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 05/08/2026

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 Complaint #: NJ 3005438 Survey Date: 5/8/26 Census: 144 Sample: 29 + 2 Closed Records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		05/23/2026
F0800 SS = F	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure staff responsible for the facility food and nutrition services necessary had the skills and competencies to ensure a) the facility was maintained in a clean and sanitary manner, b) the mechanical dish machine was functioning appropriately, c) menus were followed to ensure appropriate portion sizes were provided and recipes were utilized to ensure nutritional adequacy of the food served, and d) residents received appetizing meals. The deficient practice affected all residents who resided in the facility, placed the residents at potential nutritional risk, and at risk for potential foodborne illness. The evidence was as follows: Refer to: F803, F804, F812	F0800	FACILITY RESPONSE Completion (X5): 06/05/2026 Element #1 The U. S. FOIA (b) (2) was promptly trained by the Regional Director to ensure that the staff responsible possess the necessary skills and competencies to maintain a clean and sanitary facility, as well as to ensure that the dishwasher is functioning properly. Additionally, the menus and portion sizes must adhere to the recipes to guarantee the nutritional adequacy of the food being served, ensuring that the residents receive appetizing meals. Element #2 Because the deficient practice had the potential to affect all residents receiving meals, the facility conducted a department review that included: Observation of all meal services for accuracy, temperature, portion sizes, and completeness. Re-education of the U. S. FOIA (b) (2) on all State and	06/18/2026

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 05/08/2026

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
F0800 SS = F	Continued from page 1 On 05/3/26 from 6:28 PM-7:00 PM, the surveyor conducted an initial tour of the kitchen with the U. S. FOIA (b) (2) and observed debris and soiled areas in the walk in refrigeration units, the food storage areas, on storage racks, on the ceiling, and on exterior of equipment, tables and the ice machine. The surveyor also observed the dish machine was in use. Food preparation items, and dishware were placed in the machine by one person and another removing the clean items. The surveyor, in the presence of the U. S. FOIA, observed that as the racks containing dishware were being placed through the machine, the wash temperature was 147 degrees Fahrenheit (F) and also observed at 146 F. When the surveyor asked the U. S. FOIA what the temperature requirement was for the wash cycle, the U. S. FOIA stated 150 F, and the U. S. FOIA stated that "our log has 150 F, and I am going to go with that." At that time the surveyor asked for the temperature log for the dish machine and the staff pointed to an empty clipboard affixed to the wall. At that time, the surveyor continued to watch the staff place dishes through the dish machine which was 146 F, 145 F and 147 F, and the surveyor then asked where the plaque was located that was affixed to the dish machine that provided the manufacturer specifications to run the dish machine. The U. S. FOIA did not respond to the surveyor and the surveyor then bent down and observed the specification plaque affixed to the machine with the chemical company name and model and serial number of the machine which documented: Hot Water Sanitizing 160F, Minimum Wash Tank Temperature … When the surveyor showed the U. S. FOIA the plaque and then asked the U. S. FOIA if 150 F for the wash temperature would have met the manufacturer temperature requirements, the U. S. FOIA stated she was going to make the machine a low temperature machine. The U. S. FOIA said she was going to put it in "chemical sanitizing mode" and took a bottle of chemical and was setting up the chemical attached to the machine. When again asked if the 150 F was meeting the 160 F requirement, the U. S. FOIA confirmed it was not because it was at 149 F. On 5/3/26 at 7:30 PM, the surveyor interviewed Resident #69 and Resident #75 in their room. When asked about the meals both residents stated the food "was NJ Ex Order 26.4(b)(1)," the hot food was served cold and the "NJ Ex Order 26.4(b)(1)." Resident #69 also stated they were on a NJ Ex Order 26.4(b)(1)	F0800	Continued from page 1 Federal mandated in-services by the U. S. FOIA (b) (2) completed on 5/29/2026. Review of all kitchen sanitation areas, including walk-ins, dry storage, equipment, and tray line processes. Daily check of the dishwasher for correct temperatures recorded three times a day. Element #3 All dietary staff were educated by the U. S. FOIA (b) on 5/29/2026: Manufacturer dish machine temperature requirements. Menu compliance, portion control, and use of standardized scoops and appropriate temperatures of food and recipes are followed to ensure all food is appetizing and appealing. Required use of recipes. A full sanitation schedule was implemented for walk-ins, storage racks, equipment exteriors, ceilings, and ice machine areas. The U. S. FOIA or designee will complete daily sanitation rounds. U. S. FOIA (b) (2) took and passed his National Serv Safe Manager Exam on 5/6/26 Element #4 To ensure continued compliance, The Food Service Director/Designee will conduct a sanitation, dish machine, menu, recipe and portion control audit Five (5) days a week for 4 weeks, then three (3) days a week for 4 weeks, then (1) per week on a weekly sanitation audit. Results of these audits will be presented at the facility's monthly QAPI Committee meetings by the FSD or designee for further	06/18/2026

