STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315342	A. BUILDING **01** B. WING _____	**07/06/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRICK LLC	**415 JACK MARTIN BLVD** **BRICK, NJ 08724**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 7/5/22, 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 The facility is a 2- story building, with a partial basement,that was built in 90's, It is composed of Type I fire resistant construction. The facility is divided into 6- smoke zones. The generator does 100% of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 137 certified beds. At the time of	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/19/2022

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 000	Continued From page 1 the survey the census was 78.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K 222		7/7/22

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K 222	Continued From page 2 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/05/22, it was determined that the facility failed to ensure that exit doors locked with a delayed egress device were provided with instructional signage as per the requirements of NFPA 101:2012 - Chapter 7.2.1.6.1.1(4). This deficient practice was identified in 2 of 8 egress doors and evidenced by the following: 1. At 11:52 AM, the Surveyor, Maintenance Director, Plant Operations Director and Administrator, observed that the exit/egress door by resident room # [redacted], was provided with a delayed egress system. The door was not	K 222	1. Corrective actions accomplished a. based on the RCA the team identified the cause of the deficient practice to be failure to put back "Push Until Alarm Sounds, Door Can Be Opened in 15 seconds" signage on exit/egress doors by Room [redacted] and [redacted] after the doors were painted during renovations. 2. Corrective actions taken for other residents a. All residents have the potential to be affected	

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K 222	Continued From page 3 provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button keypad and opened with the activation of the fire alarm. 2. At 12:05 PM, the Surveyor, Maintenance Director, Plant Operations Director and Administrator, observed that the exit/egress door by resident room [redacted],was provided with a delayed egress system. The door was not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button keypad and opened with the activation of the fire alarm. The Maintenance Director, Regional Plant Operations Director and Administrator, confirmed the findings at the time of the observations. The Administrator was informed of these findings during the Life Safety Code survey exit conference on 07/05/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222	3. Measures/Changes put into place: a. Signage stating "Push Until Alarm Sounds, Door Can Be Opened in 15 seconds was put on the exit/egress doors by the Director of Plant Operations near rooms [redacted] and [redacted] b. Monthly safety round compliance audit tool reviewed and revised to include exit/egress door signage 4. Corrective Actions: a. Monthly safety round compliance audit tool will be completed by the Director of Plant Operations and/or designee and results reviewed for efficacy by Director of Plant Operations on a monthly basis b. Monthly safety rounds compliance audit tool will be done for 6 months and then quarterly thereafter and results will be reported at the Monthly QAPI meetings by the Director of Plant Operations	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		7/11/22

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K 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/05/22, it was determined that the facility failed to provide stair tread marking stripe (applied as a material that is integral with the nosing of each step, each floor's landing, and handrails) with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3. The deficient practice was observed in 4 of 4 stairwells, identified by the Maintenance Director and Regional Plant Operations Director as stairwell A, B, C, and D. While touring the facility on 07/01/22, from approximately 9:40 AM to 3:00 PM, the Surveyor, Maintenance Director, Regional Plant Operations Director and Administrator, observed that the required exit/egress stairwells marking stripes were not present on each step, floor landing, and handrails for 4 of 4 stairwells. The Administrator was informed of this finding during the Life Safety Code survey exit conference on 07/05/22. NJAC 8:31.2(e) NFPA 101:2012 - 19.2.2.3, 7.2.2	K 225	1. Corrective Action Accomplished: a. Based on the RCA the team identified the cause of the deficient practice to be failure to provide stair tread marking stripe with solid and continuous marking in accordance with NFPA 101, 2012 Edition Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3 in 4 of 4 stairwells identified as stairwell A (1), B (2), 3 (C), and 4 (D) 2. Corrective actions taken: a. All residents have the potential to be affected 3. Measures/Changes put into place: a. Stair tread marking stripes added by the Director of Plant Operations to the nosing of each step, each floor's landing and handrails in stairwells A (1), B (2), C (3), and D (4) b. Monthly safety round compliance audit tool reviewed and revised to include stair tread mark stripe compliance 4. Corrective actions Monitored: a. Monthly Safety Round compliance audit tool will be completed by the Director of Plan Operations and/or designee and results completed and reviewed for efficacy by Director of Plant Operations on a monthly basis b. Monthly safety round compliance audit tool to be done monthly for six months and then quarterly thereafter. Results reported at the monthly QAPI meetings by the Director of Plant Operations	

