Maintenance Director or designee will randomly audit the maintenance work order schedule to ensure no further regulatory tasks are missed and are completed timely. This audit will be completed monthly for 3 months, then quarterly for 6 months. All findings will be reported to the administrator at the facility's monthly QAPI meeting.	

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	11/21/2023 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 K0311	11/01/2023	LSC K0372	11/01/2023	LSC K0914	11/01/2023
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	
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	
10/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO