| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315274 | A. BUILDING _____ B. WING _____ | C 04/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **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 DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>Complaint #: NJ00171995, NJ00179158, NJ00181714, NJ00183557<br><br>Survey Dates: 4/24/25 and 4/29/25<br><br>Survey Census: 118<br><br>Sample Size: 5<br><br>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. | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint #: NJ183557<br><br>Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 04/24/2025 and 04/29/2025, it was determined that the facility failed to follow standards of clinical practice for Physician Orders (POs) for medication administration and follow the Care Plan (CP) interventions for a resident (Resident #5). The facility also failed to follow its policy titled "Medication Administration". This deficient practice was identified for 1of 6 residents | F 658 | Residents affected by deficient practice:<br>The facility failed to follow standards of clinical practice for Physician Orders for medication administration and follow Care Plan interventions for resident #5.<br>Director of Nursing conducted audit on resident #5 to ensure Physician Orders for Medication Administration and Care Plan is being followed.<br>The affected resident #5 was evaluated and NP notified with [redacted] noted.Resident still resides at facility.<br>Residents affected by deficient practice: | 6/6/25 |

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

Electronically Signed | 05/30/2025

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 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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| F 658 | Continued From page 1<br>reviewed for medication administration and was evidenced by the following:<br><br>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."<br><br>According to Resident #5's Admission Record (AR), the resident was admitted with [redacted] ([redacted]) ([redacted]), and [redacted] ([redacted]).<br><br>According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #5 had a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident was [redacted].<br><br>According to Resident #5's CP with a date of [redacted], under "Focus" revealed: Resident #5 requires [redacted] r/t (related to) [redacted], under "Interventions": Give medications as ordered by physician.<br>Monitor/document side effects and effectiveness.<br>. | F 658 | All residents have the potential to be affected.<br>What corrective action will be accomplished for those residents affected by the deficient practice:<br>Facility nursing staff were re-educated by the The Director of Nursing on policy for following Physician Orders, Administering Medications, documentation of Medication Administration, Care Plans and Charting and Documentation.<br>Director of Nursing /Designee audited residents who have an order for Morphine Sulfate.<br>Measures or systemic changes to ensure that the deficiencies will not recur:<br>Director of Nursing/Designee will audit three random resident charts for missed medications, following physician orders, and care plans one time weekly x4 weeks, then monthly x2 months.<br>Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee over the duration of the audit process.<br>Based on the results of these audits, a decision will be made regarding the need to continued submission and reporting. | |

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| F 658 | Continued From page 2<br>According to Resident #2's Order Summary Report (OSR) Active Orders as of NJ Ex Order 26.4(b)(1), the OSR revealed a physician order for the following medication:<br><br>NJ Ex Order 26.4(b)(1) ) Oral NJ Ex Order 26.4(b)(1) . Give NJ Ex Order 26.4( by mouth four times a day for NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) at 04:00 A.M., 09:00 A.M, 01:00 P.M, 05:00 P.M with a start date of NJ Ex Order 26.4(b)<br><br>Review of Resident #5's Electronic Medication Administration Record (eMAR) showed medication was not administered on the following date and time.<br><br>NJ Ex Order 26.4(b)(1) ) Oral NJ Ex Order 26.4(b)(1) . Give NJ Ex Order 26.4(b) by mouth four times a day for NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) at 04:00 A.M.<br><br>Review of Resident #5's Individual Patient NJ Exec Order 26.4b1 Administration Record (declining inventory used for NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) there was no evidence of administration on the date above.<br><br>The U.S. FOIA (b) (6) ) who did not administer Resident #5's NJ Ex Order 26.4(b)(1) was unable to be reached for an interview during the survey.<br><br>On 04/24/2025, at 01:53 P.M., during an interview with the surveyor, the U.S. FOIA (b) (6) stated medication should be administered within the ordered time frame and the order is verified. She further stated, if a resident refuses medications staff should document the refusal via eMAR and progress notes. She stated blank eMAR would indicate someone didn't sign and | F 658 | | |

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| F 658 | Continued From page 3<br>that means the medication was not given.<br><br>On 04/274/2025, at 2:49 P.M., during an interview with the surveyor, the U.S. FOIA (b) (6) ), "We don't expect blanks on a MAR. Expectation is that my staff should do the five rights of med (medication) administration."The U.S. FOIA (b said if a medication is administered, it should be immediately documented by the administering nurse in the resident's eMAR. She further stated facility policy is to document all medications and there should be no blank spaces. When presented with Resident #5's eMAR for NJ Ex Order 26.4(b) , the U.S. FOIA (b confirmed the blank space for NJ Ex Order 26.4(b)(1) and that the medication was not given as ordered.<br><br>Review of the facility policy titled "Medication Administration" with an implemented date of 09/01/2024 under "Policy" reveals: "medications are administered by licensed nurses, or staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." Under "Policy Explanation and Compliance Guidelines": #21. Sign MAR after administered. For those medications requiring vital signs, record vitals onto the MAR. | F 658 | | |
| F 727 SS=D | NJAC 8:39- 11.2 (b)<br>RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility | F 727 | | 6/6/25 |

