STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315264	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD , TOMS RIVER, New Jersey, 08753

(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
F0000	INITIAL COMMENTS Complaint: NJ # 414491 Survey Date: 9/25/2025 Census: 95 Sample Size: 21 + 3 Closed Records The NJDOH conducted a Recertification and Complaint survey on 9/21/2025. The survey was officially completed on 11/17/2025. A Recertification and Complaint Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		11/19/2025
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the	F0657	F0657 Immediate corrective action for residents affected by deficient practice: Resident #36 has been discharged Identify those individuals who could be affected by the deficient practice: All residents with limb restrictions have the potential to be affected. A facility wide audit was conducted to ensure that all residents with limb restrictions have accurate Care plans interventions in place. No concerns identified Measures put in place to ensure the deficient practice will not occur for those residents affected: Education on the policy Comprehensive Care Plans and the importance of observing limb restrictions was	11/26/2025

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 reverse for further 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.

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

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F0657 SS = D	Continued from page 1 resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to review and revise comprehensive person-centered care plan that identified furnished services to attain or maintain the resident's highest practicable physical, mental, and [redacted] for a resident with a [redacted] This deficient practice was identified for 1 of 38 residents (Resident #36) reviewed for care planning. This deficient practice was evidenced by the following: On 9/22/2025 at 10:04 AM, the surveyor reviewed the electronic medical record (EMR) for Resident 26. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to:[redacted] A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's [redacted]. A review of Resident #36's Medication Administration Recor (MAR) included the following physician orders (PO): Vital Signs [redacted] every shift. Upon review of the EMR, vital sign entries identified that [redacted] was obtained from the	F0657	Continued from page 1 reviewed with license nurses initiated on 11/21/25 by the Assistant Director of Nursing. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing or designee will audit 1 medical charts for complete Care Plans for residents with Limb Restrictions weekly x 4 weeks then monthly x 2 months Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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F0657 SS = D	Continued from page 2 resident's [redacted] A review of the resident's individual comprehensive care plan (ICCP) did not identify Resident #36's [redacted] On 9/24/2025 at 10:40 AM, the surveyor interviewed Unit Manager Licensed Practical Nurse (UM/LPN #1) who advised that she was not sure if it would be added but believed it would be a good idea. On 9/252025 at 9:45 AM, the surveyor interviewed the U. S. FOIA (b) (2), in the presence of the [redacted] who acknowledged that the [redacted] was not on the care plan. A review the facility policy titled, "Comprehensive Care Plans", Implemented 9/1/24, revealed under the title "Policy": to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measure objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified […]. In addition, the following was identified under the section titled "Policy Explanation and Compliance Guidelines: […]3. The comprehensive care plan will describe at a minimum, the following: a. The services that re to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being; […] f. Resident specific intervention that reflect the resident's needs and preferences […]; 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment […]. N.J.A.C. § 8:39-11.2 (e)	F0657		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled: 8Number of residents cited: 1Based on observation, interview, record review, and review of pertinent facility documents, it was	F0677	F0677 Immediate corrective action for residents affected by deficient practice: Resident #32 was assessed on [redacted] with [redacted] noted related to NJ Ex Order 26, 4B1, a review of the care plan reflects that the resident uses NJ Ex Order 26, 4B1 [redacted] as per family request. [redacted] education conduced on [redacted] with involved [redacted] Identify those individuals who could be affected by the	11/26/2025

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F0677 SS = D	Continued from page 3 determined that the facility failed to provide appropriate NJ Ex Order 26, 4B1 for a resident who was NJ Ex Order 26.4(b)(1) staff for NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 unsampled resident (Resident #32) out of 8 residents observed during NJ Ex Order 26, 4B1 on 2 of 2 nursing units and was evidenced by the following: On 9/23/2025 at 8:56 AM, the surveyor performed NJ Ex Order 26, 4B1 with U. S. FOIA (b) (2) and observed Resident #32 in bed. U. S. FOIA (b) (2) exposed the resident's NJ Ex Order 26, 4B1 and stated that the resident NJ Ex Order 26, LPN/UM #1 proceeded to NJ Ex Order 26, 4B1. The surveyor noticed that the NJ Ex Order 26, 4B1 , 4B1 . The surveyor asked U. S. FOIA (b) (2) to NJ Ex Order 2 The surveyor observed another NJ Ex Order 26, 4B1 . The surveyor asked U.S. FOIA (b) (6) if NJ Ex Order 26, 4B1 the resident was appropriate. U. S. FOIA (b) (2) stated that it was not right and that they will educate the U. S. FOIA (b) (2) from NJ Ex Order 26 probably did it. The surveyor reviewed the medical record of Resident #32. A review of the resident's Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26, 4B1 A review of the resident's most current quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, 4B revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26 which indicated NJ Ex Order 26, 4B1 . The MDS further assessed that the resident was NJ Ex Order 26.4(b)(1) staff assistance for NJ Ex Order 26.4(b)(1) and that the resident was always NJ Ex Order 26, 4B1 A review of the resident's Individualized Care Plan (ICP) included a problem area initiated on NJ Ex Order 26, 4B, that the resident had NJ Ex Order 26, 4B1 and was NJ Ex Order 26.4(b)(1) staff for NJ Ex Order 26. On 9/24/2025 at 11:30 AM, during an interview with the survey team, the U. S. FOIA (b) (2) stated that it is not appropriate for residents NJ Ex Order 26, 4	F0677	Continued from page 3 deficient practice: All residents receiving incontinence care have the potential to be affected. A facility wide audit was conducted on 9/23/25 by the unit managers to ensure that all residents receiving incontinence care have appropriate briefs in use. No concerns identified Measures put in place to ensure the deficient practice will not occur for those residents affected: Education on Incontinence care was reviewed with all licensed nurses and Certified staff initiated on 9/23/25 by the Assistant Director of Nursing. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing or designee will audit 2 residents receiving incontinence care weekly x 4 weeks then monthly x 2 months Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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F0677 SS = D	Continued from page 4 [redacted] A review of facility-provided policy titled "Incontinence Care" date implemented on 9/27/2024, included under Policy Explanation and Compliance Guidelines: 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. N.J.A.C. 8:39 – 27.1 (a)	F0677		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by:	F0690	F0690 Immediate corrective action for residents affected by deficient practice: Resident # 115 was assessed on [redacted] and a [redacted] noted related to [redacted] status. Resident # 25 was assessed on [redacted] was secured to the [redacted] noted related to her [redacted] status. Identify those individuals who could be affected by the deficient practice: All residents receiving [redacted] have the potential to be affected. Facility wide audits were conducted on 9/23/25, 9/24/25, and 9/25/25 to ensure that all residents receiving catheter care have privacy bags in place, tubing is not kinked. No concerns identified Facility wide audits were conducted on 9/23/25, 9/24/25, and 9/25/25 to ensure that all dressings were dated and have staff initials. No concerns identified Measures put in place to ensure the deficient practice will not occur for those residents affected: Education on drainage bag placement and use of privacy bags was reviewed with all licensed nurse and certified staff was initiated on 9/23/25 by the Assistant Director of Nursing. Education on Dressing changes ensuring dates and initials are present was reviewed with all licensed nurses and certified staff was initiated on 9/23/25 by	11/26/2025