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 05/08/2026

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
F0800 SS = F	Continued from page 2 On 5/4/26 at 10:33 AM, the surveyor conducted a resident council meeting with 10 residents, and 10 of 10 residents stated they did not receive the foods that they selected, did not receive complete meals and one resident stated that they only received a bowl of broccoli as a dinner meal, and all ten residents stated the hot food was delivered cold. On 5/4/26 at 11:45 AM, the surveyor observed the menu posted in the [redacted] hallway that indicated the lunch meal was cheese ravioli with meat sauce, mixed vegetables and cinnamon apple slices, and then observed Residents #69 and #75 were in their room with their lunch trays in front of them. When asked Resident #75 about their lunch meal, which consisted of a plate of cheese ravioli and meat sauce and a small hot dog on the side. There were no vegetables and a small peanut butter and jelly sandwich was wrapped in plastic wrap and sliced apples were in a cup, with 4 ounces of skim milk. Resident #75 stated [redacted] " The residents stated they did not select those items and did not have a copy of the menu in the room. Resident #69 had a flat pancake shaped reddish item on their tray that as touching a white flat pancake shaped item, the Diet Ticket was labeled [redacted]: " peanut and butter and jelly sandwiches- 2." Resident #69 stated that they had a [redacted]. When asked what was on the tray, the resident had no idea and stated, [redacted] " On 05/5/26 at 10:57AM, the surveyor interviewed the [redacted] in the kitchen regarding the meals that were prepared. The [redacted] stated he was mostly the breakfast and lunch [redacted]. The surveyor asked the [redacted] if he also prepared the [redacted] items and the [redacted] confirmed that he also prepared the [redacted] meals. The surveyor asked if the [redacted] utilized recipes for the [redacted] foods and he stated, "No." When asked how he would know how to make the [redacted] the [redacted] stated it was basically "product water and [redacted] When asked if the menus were new, the [redacted] stated, that "we just converted to a new company" and showed the surveyor the menus and explained he used them to show what had to be prepared for each item regarding the specialized diets, and he confirmed that he did not have recipes, and he stated he knew how to cook. The [redacted] stated that the new menus started the previous month and when asked how he had prepared the [redacted] for the current meal, he stated he added chicken, product and [redacted]. When asked if the [redacted] food	F0800	Continued from page 2 recommendations or corrective action to be determined by the Interdisciplinary Team.	06/18/2026