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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) 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 07/05/22, in the presence of the Maintenance Director, Regional Plant Operations Director and Administrator, it was determined that the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous areas in	K 321	1. Corrective actions accomplished: a. Based on RCA the team identified the cause of the deficient practice to be failure to provide and maintain self-closing devices and hardware on doors to hazardous areas in accordance with	7/11/22

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K 321	Continued From page 6 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 3 of 8 hazardous areas and was evidenced by the following: 1. At 11:38 AM, the surveyor observed in unoccupied resident room #2, that approximately 25 plastic trash bins (in clear plastic bags) were being stored. The room was greater that 50 square feet in size and the door required a self-closing device installed. 2. At 12:25 PM, the surveyor observed in unoccupied resident room #3, that approximately 14 plus combustible resident room mattresses were being stored. The room was greater that 50 square feet in size and the door required a self-closing device installed. 3. At 12:29 PM, the surveyor observed in unoccupied resident room #8, that approximately 20 plus combustible resident room mattresses were being stored. The room was greater that 50 square feet in size and the door required a self-closing device installed. An interview was conducted with the Maintenance Director and Regional Plant Operations Director, who confirmed and stated that hazardous storage areas must have a door with a self-closing device. The Administrator was informed of the finding, at the Life Safety Code exit conference on 07/05/22. NJAC 8:39-31.2(e)	K 321	NFPA, 2021 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.6.3.5, 19.3.6.4, 8.3. 8.3.5.1, 8.5.6.2 and 8.7 in 3 of the 8 hazardous areas 2. Corrective actions taken for residents: a. All residents have the potential to be affected 3. Measures/Changes put into place: a. self closing devices and hardware were installed on the following doors on the Lighthouse Unit by Director of Plant Operations. Unoccupied resident room #2, unoccupied resident room #3 and unoccupied resident room #8. b. Monthly safety round compliance audit tool reviewed and revised to include self-closing door compliance in combustible storage rooms/spaces (over 50 square feet) 4. Corrective Actions monitored: a. Monthly safety round compliance audit tool will be completed by the Director of Plant Operations and/or designee and results completed and reviewed for efficacy by the Director of Plant Operations on a monthly basis b. Monthly safety round compliance audit tool to be done monthly for six months and then quarterly thereafter. Results reported at the QAPI meeting monthly by the Director of Plant Operations	

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K 353	Continued From page 7	K 353		
K 353 SS=D	Sprinkler System - Maintenance and Testing 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 observation and interviews on 07/05/22, it was determined that the facility failed to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. This deficient practice was identified for 1 of 1 "Fire Sprinkler Control Rooms" and was evidenced by the following: At 11:42 AM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed in the "Fire Sprinkler Control Room" that the drop	K 353	1. Corrective actions accomplished: a. Based on the RCA the team identified the cause of the deficient practice to be failure to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, Edition 2012, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition Section 6.2.7.1 and NFPA 25 2011 Edition Section 5.1, 5.2.2.1 in one Fire Sprinkler Control Room. 2. Corrective Actions taken for residents: a. All residents have the potential to be affected	7/11/22

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K 353	Continued From page 8 ceiling around an approximately 5" black pipe and BX electrical cable had oversized cuts into the ceiling approximately 2" x 1" and 2"x 2". The sprinkler head was approximately 12" from the openings in the ceiling and would delay the activation of the fire sprinkler head in the event of a fire. The Maintenance Director confirmed the above findings during the observations. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 07/05/22. NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1.	K 353	3. Measures/Changes put into place: a. Ceiling tile was replaced to fit tighter to ensure the ceiling was smoke resistant and fire rated by the Director of Plant Operations. Fire rated caulk applied to close the penetration around pipe/cables b. Monthly safety round compliance audit tool reviewed and revised to include ceiling tiles throughout the facility to be smoke resistant and fire rated around any penetration. 4. Corrective actions monitored: a. Monthly safety round compliance audit tool will be completed by the Director of Plant Operations and/or designee and results completed and reviewed for efficacy by the Director of Plant Operations on a monthly basis b. Monthly safety round compliance audit tool to be done monthly for six months and then quarterly thereafter and results reported at the monthly QAPI meeting by the Director of Plant Operations	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363		7/11/22

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K 363	Continued From page 9 materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/05/22, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in	K 363	1. The Corrective Actions accomplished: a. Based on the RCA the team identified the cause of the deficient practice to be failure to ensure that the corridor doors were able to resist the passage of smoke in accordance with the requirements of the NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5 in the six (18) of the 50 resident room doors.	