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F0690 SS = D	Continued from page 5 Based on observation, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) maintain proper care for a resident with a NJ Ex Order 26, 4B1 [redacted]; b.) ensure a resident's NJ Ex Order 26, 4B1 remained in a NJ Ex Order 26 [redacted] c.) document a resident's NJ Ex Order 26.4(b)(1) [redacted] as ordered by the physician. This deficient practice was identified for 2 of 3 residents (Resident # 25 and Resident # 115) reviewed for NJ Ex Order 26, 4B1. This deficient practice was evidenced by the following: 1.) On 09/23/2025 at 9:00 AM, Surveyor #1 completed NJ Ex Order 26, 4B1 with the U.S. FOIA (b) (6) [redacted]) on the NJ Ex Order 26, 4B1 Unit, Resident #115 was observed lying in bed with the head of the bed elevated approximately 45 degrees. The resident's NJ Ex Order 26 was NJ Ex Order and secured with white tape that was NJ Ex Order 2 NJ Ex Order 26, 4B1 NJ Ex Order 26, [redacted]. A NJ Ex Order 26, 4B1; however, it was not NJ Ex Order 26, 4B1 A review to the admission record, an admission summary, revealed the resident was admitted to the facility with diagnoses including, but not limited to, NJ Ex Order 26, 4B1 [redacted] A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated NJ Ex Order 26, 4B1, included a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4 [redacted], indicating NJ Ex Order 26, 4B1. Further review of Section NJ E NJ Ex Order 26, 4B1 revealed that the resident has a NJ Ex [redacted] A review of the resident's individual comprehensive care plan, dated NJ Ex Order 26, 4B1, identified a focus area related to the presence of a NJ Ex Order 26, 4B1 [redacted], along with an intervention to NJ Ex Order 26, 4B1	F0690	Continued from page 5 the Assistant Director of Nursing. Education on the policy Documentation in Medical Record and the importance of completing timely documentation in the "Treatment Admission Record (TAR)" was reviewed with license nurses was initiated on 11/21/25 by the Assistant Director of Nursing. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing or designee will audit 2 medical charts for complete Treatment Admission Records (TAR) for residents receiving catheter care weekly x 4 weeks then monthly x 2 months Director of Nursing or designee will perform 2 observations of drainage bags and tubing for residents receiving catheter care weekly x 4 weeks then monthly x 2 months Director of Nursing or designee will perform 2 observations of dressings for date and initials weekly x 4 weeks then monthly x 2 months Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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F0690 SS = D	Continued from page 6 A review of the order summary report, dated as of NJ Ex Order 26, 4B1 included the following physician orders (PO): a PO, dated NJ Ex Order 26, 4B1, for NJ Ex Order 26, 4B1 [redacted]. During an interview with Surveyor #1 on 09/23/2025 at 9:30 AM, the U. S. FOIA (b) (2) stated that the NJ Ex Order 26.4 for Resident #15's NJ Ex Order 26, 4B1 is NJ Ex Order 26.4 daily and should always be dated, an undated NJ Ex Order 26.4 makes it unclear whether it has been NJ Ex Order 26.4(U.S. FOIA (b) (6) also noted that the NJ Ex Order 26.4(b)(1) for the NJ Ex Order 26.4(b)(1) should not have been positioned at the bottom of the resident's bed but rather placed in a NJ Ex Order 26, 4B1 [redacted] to prevent NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1 [redacted]. During an interview with Surveyor #1 on 09/24/2025 at 11:42AM, the U. S. FOIA (b) (2) stated that NJ Ex Order 26, 4B1 [redacted] depending on the type of appliance the resident arrives with from the hospital. There should be no tape applied to the NJ Ex Order 26, 4B1 [redacted] and the NJ Ex Order 26, 4B1 should be secured to the side of the bed to allow gravity to NJ Ex Order 26, 4B1 [redacted]. A review of a facility policy undated titled, "Nephrostomy Tube", revealed that, "Residents with nephrostomy will receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Check tube(s) frequently for kinks or obstructions. These are likely to occur if the resident lies on the insertion sites." A review of a facility policy undated titled, "Clean Dressing Change", under policy explanation and compliance guidelines revealed that, "Secure dressing. Mark with initials and date." NJAC 8:39-27.1 (f) 2.) On 9/23/2025 at 8:36 AM, Surveyor # 2 observed from the hallway Resident #25's NJ Ex Order 26, 4B1 [redacted]. Surveyor # 2 reviewed the medical record for Resident #25.	F0690		