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 05/08/2026

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
F0800 SS = F	Continued from page 3 should be [NJ Ex Order] he stated that it should not be [NJ Ex Orde] and be [NJ Ex Order 26.]. On 5/5/26 at 11:06 AM, a person interjected themselves into the interview with the [U. S. FOIA] and when asked who he was, he stated he was the U. S. FOIA (b) (2) of the new food service company and he was responsible for the kitchen, and stated they had recipes. The [U. S. FOIA] entered the kitchen from the office and placed a large book down on the counter by the [U. S. FOIA] and stated, "she needed to make a change and the recipe book was in her office." The surveyor went back to interview the [U. S. FOIA b] regarding the book provided and he confirmed that he had not been provided that recipe book. On 5/5/26 at 11:18 AM, during the tray line production in the kitchen the surveyor observed the tray line in progress and staff confirmed the main meal was teriyaki chicken, steamed rice, broccoli and bread and there was [NJ Ex Order 26.4(b)(1)]. All the modified consistency items had a 2- ounce blue handled scoop. On the tray line and surveyor asked the U. S. FOIA (b) (2) what the portions for the [NJ Ex Orde] items were. The U. S. FOIA (b) (2) interjected and stated, "all protein should be 2 ounces" and the surveyor asked why one of the [NJ Ex Orde] items had a four-ounce scoops in the steam table, and the [U. S. FOIA] stated, "all 2oz scoops for everything." The [U. S. FOIA] then told the staff to have all blue 2-ounce scoops and the [U. S. F] told the [U. S. FOIA] they did not have that many, and the [U. S. FOIA] then told the [U.S. F] to change it to a 2-ounce scoop. The first tray was removed the meal truck on the [NJ Ex Order 26] unit at 11:37 AM, and the last tray at 11:46 PM. The U. S. FOIA (b) (2) from the new company observed the surveyor during the test-tray observation. The surveyor asked him what the temperature standards when the food was served to the resident and he stated the cold food was 40 degrees Fahrenheit (F) in the kitchen and the hot food was 135 degrees F in the kitchen. The [U.S. FO] did not respond when asked what the temperatures of the food should be when it reached the residents. The juice and milk were 54 degrees Fahrenheit (F) per the [U. S. FOIA] thermometer, and the surveyor tested the milk and juice which was 53 F per the surveyor's thermometer. When asked to provide a copy of the policy for food temperatures, the [U.S. FOIA] exclaimed, "palatability is not a policy!" The surveyor then placed a teaspoon into the top of the [NJ Ex Order 26.4(b)], which was [NJ Ex Orde] and the spoon stuck straight up and did not move. The surveyor then	F0800		06/18/2026

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 05/08/2026

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
F0800 SS = F	Continued from page 4 asked the [U. S. FO] if that was supposed to be the consistency of the [NJ Ex Order] rice? The [U. S. FO] did not respond to the surveyor's inquiry. On 5/5/26 at 11:56 AM, the surveyor immediately went to Resident #69 and #75's room who had their lunch meals in front of them. When asked about the food, Resident #75, had only a piece of chicken on their plate and stated, "NJ Ex Order 26.4(b)(1) [redacted]" Resident #75 stated, they never received what they ordered and they never get copies of the menus to confirm what they ordered. Both meal tickets were reviewed, and Resident #75 stated, [NJ Ex O] [redacted] When asked if the milk and juice were at a good temperature, both residents stated, NJ Ex Order 26.4(b)(1) [redacted]." There was 4 ounces of milk on the tray, although 8 ounces was printed on the meal ticket. On 5/5/26 at 1:30 PM, the surveyor interviewed the U. S. FOIA (b) (2) [redacted] The surveyor shared the concerns regarding the meal observations and asked both what their involvement was with the oversight of the Dietary Department. Both stated they were not involved with the Dietary Department (DD), which was a new management company, other than providing preferences to the DD and were responsible to provide the nutrition assessments and other services to the residents. On 05/6/26 at 10:31 AM, the surveyor conducted a telephone call with the dish machine [U. S. FOIA (b) (2)] [redacted] who stated he was contacted on 5/3/26 by the facility to look at the dish machine due to temperature issues and conducted a service call the following day. The [U. S. FO] stated he provided routine service to the dish machine and had never been made aware of temperature issues by the facility prior to 5/3/26. The [U. S. FO] also confirmed that the minimum dish machine wash temperature should be 160 F per manufacturer specification, per the plaque. When asked if placing a chemical sanitizer on the machine and placing it in low temperature mode would fix the issue with the improper wash temperature, the [U. S. FO] stated that adding the chemical "had nothing to do with the wash temperature" and stated that would only work as a high temperature rinse override, using a sanitizer, and the high temperature rinse was not malfunctioning. The [U. S. FO] then confirmed that the wash temperature was not functioning at the appropriate level, which would affect the machine's ability to clean the soiled items. The [U. S. FO] provided the surveyor with a copy of a Service Visit Report	F0800		06/18/2026