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K 363	Continued From page 10 place. This deficient practice was identified in six (18) of 50 resident room doors (single door with opening sidelight doors) observed and was evidenced by the following: The following resident room doors, when closed left a gap at the top of the room door's, approximately 1/4 to 1/2 inch, due to a malfunction in the door hardware installation, causing the door to not fit properly in its frame in the following rooms: [redacted] An interview was conducted with the Maintenance Director and Regional Plant Operations Director, at the time of the observations who confirmed the above findings. The Administrator was informed of the finding at the Life Safety Code exit conference on 07/05/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	2. Corrective actions for residents: a. All residents have the potential to be affected 3. Measures/Changes put into place: a. Door hardware fixed to ensure the door properly fits in its frame in the following rooms: [redacted] by the Director of Plant Operations. b. Monthly safety round compliance audit tool reviewed and revised to include corridor door inspection to resist the passage of smoke 4. Corrective actions monitored: a. Monthly safety round compliance audit tool will be completed by the Director of Plant Operations and/or designee and results completed and reviewed for efficacy by the Director of Plant Operations b. Monthly safety round compliance audit tool to be done for six months and then quarterly thereafter and results reported at the QAPI meeting monthly by the Director of Plant Operations	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard	K 911		7/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315342	A. BUILDING **01** B. WING _____	**07/06/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRICK LLC	**415 JACK MARTIN BLVD** **BRICK, NJ 08724**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 11 citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/05/22, it was determined that the facility did not maintain the required clearance around electrical panels, electrical equipment and controls in accordance with NFPA 101, 2012 LSC Edition, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26. This deficient practice of not ensuring 36" in-front of the electrical panels will prevent staff and emergency personnel from disconnecting the electrical power quickly in the event of an emergency. In addition, cardboard storage boxes and paper stored in front of electrical equipment may provide an ignition source and pose a potential fire risk. The deficient practice was observed in 1 of 4 electrical rooms observed, and was evidenced by the following: At 12:30 PM, in the first floor electrical room, the surveyor observed that storage was in front of the generator transfer switch. The items blocking the large electrical panel, were floor maintenance equipment: (shop vacuum, 2-electric floor cleaning machines and a 5-gallon pail of floor polish) potentially causing a delay in the shutoff of any electrical equipment in that area of the facility. The observation's were confirmed by the Maintenance Director, Regional Plant Operations Director and Administrator, during the tour of the electrical rooms in the facility.	K 911	1. Corrective actions accomplished: a. Based on the RCA the team identified the cause of the deficient practice to be failure to maintain the required 36" clearance around electrical panels, electrical equipment and controls in accordance with NFPA 101, 2012 LSC Editions, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 15.5.1.2, and NFPA 70 2011 Edition, Section 110/26 in 1 of 4 electrical rooms 2. Corrective actions taken for residents: a. All residents have the potential to be affected 3. Measures/Changes put into place: a. Maintenance equipment including shop vacuum, 2 electrical floor cleaning machines, and a 5 gallon pail of floor polish was removed by the Director of Plant Operations b. 36" clearance area taped off in electrical room around the electrical panel, equipment and controls c. Monthly safety round compliance audit tool reviewed and revised to include 36" clearance around the electrical panel and electrical equipment. 4. Corrective actions monitored: a. Monthly safety round compliance audit tool will be completed by the Director of Plant Operations and/or designee and results completed and reviewed for	

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K 911	Continued From page 12 The Administrator was informed of the finding at the life safety code exit conference on 07/05/22. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	efficacy by the Director of Plant Operations on a monthly basis b. Monthly safety round compliance audit tool to be done monthly for six months and then quarterly thereafter and results reported at the QAPI monthly meeting by the Director of Plant Operations	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		7/7/22