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F0690 SS = D	Continued from page 7 A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Ex Order 26, 4B1) . A review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, identified that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1 which indicated the resident's cognition NJ Ex Order 26, 4B1 . Review of Section NJ of the MDS identified Resident #25 with an NJ Ex Order 26, 4B1 A review of the Treatment Administration Treatment (TAR) included the following physician orders (PO): A PO, with a start date of NJ Ex Order 26, 4B1 (every) shift and was needed every shift. The following dates were blank without any nursing initials for the month of NJ Ex Order 26.4(b)(1) Evening Shift NJ Ex Order 26 Night Shift; NJ Ex Order 26 Evening Shift. A PO, with a start date of NJ Ex Order 26, 4B1, to monitor NJ Ex Order 26, 4B1] for (signs/symptoms) NJ Ex Order 26, 4B1 every shift. The following dates were blank without any nursing initials for the month of NJ Ex Order 26, 4B1 A PO, with a start date of NJ Ex Order 26, 4B1, to NJ Ex Order 26, 4B1 shift. The following dates were blank without any nursing initials for the month of NJ Ex Order 26, 4B1 A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Ex Order 2 that the resident had an NJ Ex Order 26, 4B1 Interventions included: monitor and document intake and output as per facility policy; monitor/record/report to U.S. FC for (signs/symptoms) of NJ Ex O On 9/24/2025 at 10:04 AM, Surveyor # 2 interviewed Certified Nursing Assistant (CNA #1) who confirmed that NJ Ex Order 26, 4B1 were to be placed in NJ Ex Order 26.4(. When asked how NJ Ex Order 26, 4B1 were monitored, CNA #1 responded that they NJ Ex Order 26.4(b)(1) , measure the amount, and report NJ Ex Order 26.4(b) to the nurse who was responsible for documenting the amount. When asked why the documentation of the NJ Ex Order 26.4(b)(1) was important, CNA #1 stated that this was part of the resident's plan of care.	F0690		

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F0690 SS = D	Continued from page 8 On 9/24/2025 at 10:10 AM, Surveyor # 2 interviewed Licensed Nurse Practitioner (LPN #1) who confirmed that either the CNA or the nurse can empty the NJ Ex Order 26 [redacted] and measure the amount, but the nurse was responsible for documenting the amount in the chart. When asked how NJ Ex Order 26, 4B1 are to be maintained at bedside, UMLPN #1 reported that they were to be in a NJ Ex Order 26, 4B1. When asked about blanks in the MAR, UMLPN#1 stated that there should never be blanks because it could mean NJ Ex Order 26, 4B1 On 9/24/2025 at 10:40 AM, Surveyor # 2 interviewed Unit Manager Licensed Practical Nurse (UM/LPN #1) who described that the care of NJ Ex Order 26, 4B1 included monitoring for signs/symptoms of NJ Ex Order 26, 4B1 [redacted] maintained in NJ Ex Order 26.4(b)(1), and that the nurses were responsible for documentation of the NJ Ex Order 26, 4B1. The surveyor provided pictures of the NJ Ex Order 26, 4B1 device as observed on initial tour. UM/LPN#1 confirmed the finding. When asked if there should be blanks on the TAR, UM/LPN#1 denied. On 9/24/2025 at 11:44 AM, Surveyor # 2 interviewed the U. S. FOIA (b) (2), in the presence of the U.S. FOIA (b) (6) [redacted], who acknowledged that NJ Ex Order 2 [redacted] are to be maintained in NJ Ex Order 26.4(b)(1) and that physicians orders should be completed in their entirety and identify as such in the electronic medical record. A review the facility policy titled, "Catheter Care", Implemented 9/27/24,, revealed under the title "Policy": It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Additionally, under the title "Policy Explanation": 1. Catheter Care will be performed every shift and as needed by nursing personnel. 2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use [...]. A review the facility policy titled, "Documentation in Medical Record", Implemented 10/1/24, revealed under the title "Policy": Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information not provide a picture of the resident's progress through complete, accurate, and timely documentation. N.J.A.C. § 8:39-19.4 (a)	F0690		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning	F0695	F0695	11/26/2025

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F0695 SS = D	Continued from page 9 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review and review of other pertinent facility documentation, it was determined that the facility failed to contain NJ Ex Order 26, 4B1, specifically NJ Ex Order 26.4(b)(1) [redacted]) in NJ Ex Order 26.4(b)(1) for 1 of 1 resident (Resident #65) reviewed for NJ Ex Order 26.4(b)(care. This deficient practice was evidenced by the following: Findings include: On 09/21/2025 at 11:04 AM Resident #65 was observed seated in the activity room. Staff indicated to the surveyor that Resident #65 was NJ Ex Order 26, 4B1 According to the Admission Record Resident #65 was admitted to the facility with the following but not limited to diagnoses: NJ Ex Order 26, 4B1 [redacted] A review of the resident assessment/minimum data set (MDS), an assessment tool, dated NJ Ex Order 26, 4B1 revealed that Resident #65 had a Brief Interview for Mental Status NJ Ex Order 26, 4B1 which indicated NJ Ex Order 26, 4B1 [redacted]. According to Section NJ Ex Resident #65 required NJ Ex Order 26, 4B1 [redacted] Section NJ E revealed that Resident #65 received NJ Ex Order 26, 4B1 on admission to the facility and while a resident.	F0695	Continued from page 9 Immediate corrective action for residents affected by deficient practice: Resident #65 was assessed on NJ Ex Order 26, the NJ Ex Order 26, 4B1 was replaced and stored in NJ Ex Orde with NJ Ex Order 26, 4B1 noted related to NJ Ex NJ Ex Order 26 use. Identify those individuals who could be affected by the deficient practice: All residents receiving oxygen therapy have the potential to be affected. A facility wide audit was conducted to ensure that all residents receiving oxygen therapy had the tubing dated and in bags when not in use. No concerns identified Measures put in place to ensure the deficient practice will not occur for those residents affected: Education on the oxygen therapy regarding storage in bags when not in use and tubing being dated and changed weekly was reviewed with license nurses was initiated on 9/24/25 by the Assistant Director of Nursing. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing or designee will audit 2 residents receiving oxygen therapy for tubing dates and proper storage weekly x 4 weeks then monthly x 2 months Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315264	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0695 SS = D	Continued from page 10 According to the Order Summary Report with active orders as of NJ Ex Order 26.4(b)(1), Resident #65 had the following physician order: NJ Ex Order 26, 4B1 [redacted] Order Date: NJ Ex Order 26, 4B1 A review of the comprehensive care plan revealed that Resident #65 had the following care plan Focus: NJ Ex Order 26, 4B1 [redacted] On 09/22/2025 at 9:21 AM Resident #65 was observed seated in a wheelchair in their room. Resident #65 was NJ Ex Or and did not respond to the surveyor's voice. NJ Ex Order 2 [redacted] On 09/23/2025 at 8:54 AM Resident #65 was observed in bed with the head of bed elevated and eating his/her breakfast meal. The surveyor observed the NJ Ex Order 2 [redacted] on the window side of the bed and not in use. The surveyor observed the NJ Ex Order 26, 4B1 on the floor next to the bed. The NJ Ex Order 26, 4B1 were in direct contact with the floor, not covered, and NJ Ex Order 26, 4B1 [redacted] On 09/23/2025 at 11:13 AM the surveyor entered room of Resident #65 after knocking. Resident #65 was not present. The surveyor observed the NJ Ex Order 26, 4B1 located on the window side of the bed. The NJ Ex Order 26, 4B1 was not in use. The NJ Ex Order 26, 4B1 were observed to be on the floor in the same manner as the previous observation. The NJ Ex Order 26, 4B1 were exposed to NJ Ex Order 26, 4B1 while in contact with the floor. The NJ Ex Order was observed to be dated "NJ Ex Order 26.4(b)." On 09/24/2025 at8:42 AM Resident #65 was observed lying in bed with their eyes closed. NJ Ex Order 26, 4B1 was not in use and the NJ Ex Order 26, 4B1 was observed to be on the floor and NJ Ex Order 26.4(b)(1) The NJ Ex Order [redacted] were in contact NJ Ex Order 26, 4B1 [redacted] At 8:48 AM the surveyor interviewed the U. S. FOIA (b) (2) assigned to Resident	F0695		