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 05/08/2026

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
F0800 SS = F	Continued from page 5 for the 4/5/26 visit that revealed Request Description: Temperature at 149 F. Service Comments: "I increased the washer heating element. We verified after that, that the wash cycle was running at 160+ F." On 05/5/26 at 1:56 PM, both the U. S. FOIA (b) (2) were again interviewed regarding the menus and recipes used by the facility and asked if they reviewed and approved them for nutritional adequacy. They both stated that the facility should be using recipes for consistency and nutritional adequacy. When asked if the residents who required altered consistency foods such as puree, should be provided with smaller portions, the U. S. FOIA stated, "no, it should be equal." When asked who was responsible for overseeing the menus and ensuring they were nutritionally adequate, The U. S. FOIA stated they were not involved, but the management company should have someone review the menus. On 5/6/26 at 12:43 PM, the U. S. FOIA (b) (2) for the facility brought the U. S. FOIA (b) (2) the contracted U. S. FOIA (b) and the U. S. FOIA (b) employee file and any education that was requested by the surveyor. When asked the U. S. FOIA (b) her role with the U. S. FOIA (b) Department, she started, "I am an attorney" The surveyor asked what qualifications, training and competencies the U. S. FO had to ensure appropriate oversight of the Dietary Department. When asked the U. S. FOIA (b) if the U. S. FO had formal education, the U. S. FOIA (b) stated the U. S. FO did not have a degree, and that she trained the U. S. FO. When asked what training she provided, she stated she was a U. S. FOIA (b) (2) and she trained him on how to complete a kitchen walk -through (for sanitation purposes). When asked if the U. S. FO had any nationally recognized training in food service sanitation, the U. S. FOIA (b) stated "his Serve Safe" was expired. The training provided by the U. S. FOIA (b) included online training for discrimination, harassment in the workplace, bloodborne pathogens, preventing back injuries, standard precautions and there were no other training, competencies or education provided. On 05/06/26 at 1:23 PM, the surveyor conducted a telephone interview with the U. S. FOIA (b) (2)) who stated she oversaw a team of U. S. FOIA (b) (2) who wrote the menus for a separate company that the Food Management company contracted with to purchase menus. The U. S. FOIA stated she was familiar with menu requirements for the population at the facility. The	F0800		06/18/2026

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 05/08/2026

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
F0800 SS = F	Continued from page 6 U. S. FOIA stated she worked only for the menu company and was not affiliated with the U. S. FOIA (b) (2) company, and she was the one that certified the nutritional adequacy of the menu by signing them. When asked if she communicated at all with the facility, she stated that the menus were changed only if they were “not locked”, otherwise the facility was responsible for following the menu program and must contact the company via an 800 number to make any changes. When asked if her company provided recipes for the menus, she confirmed that there were recipes provided for the menus, including for the modified diets. When asked if it was important to follow the menus, the U. S. FOIA stated there “were very specific recipes and the methodology to prepare the items, it is important to use the recipes, otherwise you won’t get a standardized product and that would affect the nutritional quality of the menus.” When asked if it was important to provide 8 ounces of milk vs. 4 ounces, she stated, “Yes”, and that her company wrote the menus, and it was “up to the facility to comply” with them. The U. S. FOIA confirmed that “compliance of the menus was facility based.” The U. S. FOIA stated if the menu was provided as written, the facility “has to comply” and it was the responsibility of their corporate oversight to monitor the facility compliance. The U. S. FOIA further stated that “my signature certifies that the menu meets the nutritional requirements” and the compliance is up to the facility to monitor. On 05/08/26 at 10:09 AM, the survey team informed the U. S. FOIA (b) (2) of the above concerns. On 05/08/26 at 1:18 PM, during the exit conference no additional pertinent information was provided. A review of the FSD jobs description signed 3/28/26 revealed. As the FSD, you are responsible for the management, supervision and direction of the food service staff and program within the facility. In addition, the FSD is responsible for ... planning and preparing of appealing and nutritious, heart-health, tasteful, fresh, food for residents and guests ...Essential Job Functions included ...ensures established sanitation and safety standards are maintained. A review of the DM's job description revealed Primary Duty: manages multiple facilities ...according to ..federal/state requirements. Provides	F0800		06/18/2026

