DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES			Г		APPROVED
CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			0	MB NO.	0938-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		315274	B. WING	i			C 09/2023
NAME OF F	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	50/2020
COMPLE	TE CARE AT LAURE	LTON, LLC			175 JACK MARTIN BLVD BRICK, NJ 08724		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F	000			
		ey was conducted on behalf of partment of Health.					
	NJ00159114, NJ00	149749, NJ00158244, 159548, NJ00160165, 0164070 and NJ00166914					
	Survey Dates: 11/0	7/23 to 11/09/23					
	Survey Census: 10	0					
	Sample Size: 6						
	42 CFR PART 483	TH THE REQUIREMENTS OF , SUBPART B, FOR LONG LITIES BASED ON THIS					
	ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 11/22/2023
	nearly orgined						11/22/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			(X2) MULTIPLE CONSTRUCTION (X3) DATI A. BUILDING:			
			A. DUILDING		С	
		061532	B. WING	1/09/2023		
ME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
OMPLE	TE CARE AT LAURE	I TON. I I C	K MARTIN BL NJ 08724	LVD		
X4) ID		TEMENT OF DEFICIENCIES	ID		(X5)	
RÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE DATE	
S 000	Initial Comments		S 000			
	NJ00159114, NJ00	149749, NJ00158244, 159548, NJ00160165, 164070 and NJ00166914				
	Survey Dates: 11/0	7/23 to 11/09/23				
	Survey Census: 10	0				
	Sample Size: 6					
	Standards in the Ne Code, Chapter 8:39 Long Term Care Fa submit a plan of co completion date, fo that the plan is imp deficiencies may re accordance with th Jersey Administrati	a compliance with the ew Jersey Administrative 9, Standards for Licensure of acilities. The facility must rrection, including a ar each deficiency and ensure lemented. Failure to correct esult in enforcement action in e Provisions of the New ve Code, Title 8, Chapter 43E ensure Regulations.	,			
S 560	8:39-5.1(a) Mandat	tory Access to Care	S 560		12/22/2	
		l comply with applicable l local laws, rules, and				
	by: Complaint #: NJ00 NJ00159114, NJ00	NT is not met as evidenced 149749, NJ00158244, 159548, NJ00160165, 164070 and NJ00166914		S 560- 8:39- 5.1(a) Mandatory Access to Care 1. The facility leadership team has met on an ongoing basis and continues to identify		
	Based on review of documentation, it w	f pertinent facility /as determined that the facility	,	staffing challenges and areas of improvement for licensed and certified		

Electronically Signed

STATE FORM

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If continuation sheet 1 of 4