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F0695 SS = D	Continued from page 11 #65 for that shift. The [redacted] followed the surveyor into Resident #65's room and told the surveyor that the [redacted] should not be on the floor and that it should be [redacted] when not in use because it as an "infection control issue." The [redacted] removed the [redacted] from the [redacted] and said she was going to replace the [redacted] with a new set. On 09/24/2025 at 11:43 AM during a meeting with facility administration the facility [redacted] told the surveyor that when not in use ([redacted] it should be bagged at the bedside. The surveyor asked the [redacted] why It was important to protect [redacted] equipment when not in use and the [redacted] relied, it is [redacted] to prevent "contamination." A review of the facility provided policy titled Oxygen Administration, date implemented: 9/27/2024, revealed the following under the heading Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. In addition, the following was observed under Policy Explanation and Compliance Guidelines: 4. (d.) Keep delivery devices covered in plastic bag when not in use. N.J.A.C. 8:39- 27.1 (a)	F0695		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to a.) follow a physician's order for medications with a parameter and acceptable professional standards of practice; and b.) follow physician's order to not take [redacted] for 1 of 38 residents (Resident #36) reviewed for medication	F0760	F0760 Immediate corrective action for residents affected by deficient practice: Resident #36 has been discharged. Identify those individuals who could be affected by the deficient practice: All residents receiving medication with hold parameters and with [redacted] have the potential to be affected. A facility wide audit was conducted to ensure that all residents receiving medications with hold parameters and limb restrictions have accurate Medication Administration Records.	11/26/2025

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F0760 SS = E	Continued from page 12 administration. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 9/22/2025 at 10:04 AM, the surveyor reviewed the electronic medical record (EMR) for Resident 26. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Ex Order 26, 4B1 [redacted] A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, 4 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1, which indicated the resident's NJ Ex Order 26, 4B1 . The surveyor requested Resident #36's Pharmacy Consultant Recommendations and Facility Response: NJ Ex Order 26.4(b): Please review order for NJ Ex Order 26, 4 precautions. Documentation shows use of NJ Ex Order 26, 4B1 [redacted]; Medication error(s) noted. NJ Ex Order 26, 4B1 [redacted] Please review.	F0760	Continued from page 12 1:1 education was conducted by the Director of Nursing on 9/22/25 with nurses noted with medication errors identified during this audit Measures put in place to ensure the deficient practice will not occur for those residents affected: Education on Medication hold parameters was reviewed with license nurses was initiated on 9/22/25 by the Assistant Director of Nursing. Education on Limb restrictions was reviewed with license nurses was initiated on 9/24/25 by the Assistant Director of Nursing. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing or designee will audit 2 medical charts for accurate Medication Administration Records (MAR) for residents receiving medications with hold parameters and limb restrictions weekly x 4 weeks then monthly x 2 months Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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F0760 SS = E	Continued from page 13 Facility provided the following response: “Action taken: Staff Educated”. NJ Ex Order 26.4(b): Please review order for NJ Ex Order 26, 4 precautions. Documentation shows use of NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 monitoring; Medication error(s) noted. NJ Ex Order 26, 4B1 is not always held as required by physicians hold order. Please review. Facility provided the following response: “Action taken: Staff Educated”. NJ Ex Order 26.4(b): Please review order for NJ Ex Order 26, 4 precautions. Documentation shows use of NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 monitoring; Medication error(s) noted. Facility provided the following response: “[resident discharged]” A review of Resident #36’s Medication Administration Recor (MAR) included the following physician orders (PO): Vital Signs NJ Ex Order 26, 4B1 NJ Ex Ord review of the EMR, vital sign entries NJ Ex Order 26, 4B1 was obtained from the resident’s NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 A PO, with a start date of NJ Ex Order 26.4(b)(for NJ Ex Order 26, 4B1 Hold if NJ Ex Order 26, 4) NJ Ex Order 26, 4 Upon review of the NJ Ex Order 26 MAR, on the following dates NJ Ex Order 26, 4B1 . Upon review of the NJ Ex O MAR, on the following dates NJ Ex Order 26, 4B1 : NJ Ex Order 26, 4B1 .	F0760		