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 05/08/2026

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
F0800 SS = F	Continued from page 7 leadership, support and guidance to ensure that dietary quality standards ...are met. Ensures that all required in-services are provided and documented for each employee in area of responsibility. Is able to perform the job assignments of the FSD, Dishwasher Cook, Dietary Aide .... Education and Experience and equivalent combination of education, training and experience will be considered. Bachelor degree in management or related field is highly preferred. Must be able to successfully complete regulatory compliance courses and identify issues and implement necessary changes. Two years experience in dietary services in a healthcare environment and personnel supervision is required. must have considerable knowledge of dietary safety/sanitation requirements and procedures. NJAC 8:39-17.4(a)3	F0800		06/18/2026
F0803 SS = F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.	F0803	The U. S. FOIA (b) (2) was immediately in-serviced by the District Manager of Food Services on 5/5/2026 on ensuring staff follow proper dietary recipes, diet spreadsheets and ensuring all food items on the spreadsheets were offered to the residents according to their needs. Element #2 Residents residing in the facility have the potential to be affected. A one-time audit was done on 5/15/2026 of all residents to ensure their meal tray matched the menu and tray ticket and portion sizes were appropriate. Element #3 The Menu Meets Residents Needs/Prepared in Advanced policy was reviewed by Administration on 5/29/2026 and deemed appropriate for education. The Food Service Director educated The Dietary Department on following correct diet spreadsheets and producing correct food items that correspond with the menu and portion sizes. Element #4 To ensure continued compliance, The FSD/Designee will conduct weekly meal tray audits to ensure the meal matches the menu and portion sizes (5) times a week for four (4) weeks, then once (1) per week monthly thereafter for 3 months. Results of these audits will be presented by the FSD or designee at the facility's monthly QAPI Committee meetings for further recommendations or corrective actions.	06/18/2026

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 05/08/2026

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
F0803 SS = F	Continued from page 8 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure a process was in place to ensure that menus and recipes were followed and appropriate portion sizes were provided to the residents. This deficient practice was identified for 10 of 10 residents who attended a resident council meeting and for Resident #69 and Resident #75 reviewed for food, and was evidenced by the follwoing: On 5/3/26 at 7:30 PM, the surveyor interviewed Resident #69 and Resident #75 in their room. When asked about the meals both residents stated the food "NJ Ex Order 26.4(b)(1) " the hot food was served cold and the "NJ Ex Order 26.4(b)(1) ." Resident #69 also stated they were on NJ Ex Order 26.4(b)(1) . On 5/04/26 at 10:33 AM, the surveyor conducted a resident council with 10 residents, and 10 of 10 residents stated they did not receive the foods that they selected, did not receive complete meals and, and one resident stated that they only received a bowl of broccoli as a dinner meal, and all ten residents stated the hot food was delivered cold. On 5/4/26 at 11:45 AM, the surveyor observed the menu posted in the NJ Ex Order 26 hallway that indicated the lunch meal was cheese ravioli with meat sauce, mixed vegetables and cinnamon apple slices, and then observed Residents #69 and #75 were in their room with their lunch trays in front of them. When asked Resident #75 about their lunch meal, which consisted of a plate of cheese ravioli and meat sauce and a small hot dog on the side. There were no vegetables and a small peanut butter and jelly sandwich was wrapped in plastic wrap and sliced apples were in a cup, with 4 ounces of skim milk. Resident #75 stated NJ Ex Order 26.4(b)(1) " The residents stated they did not select those items and did not have a copy of the menu in the room. Resident #69 had a flat pancake shaped reddish item on their tray that as touching a white flat pancake shaped item, the Diet Ticket was labeled NJ Ex Order 26.4(b)(1) : "NJ Ex Order 26 peanut and butter and jelly sandwiches- 2." Resident #69 stated that they had a NJ Ex Order 26. 4B1 . When asked what was on the tray, the resident had no idea and stated, NJ Ex Order 26.4(b)(1) " On 05/05/26 at 10:57AM, the surveyor interviewed the U. S. FOIA P in the kitchen regarding the meals that were prepared. The U. S. FOIA P stated he was mostly the	F0803		06/18/2026