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| F 727 | Continued From page 4<br>must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint #: NJ183557<br><br>Based on interview and review of facility documents on 5/22/25, it was determined that the facility failed to ensure a Registered Nurse (RN) worked for at least eight consecutive hours a day for 1 of 21 days reviewed. This deficient practice was evidenced by the following:<br><br>Review of the "Nurse Staffing Reports" completed by the facility for the weeks of 02/09/25 through 02/15/25, 04/06/2025 through 04/12/2025, and 04/13/2025 through 04/119/25, revealed that the facility had no RN coverage for all shifts on 02/09/25<br><br>The surveyor reviewed the facility's policy titled "Nursing Services and Sufficient Staff" updated 03/05/25 which indicated, " It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility's census, acuity and diagnoses | F 727 | Residents affected by deficient practice:<br>Facility failed to ensure a Registered Nurse (RN) worked for at least eight consecutive hours a day for 1 of 21 days.<br>Residents affected by deficient practice:<br>All residents have the potential to be affected.<br>No residents were effected.<br>What corrective action will be accomplished for those residents affected by the deficient practice:<br>The Facility continues to actively fill all open Registered Nurse positions to comply with Federal Nursing Regulation to have at 8 consecutive hours a day, 7 days a week.<br>Staff requirements and facility policy were reviewed with Human Resources and Staffing Coordinator, who were able to reiterate Registered Nurse minimum staffing requirements.<br>The facility is taking the following measures to ensure this deficient practice does not occur. The facility focused on recruitment and retention strategies as following: identify vacant Registered | |

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| F 727 | Continued From page 5<br>of the resident population will be considered based on the facility assessment."<br><br>NJAC 8:39-25.2(h) | F 727 | Nurse positions daily and attempt to fill positions with current Registered Nurses staff or agency; work diligently with Administrator, Director of Nursing and Corporate Recruiter to advertise, recruit and hire sufficient Registered Nurse staff.<br>Measures or systemic changes to ensure that the deficiencies will not recur:<br>Administrator/Designee to audit schedule weekly x 4 weeks to ensure 8 hours, 7 days of week of Registered Nurse coverage.<br>Administrator/designee to conduct compliance audits on effectiveness of hiring strategies to include open Registered Nurses, reporting on new hires, successful strategies-to-hire, and implementation of employee retention programs. The duration of all audits will consist of completion one-time weekly x 4 weeks then three-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. | |

New Jersey Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061532 | A. BUILDING: _____ B. WING _____ | C 04/24/2025 |

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| S 000 | Initial Comments<br><br>The facility was not in compliance with the standards in the New Jersey Administrative code, 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. | S 000 | | |
| S 560 | 8:39-5.1(a) Mandatory Access to Care<br><br>The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint #: NJ00171995, NJ00179158, NJ00181714, NJ00183557<br><br>Based on interviews and review of facility documents on 03/11/2025 and 03/12/2025, it was determined that the facility failed to ensure staffing ratios were met for 1 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents.<br>Findings include:<br><br>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 | S 560 | Residents affected by deficient practice:<br>The facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey.<br>Identify those individuals who could be affected by the deficient practice:<br>All residents have the potential to be affected by this deficient practice. All residents were monitored for any adverse effects of the deficient practice with none noted.<br>What corrective action will be accomplished for those residents affected by the deficient practice: | 6/6/25 |

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

Electronically Signed | 05/30/25

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| S 560 | Continued From page 1<br>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:<br><br>One Certified Nurse Aide (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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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.<br><br>For the week of Complaint staffing from 02/09/2025 to 02/15/2025, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:<br><br>On 02/09/25 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs.<br><br>On 02/10/25 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs.<br><br>On 02/13/25 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs.<br><br>On 02/14/25 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs.<br><br>On 02/15/25 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs.<br><br>For the 2 weeks of staffing prior to survey from | S 560 | The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Human Resource Director, who was able to reiterate minimum staffing requirements for nursing homes The facility is taking the following measures to ensure this deficient practice does not occur. The facility is focusing on recruitment and retention strategies as following: identify vacant positions daily and attempt to fill positions with current CNA staff or agency; work diligently with Administrator, Director of Nursing and Corporate Recruiter to advertise, recruit and hire sufficient CNA staff; continue to develop programs to attract Nursing Assistants including sign-on bonuses', shift bonuses, etc.; work with CNA class instructors to identify potential students; promote in-house programs to increase retention of current staff.<br>Measures or systemic changes to ensure that the deficiencies will not recur: Administrator/designee to conduct compliance audits on effectiveness of hiring strategies to include open CNA and Licensed Nurse positions, hires, successful strategies-to-hire, and implementation of employee retention programs. The duration of all audits will consist of completion one-time weekly x 4 weeks then three-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these | |

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| | 061532 | A. BUILDING: _____ B. WING _____ | C 04/24/2025 |

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| S 560 | Continued From page 2<br>04/06/2025 to 04/19/2025, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows:<br><br>On 04/06/25 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs.<br><br>On 04/09/25 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs.<br><br>On 04/11/25 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs.<br><br>On 04/14/25 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs.<br><br>On 04/15/25 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs.<br><br>On 04/16/25 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs.<br><br>On 04/18/25 had 13 CNA s for 113 residents on the day shift, required at least 14 CNAs. | S 560 | audits, a decision will be made regarding the need for continued submission and reporting. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 315274 Y1 | A. Building<br>B. Wing Y2 | 6/6/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMPLETE CARE AT LAURELTON, LLC | 475 JACK MARTIN BLVD<br>BRICK, NJ 08724 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix F0658 | Correction | ID Prefix F0727 | Correction | ID Prefix | Correction |
| Reg. # 483.21(b)(3)(i) | Completed | Reg. # 483.35(b)(1)-(3) | Completed | Reg. # | Completed |
| LSC | 06/06/2025 | LSC | 06/06/2025 | 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 |
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| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |
|---|---|
| 4/24/2025 | ☐ YES ☐ NO |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 061532 Y1 | A. Building<br>B. Wing Y2 | 6/6/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMPLETE CARE AT LAURELTON, LLC | 475 JACK MARTIN BLVD<br>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 Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix S0560 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 8:39-5.1(a) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 06/06/2025 | 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 | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |
|---|---|
| 4/24/2025 | ☐ YES ☐ NO |