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F0760 SS = E	Continued from page 14 Upon review of the NJ Ex Order 26, 4B1 MAR, on the following dates NJ Ex Order 26, 4B1 : NJ Ex Order 26, 4B1 On 9/24/2025 at 10:10 AM, the surveyor interviewed Licensed Nurse Practitioner (LPN #1) who confirmed that she was aware that the medication NJ Ex Order 26, 4B1 has patient specific parameters. When asked why the parameters are important with NJ Ex Order 26, 4B1 LPN #1 responded that it was only to be given when resident's NJ Ex Order 26, 4B1 . LPN #1 further explained that if it was given outside of the physician's order then it would be considered a medication error. LPN #1 acknowledged that there was consistent education in the facility regarding medication parameters and the administration of medications. On 9/24/2025 at 10:40 AM, the surveyor interviewed Unit Manager Licensed Practical Nurse (UM/LPN #1) who advised that physician orders are always to be followed. When inquired about the medication NJ Ex Order 26, 4B1 UM/LPN #1 stated that there is always ongoing education regarding physician ordered parameters. UM/LPN #1 confirmed that the medication should not be administered to residents if the NJ Ex Order 26, 4B1 was over the specific parameters. If it was given, then it would be considered a medication error. The surveyor reviewed the EMR documentation regarding the NJ Ex O and parameters to which UM/LPN #1 confirmed that physician orders were not followed. UMLPN #1 further acknowledged that education was consistently provided regarding regarding medication parameters, specifically the medication NJ Ex Order 26, 4B1 On 9/252025 at 9:45 AM, the surveyor interviewed the U. S. FOIA (b) (2) , in the presence of the U. S. FOIA (b) (2) who acknowledged that pharmacy consultant identified that Resident #36's NJ Ex Order 26, 4B parameters and NJ Ex Order 26, 4B1 and that they were not being followed for NJ Ex Order 26.4(b)(1) despite both staff education and facility wide education. A review of the facility's "Medication Administration" Policy, Implemented 9/1/24, included under the heading "Policy Explanation and Compliance Guidelines": […] 8. Obtain and Record vital sings, when applicable or per physician orders, When applicable hold medication for those vital signs outside of the physician's prescribed parameters [...].	F0760		

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F0760 SS = E	Continued from page 15 A review of the facility's "Medication Error" Policy, Implemented 9/27/24, included under the heading "Policy Explanation and Compliance Guidelines": 1. The facility shall ensure a medications will be administered as follows: a. According to Physician's Orders […]; 4. The facility will consider factors indicating errors in medication administration including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order; 8. If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible; b. Monitor and document the resident's condition, including response to medical treatment or nursing interventions; c. Document actions taken in the medical record; d. Once the resident is stable, the nurse report the incident to the appropriate supervisor and completes the incident or occurrence report. N.J.A.C. § 8.39-29.2 (d)	F0760		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F0761	F0761 Immediate corrective action for residents affected by deficient practice: The medication was immediately removed and label appropriately, the discharged resident was contacted and the medication was picked up. Identify those individuals who could be affected by the deficient practice: All residents receiving medication brought in from home have the potential to be affected. A facility wide audit was conducted by the Unit Managers on 9/24/25 to ensure that all medications brought in from home have accurate labeling and storage. No concerns identified Measures put in place to ensure the deficient practice will not occur for those residents affected: Education on Medications brought in from home was reviewed with license nurses was initiated on 9/23/25 by the Assistant Director of Nursing. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur:	11/26/2025

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F0761 SS = D	Continued from page 16 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 store medical supplies in accordance with professional standards, as evidenced by the presence of expired supplies. This deficient practice was identified in 1 of 2 medication storage rooms inspected. The deficient practice was evidenced by the following: On 9/23/2025 at 10:25 AM, the surveyor inspected the [redacted] Unit Medication medication storage room in the presence of Registered Nurse (RN #1) who advised that the nurses are responsible for maintaining the storage room. The surveyor observed inside the locked medication refrigerator a [redacted] The medication did not have a patient's name or dosage. RN #1 confirmed that the medication should have patient's name. On 9/23/2025 at 10:25 AM, the surveyor interviewed Unit Manager Licensed Practical Nurse (UM/LPN #2) who confirmed that the medication was brought in by a resident's family, but they were recently discharged and no longer in the building. UM/LPN #2 confirmed that the medication should be labeled with the resident's name. On 9/24/2025 at 11:44 AM, the surveyor interviewed the [redacted] who acknowledged that the medication should have been identified with a resident's name and administration dosage. A review of the facility's "Medications Brought to the Facility by the Resident/Family" Policy, implemented 10/31/24, included under the heading "Policy Interpretation and Implementation": 1. The facility shall ensure medications will be administered as follows: a. According to Physician's Orders […]; N.J.A.C. § 8:39-29.4 (g)	F0761	Continued from page 16 Director of Nursing or designee will audit 2 medication storage areas for medications brought in from home weekly x 4 weeks then monthly x 2 months Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	F0880 Immediate corrective action for residents affected by deficient practice: 1:1 education was conducted with the [redacted]	11/26/2025

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F0880 SS = D	Continued from page 17 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	Continued from page 17 U. S. FOIA (b) (2) on 9/24/25 by the Unit Manager regarding linen handling and with the U. S. FOIA (b) (2) on 9/23/25 by the Director of Nursing regarding use of PPE with regards to N J Ex Ot Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. A facility wide audit was conducted on 9/24/25 by the Assistant Director of Nursing to ensure that no soiled linen bags were left unsecured in resident areas. No concerns identified Measures put in place to ensure the deficient practice will not occur for those residents affected: Education on Linen handling and Enhanced Barrier Precautions was reviewed with all Direct Care staff was initiated on 9/23/25 by the Assistant Director of Nursing. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing or designee will perform 2 observations of patient care of residents on Enhanced Barrier Precautions weekly x 4 weeks then monthly x 2 months Director of Nursing or designee will perform 2 observations of linen handling weekly x 4 weeks then monthly x 2 months Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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F0880 SS = D	Continued from page 18 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. 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 a.) NJ Ex Order 26.4(b)(1) were appropriately handled in the nursing unit and b.) appropriate Personal Protective Equipment (PPE) was utilized during NJ Ex Order 26, 4B1 round to a resident who required NJ Ex Order 26.4(b)(1)), to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of infection control practice. This deficient practice was identified for 1 unsampled resident (Resident #49) observed during NJ Ex Order 26, 4B1 tour and occurred on 1 of 2 resident units NJ Ex Order 26.4(b) unit), respectively and was evidenced by the following: Reference: “Enhanced Barrier Precautions (EBP) are an infection prevention and control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes, including the routine use of gloves and gowns during all high-contact resident care.” https://www.nj.gov/health/cd/documents/topics/hai/EBP_in_Nursing_Homes_Algorithm.pdf 1.) On 9/23/2025 at 8:38 AM, during an NJ Ex Order 26, 4B1 tour with Certified Nursing Assistant (CNA) #1, the surveyor observed an NJ Ex Or sign on an unsampled resident’s door. The surveyor also observed an untied plastic bag containing linen on the floor next to the PPE bin outside the room. CNA #1 confirmed that the	F0880		