11/22/23

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New Jersey Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:	Now lor	sev Department of H	lealth			FORM APPROVED
Image: Name of Provider or supplier STREET ADDRESS, CITY, STATE, ZIP CODE 11/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMPLETE CARE AT LAURELTON, LLC 475 JACK MARTIN BLVD BRICK, NJ 08724 ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLET DATE	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			COMPLETED
COMPLETE CARE AT LAURELTON, LLC 475 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 (X5) COMPLET DATE			061532	B. WING		
COMPLETE CARE AT LAURELTON, LLC BRICK, NJ 08724 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATECOMPLET DATE	COMPLE	TE CARE AT LAURE			LVD	
	PREFIX	(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETE
 S 560 Continued From page 1 S 560 Continued From page 1 Release the potential to support the state of New Jersey for 17 of 28 day shifts as follows: This deficient practice had the potential to affect all residents. 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 as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes, The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shif. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall sperform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 4 weeks of staffing from 09/20/2023 to 09/02/2023 and 10/22/2023 to 11/04/2023, the staffing Teomy completed by the facility for the day shift to resident for the eads with a direct staff member shall be collad. As per the "Nurse Staffing Report" completed by the facility for the 4 weeks of staffing from 09/20/2023 and 10/22/2023 to 11/04/2023, the staffing to resident for the day shift to resident for the day shift to resident for the ead with the staffing requirement of one CNA to eight residents for the day shift as documented below: 	S 560	failed to ensure sta maintain the require ratios as mandated for 17 of 28 day shi practice had the po Findings include: Reference: New Je (NJDOH) memo, da with N.J.S.A. (New 30:13-18, new mini nursing homes," inc Governor signed in codified as N.J.S.A established minimun nursing homes. The effective on 02/01/2 One Certified Nurse residents for the da member to every 10 shift, provided that shall be CNAs and be signed into work shall perform nurse care staff member night shift, provided member shall sign perform CNA duties As per the "Nurse S the facility for the 4 08/20/2023 to 09/02 11/04/2023, the sta meet the minimum eight residents for the	fing ratios were met to ed minimum staff-to-resident by the state of New Jersey fts as follows: This deficient tential to affect all residents. ersey Department of Health ated 01/28/2021, "Compliance Jersey Statutes Annotated) mum staffing requirements for dicated the New Jersey to law P.L. 2020 c 112, . 30:13-18 (the Act), which im staffing requirements in e following ratio (s) were 2021: e Aide (CNA) to every eight by shift. One direct care staff 0 residents for the evening no fewer of all staff members each direct staff member shall c as a certified nurse aide and e aide duties: and one direct to every 14 residents for the d that each direct care staff in to work as a CNA and s. Staffing Report" completed by weeks of staffing from 2/2023 and 10/22/2023 to ffing to resident ratios did not requirement of one CNA to	S 560	needs. Recruitment efforts includ competitive hiring rates, online advertisements, local community advertisements, market competition on bonus, refer a friend bonus for employees, onsite and on the spe- interview availability, and continu- agency staff to supplement. The also utilizes the assistance of nur- management, physical therapist a occupational therapists to assist direct care as directed by the Dire Nursing. 2. All residents have the potentia affected. 3. The facility has implemented a significantly above market rate for nursing aides including a sign-on when appropriate. The facility cor- utilize online recruitment and job immediate interviews and conting offers. The facility implemented a expediated but robust onboarding process. The facility will use ager as needed to meet current and fu- staffing needs. 4. The Director of Nursing or Des will meet with the staffing coordin to review call outs if any, facility of vs. staffing needs. The Director o or Designee will monitor call outs staffing ratios weekly until the recr is met. Audits will be conducted 3 for 1 month and 5 x monthly for 2 The results of the audit will be for to the Administrator who will repo- results will be sent to the QAPI co- monthly for further review and	ive sign r current ot ed use of center rse and with ector of al to be r certified bonus ntinues to fairs with gency in G ncy staff iture signee pator daily census of Nursing and guirement Bx weekly months. warded or the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
	061532		B. WING		C 11/09/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMPLE				_VD		
		BRICK, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
S 560	Continued From pa	age 2	S 560			
	09/02/2023, the fac	of staffing from 08/20/2023 to sility was deficient in CNA ts on 11 of 14 day shifts as		AUdit Tool in Attachments		
	day shift, required a -08/21/23 had 12 C day shift, required a -08/22/23 had 12 C day shift, required a -08/23/23 had 10 C day shift, required a -08/25/23 had 11 C day shift, required a	CNAs for 106 residents on the at least 13 CNAs. CNAs for 106 residents on the at least 13 CNAs. CNAs for 106 residents on the at least 13 CNAs. CNAs for 109 residents on the at least 14 CNAs. CNAs for 108 residents on the				
	day shift, required a -08/29/23 had 10 C day shift, required a -08/30/23 had 13 C day shift, required a -09/01/23 had 10 C day shift, required a -09/02/23 had 12 C day shift, required a	CNAs for 108 residents on the at least 13 CNAs. CNAs for 109 residents on the at least 14 CNAs. CNAs for 103 residents on the at least 13 CNAs. CNAs for 103 residents on the at least 13 CNAs.				
	from 10/22/2023 to	of staffing prior to survey 11/04/2023, the facility was affing for residents on 6 of 14 s:				
	day shift, required a -10/28/23 had 12 C day shift, required a	NAs for 103 residents on the				

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New Jer	sey Department of H	lealth				APPROVE	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		061532	B. WING			C 09/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
		475 140	K MARTIN BLV				
		BRICK, I	NJ 08724			1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
S 560	Continued From pa	age 3	S 560				
	day shift, required a -11/03/23 had 11 C day shift, required a	NAs for 101 residents on the at least 13 CNAs. NAs for 102 residents on the at least 13 CNAs. NAs for 102 residents on the NAs for 102 residents on the					

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /		DATE OF REVI	SIT		
IDENTIFICATION NUMBER	A. Building				
061532 _{Y1}	B. Wing		Y2	12/22/2023	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		-	
COMPLETE CARE AT LAURELTON, LLC 475 JACK MARTIN BLVD					
		BRICK, NJ 08724			

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM DATE		ITEM		DATE	ITEM		DATE	
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	S0560	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	8:39-5.1(a)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		12/22/2023	LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC _		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC _		_	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
REVIEWE		REVIEWED BY	DATE	SIGNATURE OF	SURVEYOR		DATE	
STATE AG		(INITIALS)						
REVIEWED BY REVIEWED BY CMS RO (INITIALS)		DATE	TITLE		DATE	DATE		
FOLLOWUP TO SURVEY COMPLETED ON 11/9/2023				FOR ANY UNCORRE				s 🗆 no