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 05/08/2026

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
F0803 SS = F	Continued from page 9 breakfast and lunch [redacted]. The surveyor asked the [redacted] if he also prepared the [redacted] items and the [redacted] confirmed that he also prepared the [redacted] meals. The surveyor asked if the [redacted] utilized recipes for the [redacted] foods and he stated, "No." When asked how he would know how to make the purees, the [redacted] stated it was basically "[redacted]." When asked if the menus were new, the [redacted] stated, that "we just converted to a new company" and showed the surveyor the menus and explained he used them to show what had to be prepared for each item regarding the specialized diets, and he confirmed that he did not have recipes. The [redacted] stated that the new menus started the previous month and when asked how he had prepared the [redacted] for the current meal, he stated he added chicken, product and [redacted]. When asked if the [redacted] food should be [redacted] he stated that it should not be [redacted] and be [redacted]. The [redacted] again stated that he was not provided with a recipe book, but he knew how to [redacted] On 5/5/26 at 11:18 AM, during the tray line production the surveyor observed the tray line in progress and staff confirmed the main meal was teriyaki chicken, steamed rice, broccoli and bread and there was [redacted]. All the modified consistency items had a 2- ounce blue handled scoop. On the tray line and surveyor asked the [redacted] what the portions for the puree items were. The [redacted] interjected and stated, "all protein should be 2 ounces" and the surveyor asked why one of the puree items had a four-ounce scoop, the [redacted] stated, "all 2oz scoops for everything." The [redacted] then told the staff to have all blue 2-ounce scoops and the [redacted] told the [redacted] they did not have that many, and the [redacted] then told the [redacted] to change it to a 2-ounce scoop. On 5/5/26 at 11:56 AM, the surveyor immediately went to Resident #69 and #75's room who had their lunch meals in front of them. When asked about the food, Resident #75, had only a piece of chicken on their plate and stated, [redacted] Resident #75 stated, they never received what they ordered and they never get copies of the menus to confirm what they had ordered. Both meal tickets were reviewed, and the resident stated, [redacted]" When asked if the milk and juice were at a good temperature, both residents stated, [redacted]." There was 4 ounces of milk on the tray, although 8 ounces was printed on the meal ticket.	F0803		06/18/2026

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 05/08/2026

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
F0803 SS = F	Continued from page 10 On 5/5/26 at 1:30 PM, the surveyor interviewed the U. S. FOIA (b) (2) The surveyor shared the concerns regarding the meal observations and asked both what their involvement was with the oversight of the Dietary Department. Both stated they were not all involved with the Dietary Department (DD) which was a new management company, other than providing preferences to the DD and were responsible only to provide the NJ Ex Order 26. assessments and other clinical services to the residents. On 05/05/26 at 1:56 PM, both the U. S. FOIA (b) (2) were again interviewed regarding the menus and recipes used by the facility and asked if they reviewed and approved them for nutritional adequacy. They both stated that the facility should be using recipes for consistency and nutritional adequacy. When asked if the residents who required altered consistency foods such as puree, should be provided with smaller portions. The U. S. FOIA stated, “no, it should be equal.” When asked who was responsible to oversee the menus and ensure they were nutritionally adequate, the U. S. FOIA stated they were not involved, but the management company should have someone to review the menus. On 5/6/26 at 9:21 AM, the facility provided the surveyor with the Menus and Spreadsheets for the menus (portion size breakdown for nutritional adequacy) which was originally requested on 5/3/26 during the entrance conference. The menu revealed 2% milk was listed. The spreadsheets revealed the Chicken Teriyaki Puree was a 3-ounce portion, The NJ Ex Orde rice, and NJ Ex Orde broccoli was listed as a #8 scoop (4-ounce portion), mashed potato was listed as 4-ounce portion and there were no NJ Ex Orde hot dog and a bun listed. None of the items were 2-ounce portion sizes as stated by the U. S. FOIA. A further review of the Spreadsheets revealed that 8 ounces of milk was served with breakfast and lunch. On 05/06/26 at 1:23 PM, the surveyor conducted a telephone interview with the U. S. FOIA (b) (2) who stated she oversaw a team of Dietitians who wrote the menus for a separate company that the Food Management company contracted with to purchase the menus. The U. S. FOIA stated she was familiar with menu requirements for the population at the facility. The U. S. FOIA stated she worked only for the menu company	F0803		06/18/2026