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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
F0880 SS = D	Continued from page 19 content of the bag was NJ Ex Order 26.4(b)(1) from the resident. CNA #1 completed hand hygiene and donned gown and gloves. CNA #1 assisted the resident in the NJ Ex Order 26.4(b) The surveyor observed the resident to be wearing a NJ Ex Order 26, 4B1 connected to a NJ Ex Order 26, 4B1 bag. CNA #1 exposed the resident's NJ Ex Order 26, 4B1 for the surveyor to view. The NJ Ex Order 26, 4B1. CAN #1 continued to assist the resident in NJ Ex Order 26.4(b)(1). The plastic bag containing the NJ Ex Order 26.4(b)(1) remained outside the doorway of the unsampled resident's room. On 9/23/2025 at 11:38 AM, during an interview with the surveyor, the U. S. FOIA (b) (2) stated that NJ Ex Order 26.4(b)(1) needs to be sealed in a plastic bag and goes straight to the dirty utility room. The U. S further stated that nothing stays on the floor. On 9/24/2025 at 11:30 AM, during an interview with the survey team, the U. S. FOIA (b) (2) stated that soiled linen should be sealed in a plastic bag and taken to the soiled utility room at once and not sit on the floor. A review of the facility-provided policy date implemented on 9/27/2024 titled "Handling Soiled Linen" included under Policy Explanation and Compliance Guidelines the following: 4. Used or soiled linen shall be collected at the bedside and placed in a linen bag or designated lined receptacle. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom. 2.) On 9/23/2025 at 9:03 AM, during an NJ Ex Order 26, 4B1 tour with U.S. FOIA (b) (6)), the surveyor observed an NJ Ex O sign outside Resident #49's room. A PPE bin was also observed by the doorway. U. S. FOIA (b) (2) washed their hands and donned gloves but did not put on a protective gown. U. S. FOIA (b) (2) pulled the resident's bed linen and exposed the resident's NJ Ex Orde The surveyor asked U. S. FOIA (b) (2) to NJ Ex Order 2 the NJ Ex Order 26.4(b)(1), too. U. S. FOIA (b) (2) NJ Ex Order the resident to NJ Ex Order 26 and NJ Ex Order 26.4(b)(1 the NJ Ex Order 26, 4B1 . The green NJ Ex Order 26, 4B1 was observed to be NJ Ex Order 26, 4B1. U. S. FOIA (b) (2) NJ Ex Order 26.4(b)(the NJ Ex Or and stated to the surveyor that the resident would get NJ Ex Order 26.4(The surveyor asked U.S. FOIA (b) (6) why the resident was on NJ Ex O U. S. FOIA (b) (2) stated that the resident had an NJ Ex Order 2 On 9/23/2025 at 11:38 AM, during an interview with the surveyor, the U.S stated that staff needs to wear gown and gloves when doing close and prolonged high contact	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315264	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

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COMPLETE CARE AT BEY LEA, LLC	**1351 OLD FREEHOLD ROAD , TOMS RIVER, New Jersey, 08753**

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F0880 SS = D	Continued from page 20 care activities to residents on [redacted] The [redacted] also stated that NJ Ex Order 26, 4B1 is included in the high contact care activities. On 9/24/2025 at 11:30 AM, during an interview with the survey team, the [redacted] stated that NJ Ex Order 26, 4B1 is included in the high-contact activities requiring staff to wear gown and gloves for residents on [redacted] A review of the facility-provided policy date implemented on 9/1/2024 titled " Enhanced Barrier Precautions" included under Definitions: "Enhanced Barrier Precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. N.J.A.C. 8:39 – 19.1 (a) N.J.A.C. 8:39 – 19.4 (a) (c)	F0880		

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		11/20/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint # 414491 Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 21 out of 21 day shifts and 3 out of 21 night shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and	S0560	S0560 Residents affected by deficient practice: No residents were identified Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: All residents were monitored for any adverse effects with none noted. The facility has implemented a competitive market rate for all nursing staff including Registered Nurses. The facility continues to utilize online recruitment with immediate interviews and contingency offers. The Director of Nursing, Unit Managers, Staffing Coordinator and HR Director were re-educated by the Licensed Nursing Home Administrator on the minimum staffing hours plus acuity hours related to in-house census to ensure that sufficient staffing hours are maintained as required. The Director of Nursing, Unit Managers, Staffing Coordinator and HR Director were re-educated by the	11/26/2025