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	315342	A. BUILDING **01** B. WING _____	**07/06/2022**

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K 918	Continued From page 13 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 07/05/22, in the presence of the Maintenance Director, Regional Plant Operations Director and Administrator, it was determined that the facility did not ensure a remote manual stop station for 1 of 1 generator, 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: At 12:19 PM, the surveyor, Maintenance Director, Regional Plant Operations Director and Administrator, observed the exterior diesel generator. There was no remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator observed outside the enclosure housing the prime mover. An interview was conducted during the observation with the Maintenance Director, Regional Plant Operations Director and Administrator, where they stated that at the time of observation, the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation located outside the enclosure housing the prime mover. The Administrator was informed of the finding at the Life Safety Code exit conference on 07/05/22.	K 918	1. Corrective actions accomplished: a. Based on the RCA the team identified the cause of the deficient practice to be failure to ensure a remote manual stop station for the generator was installed in accordance with the requirement of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1 2. Correction actions taken for residents: a. All residents have the potential to be affected 3. Measures/changes put into place: a. Electrician installed a remote manual stop station for the generator on the parking lot light pole adjacent to the generator away from the generator housing enclosure b. Monthly safety round compliance audit tool reviewed and revised to include remote manual stop station for generator 4. Corrective actions monitored: a. Monthly safety round compliance audit tool will be completed by the Director of Plant Operations and/or designee and results completed and reviewed for efficacy by Director of Plant Operations b. Monthly safety round compliance audit tool to be done monthly for six months	

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K 918	Continued From page 14 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	and then quarterly thereafter. Results will be reported at the monthly QAPI meeting by the Director of Plant Operations	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/05/22, the facility failed to prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5,	K 920	1. Corrective actions accomplished: a. Based on the RCA the team identified the cause of the deficient practice to be failure to prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding	7/7/22

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K 920	Continued From page 15 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was idenitified in1 of 40 rooms observed and was evidenced by the following: At 11:40 AM, the Surveyor, Maintenance Director, Regional Plant Operations Director and Administrator, observed in resident room [redacted] that resident bed #1 (doorside) had electronics plugged into a white household grade extension cord. The extension cord was plugged into a duplex wall outlet. The finding was verified by the Maintenance Director and Regional Plant Operations Director at the time of the observation, where they stated and confirmed that extensions cords were not a substitute for fixed wiring. The Administrator was notified of the findings at the Life Safety Code exit conference on 07/05/22. NJAC 8:39-31.2(e)	K 920	75% of the capacity, in accordance with the requirements of the NFPA 101, 2012 LSC edition, Section 19.5, 19.5.1, 9.1, 9.1.2, NFPA 20 2011 LSC Edition, Section 400.8 and 590. 3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4 in room #203 2. Corrective actions taken for residents: a. All residents have the potential to be affected 3. Measures/Changes put into place: a. Extension cord was removed from room [redacted] b. Resident provided with literature education regarding extension cord usage by the Director of Plant Operations c. Administrator sent out educational literature to families regarding extension cord usage d. Monthly safety round compliance audit tool reviewed and revised to include resident room extension cord compliance 4. Corrective actions monitored: a. Monthly safety round compliance audit tool will be completed by the Director of Plant Operations and/or designee and results completed and reviewed for efficacy by the Director of Plant Operations b. Monthly safety round compliance audit tool to be done monthly for six months then quarterly thereafter. Results reported at the monthly QAPI meeting by the Director of Plant Operations	

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
315342 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/5/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRICK LLC	415 JACK MARTIN BLVD BRICK, NJ 08724

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 K0222	07/07/2022	LSC K0225	07/11/2022	LSC K0321	07/11/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	07/11/2022	LSC K0363	07/11/2022	LSC K0911	07/07/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	07/07/2022	LSC K0920	07/07/2022	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/6/2022	☐ YES ☐ NO

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
315342 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/5/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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LSC K0222	07/07/2022	LSC K0225	07/11/2022	LSC K0321	07/11/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	07/11/2022	LSC K0363	07/11/2022	LSC K0911	07/07/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	07/07/2022	LSC K0920	07/07/2022	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/6/2022	☐ YES ☐ NO