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 05/08/2026

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
F0803 SS = F	Continued from page 11 and was not affiliated with the Food Service Management company. She confirmed that she was the one that certified the nutritional adequacy of the menu by signing them. When asked if she communicated at all with the facility to change menus, etc., she stated that the menus were changed only if they were "not locked", otherwise the facility was responsible for following the menu program and must contact the company via an 800 number to make any changes. When asked if her company provided recipes for the menus, she confirmed that there were recipes provided for the menus, including for the modified diets. When asked if it was important to follow the menus, the U. S. FOIA stated there "were very specific recipes and the methodology to prepare the items, it is important to use the recipes, otherwise you won't get a standardized product and that would affect the nutritional quality of the menus." When asked what the menus were based off of to ensure nutritional adequacy, she stated that the menus were based off of the Recommended Dietary Intakes from the National Food and Nutritional Board. She stated that the base meal pattern was for 6 ounces of edible protein per day, 5-1/2 Cups of fruits and vegetables, 3 Vitamin A sources per week, 5-6 servings of gran/starches and 2-3 cups of milk daily. When asked if it was important to provide 8 ounces of milk vs. 4 ounces, she stated, "Yes", and that her company wrote the menus, and it was "up to the facility to comply" with them. The U. S. FOIA confirmed that "compliance of the menus was facility based." The U. S. FOIA stated if the menu was provided as written, the facility "has to comply" and it was the responsibility of the facility corporate oversight to monitor the facility compliance. The U. S. FOIA further stated that my signature certified that the menu met the nutritional requirements and the compliance was up to the facility to monitor. When explained the observations of a 2-ounce scoop being used for the NJ Ex Order chicken vs. the #6 scoop that was listed for the -- -Ex Order chicken. She stated the #6 scoop was a 2/3rd cup (5.3 ounces) portion, and if the facility used a 2-ounce scoop instead that would "change the nutritional adequacy of what they were offering" and they would not meet the protein requirement. The U. S. FOIA (b) stated the scoop sizes were also larger for casserole. The U. S. FOIA stated the facility "needed to utilize the recipes and the menu as written to ensure that the nutritional adequacy of the menus. The U. S. FOIA stated the facility U.S. FOIA could also review the menus. On 05/08/26 at 10:09 AM, the survey team informed the U. S. FOIA (b) (2)	F0803		06/18/2026

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 05/08/2026

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
F0803 SS = F	Continued from page 12 the U. S. FOIA (b) (2) services of the above concerns. On 05/08/26 at 1:18 PM, during the exit conference, no additional pertinent information was provided. The Person Centered Dining provided by the facility for the management company revealed: What we know...The elderly are at risk for weight loss, malnutrition, dehydration, and skin breakdown... NJAC 8:39-17.4(a)3	F0803		06/18/2026
F0804 SS = F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure that foods were prepared utilizing standardized recipes and ensure that meals were provided to residents at an appetizing temperature. The deficient practice occurred for 10 of 10 residents who attended a residents council meeting, for 2 of 2 residents reviewed for food (Resident #69 and Resident #75) and affected the nutritional adequacy and consistency of all foods served and affected all residents who resided at the facility. The deficient practice was evidenced by the following: Based on observation, interview and document review it was determined that the facility failed to ensure that foods were prepared utilizing standardized recipes and ensure that meals were provided to residents at an appetizing temperature. The deficient practice occurred for 10 of 10 residents who attended a residents council meeting, for 2 of 2 residents reviewed for food (Resident #69 and Resident #75) and affected the nutritional adequacy	F0804	Element #1 The U. S. FOIA (b) (2) was immediately in-serviced on 5/5/2026 by the District Manager on proper serving procedures to help ensure optimal food temperatures at service and that recipes are in place. U. S. FOIA (b) (2) held a food committee meeting on 5/27/2026 to discuss all concerns and update preferences as needed. Element #2 All residents residing in the facility have the potential to be affected. Registered Dietician completed an audit on all residents' nutritional status on 5/29/2026 to ensure no signs or symptoms of nutritional status change. Element #3 The Food Palatability policy was reviewed by Administration on 5/29/2026 and deemed appropriate for education. The Food Service Director educated The Dietary Department on 5/29/2026 on the proper serving procedures to help ensure optimal food temperatures at service and all recipes are followed. Element #4 To ensure continued compliance, The FSD/Designee will conduct weekly random palatability audits (5) times a week for four (4) weeks, then once (1) per week monthly thereafter for 3 months, to ensure proper food temperatures for resident palatability. Results of these audits will be presented by the FSD or designee at the facility's monthly QAPI Committee meetings for further recommendations or corrective actions.	06/18/2026

