STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315252	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Bayshore LLC	**715 NORTH BEERS STREET , HOLMDEL, New Jersey, 07733**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ2968468, NJ2803658, NJ2708767, NJ2618514, NJ2596284 Survey Dates: 4/14/2026 - 4/16/2026 Survey Census: 142 Sample Size: 5 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		05/11/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an	F0641	What corrective action was accomplished for residents affected by the deficient practice? Resident # 1 was affected by this deficient practice. The MDS (Minimum data set) Coordinator corrected and submitted a modified assessment correcting the inaccuracies. This was completed on 4/16/26. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with MDS submissions have the potential of being affected by this deficient practice. An audit of the last 30 days of MDS was conducted on all other residents by the Regional Clinical Reimbursement Director, no other inaccurate information noted, this was completed by 5/15/26. 3. What measures will be put in place or systemic changes are made to ensure that the deficient practice will not recur?	05/16/2026

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315252	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0641 SS = D	Continued from page 1 individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to ensure the "Minimum Data Set (MDS)" assessments were accurately coded to reflect the resident's clinical status regarding [redacted] for one of five sampled residents (Resident (R) 1) reviewed for resident assessment. This failure had the potential to affect care planning, infection risk management, and the provision of necessary services. Findings include: Review of R1's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed R1 was admitted to the facility on [redacted] with diagnoses that included [redacted] Review of R1's"MDS" with an Assessment Reference Date (ARD) of [redacted], located in the EMR under the "MDS" tab, revealed R1 was coded as having an [redacted]. Review of physician orders, treatment records, and nursing documentation found in the EMR revealed no evidence that R1 had an [redacted] during the assessment period. During an interview on 04/16/26 at 12:24 PM, the [redacted] stated that a [redacted] entered incorrect information in the point of care system, which was subsequently used to complete the "MDS" without verification. Review of the facility's policy titled, "MDS 3.0 Completion," revised 01/01/21, indicated that all disciplines were to follow the guidelines in Chapter 3	F0641	Continued from page 1 [redacted] was in-serviced by the Regional Clinical Reimbursement Director. On Thursday 5/14/26 on the importance of ensuring accurate coding on the MDS assessments. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Regional Clinical Reimbursement Director or designee will audit 10 MDS submissions every 2 weeks for 1 month, then 10 monthly for 3 months. Audits results will be brought to the Quality Assurance and Performance Improvement (QAPI) committee to ensure that the facility's correction for the deficient practice will not recur. The QAPI Committee meets monthly.	05/16/2026

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F0641 SS = D	Continued from page 2 of the Resident Assessment Instrument (RAI) Manual when coding assessments. Review of the October 2024 RAI Manual, page 1-5, revealed, ". . . An accurate assessment requires collecting information from multiple sources . . . information obtained should cover the same observation period . . . and should be validated for accuracy (what the resident's actual status was during the observation period) by the interdisciplinary team completing the assessment."	F0641		05/16/2026

New Jersey Department of Health

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S0000	Initial Comments COMPLAINT #: NJ2968468, NJ2803658, NJ2708767, NJ2618514, NJ2596284 CENSUS: 142 SAMPLE SIZE: 5 The facility was 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		05/11/2026
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 #: NJ2968468, NJ2803658, NJ2708767, NJ2618514, NJ2596284 Based on interviews and review of facility documents on 04/16/2026, it was determined that the facility failed to ensure staffing ratios were met. 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.	S0560	Residents affected by deficient practice: The facility failed to comply with applicable Federal, State, and local laws, rules, and regulations by not ensuring staffing ratios were met. No residents were identified to be affected by this deficient practice. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: The Administrator, Director of Nursing, and Staffing Coordinator were re-educated on the minimum staffing requirements. The facility has contracted with multiple staffing agencies to supplement their staff for the missing shifts to meet the staffing ratios. Measures or systemic changes to ensure that the deficiencies will not recur:	05/16/2026

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S0560	Continued from page 1 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 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. The facility was not compliant with the following: For the two weeks of staffing prior to the complaint survey from 03/29/2026 to 04/11/2026, the facility was deficient in CNA staffing for residents on 12 of 14-day shifts. On 03/29/26, the facility had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. On 03/30/26, the facility had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. On 03/31/26, the facility had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. On 04/01/26, the facility had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. On 04/02/26, the facility had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 04/03/26, the facility had 15 CNAs for 139 residents on the day shift, required at least 18 CNAs. On 04/05/26, the facility had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. On 04/06/26, the facility had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs. On 04/07/26, the facility had 16 CNAs for 137 residents on the day shift, required at least 17 CNAs. On 04/08/26, the facility had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs. On 04/09/26, the facility had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 04/10/26, the facility had 14 CNAs for 140	S0560	Continued from page 1 The administrator/designee will participate in a weekly call for 3 months with a recruitment team to review open positions and recruitment tactics to improve hiring outcomes to meet the required staffing ratio. The Administrator/designee will review the staffing sheets daily to ensure compliance with the staffing ratios. Results of audit will be shared by administrator or designee and reviewed with the IDT team at the Monthly Quality Assurance Meetings and any recommended actions will be implemented, as necessary.	05/16/2026

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S0560	Continued from page 2 residents on the day shift, required at least 17 CNAs.	S0560		05/16/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 05/20/2026 in relation to the 04/16/2026 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 05/20/2026 in relation to the 04/16/2026 State of New Jersey Complaint 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		

Office of Primary Care and Health Systems Management

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