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

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S0560	Continued from page 1 pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One Certified Nursing Assistant (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility as documented below: 1.For the week of Complaint staffing from 07/06/2025 to 07/12/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/06/25 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -07/07/25 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -07/08/25 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/09/25 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/10/25 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/11/25 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/12/25 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. 2.For the 2 weeks of staffing prior to survey from 09/07/2025 to 09/20/2025, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -09/07/25 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs.	S0560	Continued from page 1 Licensed Nursing Home Administrator on the facility policy titled Nurse Services and Sufficient Staff. on 9/25/2025 The facility implemented an expediated but robust onboarding process. The facility will use agency staff as needed to meet staffing, acuity and hours requirements. Facility will continue to participate in a bi-weekly recruitment call to review open positions, recruitment tactics, and changes to improve outcomes. All these efforts will provide an opportunity to meet the required staffing minimums and acuity needs and hours. Measures or systemic changes to ensure that the deficiencies will not reoccur: Administrator/Designee will conduct 2 audits weekly for 4 weeks, then twice monthly for 2 months to ensure adequate staff is scheduled to meet resident needs. The results of the audits will be discussed at the monthly Quality Assurance Performance Improvement Meeting and quarterly over the duration of the audit process(3 months). Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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S0560	Continued from page 2 -09/08/25 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/09/25 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/10/25 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/11/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/13/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/14/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/15/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/16/25 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/17/25 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/18/25 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -09/19/25 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -09/20/25 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. On 9/24/2025 at 9:41 AM, during an interview with Surveyor #1, the Staffing Coordinator (SC) confirmed that they were familiar with the minimum staffing requirements for CNAs. The SC stated that the requirements were 1 CNA to 8 residents on the day shift (7:00 AM until 3:00 PM); 1 CNA to 14 residents on the evening shift (3:00 PM until 11:00 PM); and 1 CNA to 18 residents on the night shift (11:00 PM until 7:00 AM). When asked if the facility was meeting the requirements, the SC responded that they felt the facility was adequately staffed. The SC stated that weekend nursing supervisors work as CNAs if needed and nurses would assist the CNAs when medication administration is completed. If nurses or aids call out, they call employees to see if they want to work and if not, they contact the agency. A review of the facility-provided policy implemented on	S0560		

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S0560	Continued from page 3 9/27/2024 titled “Nursing Services and Sufficient Staff” did not include the minimum requirement for direct care staff.	S0560		

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F0000	INITIAL COMMENTS An offsite/ desk review of the facility's Plan of Correction was conducted on 1/6/2026 in relation to the 11/17/2025 Recertification survey. The facility was found to be in compliance with 42CFR Part 483, Requirements for Long Term Care Facilities.	F0000		01/19/2026

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 reverse for further 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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New Jersey State Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 1/6/2026 in relation to the 11/17/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		01/19/2026

Office of Primary Care and Health Systems Management

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K0000	INITIAL COMMENTS The NJDOH conducted a Life Safety Code survey on 9/23/25 and 9/24/25. The survey was officially completed on 11/17/2025. Complete Care at Bey Lea was found not to be in compliance 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.	K0000		11/20/2025
K0271 SS = E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 9/23/25 in the presence of the[redacted], it was determined the facility failed to ensure abrupt changes in elevation of walking surfaces in means of egress did not exceed 1/4-inch in accordance with NFPA 101: 2012 Edition, Section 7.1.6, 7.1.6.2 and 7.1.10. This deficient practice had the potential to affect 29 of 95 residents and was evidenced by the following: Observations at 10:59 AM of the corridor exterior exit by room 14 exit discharge, revealed the third concrete sidewalk pad was raised approximately 2-inches above the prior second pad and descended approximately 2-inches below the fourth pad, leaving two trip hazards in the path of egress.	K0271	K0271 Immediate corrective action for residents affected by deficient practice: Based on observation and interview on 9/23/25 in the presence of the Maintenance Director it was determined the facility failed to ensure abrupt changes in elevation of walking surfaces in means of egress did not exceed ¼ inch. Observations of the corridor exterior exit by room 14 revealed the third concrete sidewalk pad was raised approximately 2 – inches above the prior 2nd pad and descended approximately 2 inches below the 4th pad, leaving two trip hazards in the path of egress. Maintenance Director repaired the changes in elevation on 11/20/2025 (see attached photo). Identify those individuals who could be affected by the deficient practice: This has the potential to affect 29 residents Measures put in place to ensure the deficient practice will not occur for those residents affected: 1 on 1 education provided by administrator to [redacted] on 11/20/2025 on NFPA 101 on safe discharge from exits and maintaining level walkways and means of egress. Maintenance Director audited all other egress paths on 11/20/2025 to identify any other changes in elevation.	12/22/2025

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 reverse for further 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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K0271 SS = E	Continued from page 1 In an interview at the time, the U. S. FOIA (b) (2) confirmed the observation. The facility's U. S. FOIA (b) was informed of the deficient practice at the Life Safety Code (LSC) exit conference on 9/24/25 at 2:06 PM. The facility's U. S. FOIA (b) (2) was unavailable for the LSC exit conference. N.J.A.C. 8:39 - 31.2 (e)	K0271	Continued from page 1 No other concerns identified Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Maintenance Director and or designee will audit the egress paths for changes in elevation weekly for four weeks and then monthly for two months. All findings will be reported monthly to the QAPI committee. QAPI committee will determine the need for additional monitoring	
K0374 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 STANDARD is NOT MET as evidenced by: Based on observation and interview on 9/23/25 in the presence of the U. S. FOIA (b) (2) it was determined the facility failed to ensure doors in smoke barriers closed the opening, leaving only the minimum clearance necessary for operation in accordance with NFPA 101: 2012 Edition, Section 19.3.7.8, 7.2.1, 7.2.1.15, 8.5.4 and NFPA 105: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 9:39 AM of the double smoke barrier doors by laundry, revealed the right door leaf did not close all the way into its frame when tested by	K0374	K0374 Immediate corrective action for residents affected by deficient practice: Maintenance director on 11/20/25 adjusted the doors at the laundry area to ensure it properly closes to meet proper fire safety measures. See attached photo. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this practice Measures put in place to ensure the deficient practice will not occur for those residents affected: The administrator educated the U. S. FOIA (b) (2) on 11/20/2025 on facility policy regarding fire and smoke doors. The maintenance director audited all other fire and smoke barrier doors on 11/20/2025. No other concerns have been identified. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Maintenance Director and or designee will Audit 4 fire and smoke barrier doors weekly for 4 weeks and then monthly for two months All findings will be reported monthly to the QAPI committee. QAPI committee will determine the need for additional monitoring.	12/22/2025

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K0374 SS = F	Continued from page 2 releasing it from its hold open device. The right door leaf stopped at the outer edge of the left leaf. In this position, the doors would not resist the passage of smoke. In an interview at the time, the [redacted] confirmed the observation. The facility's [redacted] was informed of the deficient practice at the Life Safety Code (LSC) exit conference on 9/24/25 at 2:06 PM. The facility's [redacted] was unavailable for the LSC exit conference. N.J.A.C. 8:39 - 31.2 (e) NFPA 105	K0374		
K0918 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	K0918	K0918 Immediate corrective action for residents affected by deficient practice: Facility had the load bank test completed on 11/25/25 see attached. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice Measures put in place to ensure the deficient practice will not occur for those residents affected: The [redacted] was educated on our generator maintenance policy by the administrator on 11/20/25 specifically on the need for an (annual 90 min load bank test) and the 36 month 4 hour load test. vendor contracted and schedule set to provide our yearly load test as well the 36 month load test. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur:	12/22/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD , TOMS RIVER, New Jersey, 08753

(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
K0918 SS = F	Continued from page 3 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 STANDARD is NOT MET as evidenced by: Based on record review and interview on 9/24/25 in the presence of the U. S. FOIA (b) (2)), it was determined the facility failed to ensure diesel generators that are exercised monthly at loads less than 30% of their nameplate kilowatt (kW) rating are exercised annually with supplemental loads of 50% for 30 minutes and 75% for 1 hour for a total of 1.5 continuous hours in accordance with NFPA 110: 2010 Edition, Section 8.4, 8.4.2(2), 8.4.2.3, 8.4.9, and 8.4.9.1 through 8.4.9.7. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the diesel generator's monthly full load test log revealed the generator was not exercised at 30% or greater of its nameplate kilowatt (kW) rating during the monthly full load tests for 12 the last 12 months which would require an annual 90-minute load bank test be performed as described in NFPA 110. Further record review determined there was no documentation that an annual load bank test was performed in the last 12 months. Additional record review of the last 36 month - 4-hour load test which was conducted on 8/29/24 revealed that during the test, the generator was exercised at 22% of its nameplate kW rating which is under the 30% or greater requirement for the test. The 36 month - 4hour test would have also needed supplemental loads of 30% or if combined with the annual 90-minute test; supplemental loads of 30% for 3 hours and 75% for the last hour. No further documents were provided. In an interview at the time, the U. S. FOIA (b confirmed the record review. The facility's U. S. FOIA (b was informed of the deficient practice at the Life Safety Code (LSC) exit conference on 9/24/25 at 2:06 PM. The facility's U. S. FOIA (b) (2) was unavailable for the LSC exit conference.	K0918	Continued from page 3 The administrator and or designee will audit the generator logs weekly for 4 weeks and then monthly for 2 months for proper compliance. The results of these audits will be reviewed monthly by the QAPI committee. The QAPI committee will determine the need for additional monitoring.	

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K0918 SS = F	Continued from page 4 N.J.A.C. 8:39 - 31.2 (e) NFPA 110	K0918		
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by:	K0923	K0923 Immediate corrective action for residents affected by deficient practice: The facility placed and marked individual racks for full and empty oxygen cylinders. (See attached photo) Identify those individuals who could be affected by the deficient practice: All residents who utilize the therapy gym have the potential to be affected by this deficient practice. Measures put in place to ensure the deficient practice will not occur for those residents affected: Maintenance and therapy departments were educated by the administrator on 11/20/25 on proper oxygen storage, specifically, the separation of full and empty cylinders. The maintenance director conducted an audit on 11/20/25 on all oxygen storage throughout the facility. No concerns were identified. A second dedicated oxygen rack was permanently placed in the gym closet and labeled empty oxygen cylinders. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The maintenance director or designee will audit the oxygen storage in the therapy gym, for compliance with proper storage weekly for 4 weeks and the monthly for 2 months. The results of these audits will be reviewed monthly by the QAPI committee. The QAPI committee will determine the need for additional monitoring.	12/22/2025

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K0923 SS = D Bldg. 01	Continued from page 5 Based on observation and interview on 9/23/25 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to ensure empty oxygen cylinders were marked to avoid confusion and delay if a full cylinder was needed in a rapid manor and if empty and full cylinders are stored within the same enclosure, empty cylinders were segregated from full cylinders in accordance with NFPA 99: 2012 Edition, Section 11.6.5.2, 11.6.5.2.1 and 11.6.5.3. This deficient practice had the potential to affect the 4 residents receiving therapy in the gym at the time observed and was evidenced by the following: Observations at 11:10 AM of the gym oxygen storage closet, revealed there was a sign on the outside to the right of the door that read, "DANGER OXYGEN STORAGE, NO SMOKING, NO OPEN FLAME". On the inside of the closet on the right wall there was a sign that read, "FULL OXYGEN CYLINDERS/ READY FOR USE". On the floor in front of the sign there was a 6 cylinder rack with 6 oxygen cylinders in it. Three of the cylinders were full (in the green at 2000 psi) according to the integral pressure gauge, 2 of the cylinders were empty (in the red) and 1 was at 900 psi. There was only one rack with the one sign provided and no means to identify or separate the empty cylinders. In an interview at the time, the U. S. FOIA (b) (2) confirmed the observation and when asked what was done with the empty cylinders, the [redacted] stated they put the empties in with these. The facility's [redacted] was informed of the deficient practice at the Life Safety Code (LSC) exit conference on 9/24/25 at 2:06 PM. The facility's U. S. FOIA (b) (2) was unavailable for the LSC exit conference. N.J.A.C. 8:39 - 31.2 (e) NFPA 99	K0923		

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E0000	Initial Comments The NJDOH conducted an Emergency Preparedness survey on 9/23/25 and 9/24/25. The survey was officially completed on 11/17/2025. Complete Care at Bey Lea was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		11/20/2025

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 reverse for further 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.

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

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/ desk review of the facility's Plan of Correction was conducted on 1/6/2026 in relation to the 11/17/2025 Recertification survey. Complete Care at Bey Lea was found to be in compliance 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.	K0000		01/19/2026

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