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 05/08/2026

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
F0804 SS = F	Continued from page 13 and consistency of all foods served and affected all residents who resided at the facility. The deficient practice was evidenced by the following: On 5/3/26 at 7:30 PM, the surveyor interviewed Resident #69 and Resident #75 in their room. When asked about the meals both residents stated the food [NJ Ex Order 26.4(b)(1)] " the hot food was served cold and the [NJ Ex Order 26.4(b)(1)]." Resident #69 also stated they were on a [redacted] diet. On 5/04/26 at 10:33 AM, the surveyor conducted a resident council with 10 residents, and 10 of 10 residents stated they did not receive the foods that they selected, did not receive complete meals and, and one resident stated that they only received a bowl of broccoli as a dinner meal, and all ten residents stated the hot food was delivered cold. On 5/4/26 at 11:45 AM, the surveyor observed the menu posted in the [NJ Ex Order 26] hallway that indicated the lunch meal was cheese ravioli with meat sauce, mixed vegetables and cinnamon apple slices, and then observed Residents #69 and #75 were in their room with their lunch trays in front of them. When asked Resident #75 about their lunch meal, which consisted of a plate of cheese ravioli and meat sauce and a small hot dog on the side. There were no vegetables and a small peanut butter and jelly sandwich was wrapped in plastic wrap and sliced apples were in a cup, with 4 ounces of skim milk. Resident #75 stated "[NJ Ex Order 26.4(b)(1) [redacted]" The resident stated they did not select those items and did not have a copy of the menu in the room. Resident #69 had a flat pancake shaped reddish item on their trat that as touching a white flat pancake shaped item, the Diet Ticket was labeled [NJ Ex Order 26.4(b)(1) [redacted]: "[NJ Ex Order 26] peanut and butter and jelly sandwiches- 2." Resident #69 stated that they had a [NJ Ex Order 26. 4B1] [redacted] When asked what was on the tray, the resident had no idea and stated, [NJ Ex Order 26.4(b)(1) [redacted]" On 05/05/26 at 10:57AM, the surveyor interviewed the [U. S. FOIA (b] in the kitchen regarding the meals that were prepared. The [U. S. FOIA (b] stated he was mostly the breakfast and lunch [U. S. FOIA]. The surveyor asked the [U. S. FOIA] if he also prepared the [NJ Ex Orde] items and the [U. S. FOIA] confirmed that he also prepared the [NJ Ex Orde] meals. The surveyor asked if the [U. S. FOIA] utilized	F0804		06/18/2026

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 05/08/2026

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
F0804 SS = F	Continued from page 14 recipes for the [NJ Ex Orde] foods and he stated, "No." When asked how he would know how to make the purees, the [U. S. FOIA (b] stated it was basically "[NJ Ex Order 26] When asked if the menus were new, the [redacted] stated, that "we just converted to a new company" and showed the surveyor the menus and explained he used them to show what had to be prepared for each item regarding the specialized diets, and he confirmed that he did not have recipes. The [U. S. FOIA] stated that the new menus started the previous month and when asked how he had prepared the [NJ Ex Orde] for the current meal, he stated he added chicken, product and [NJ Ex Order 26.4(b)(1)] When asked if the [NJ Ex Orde] food should be [NJ Ex Order 2] he stated that it should not be [NJ Ex Orde] and be [NJ Ex Order 26.4] The [U. S. FOIA (b] again stated that he was not provided with a recipe book, but he knew how to cook. On 5/5/26 at 11:18 AM, during the tray line production the surveyor observed the tray line in progress and staff confirmed the main meal was teriyaki chicken, steamed rice, broccoli and bread and there was a [NJ Ex Orde] hot dog. All the modified consistency items had a 2- ounce blue handled scoop. On the tray line and surveyor asked the [U. S. FOIA (b) (2)] what the portions for the puree items were. The [U. S. FOIA (b) (2)] interjected and stated, "all protein should be 2 ounces" and the surveyor asked why one of the [NJ Ex Order 26.4(b)(1)] had a four-ounce scoop, the [U. S. FOIA] stated, "all 2oz scoops for everything." The [U. S. FOIA] then told the staff to have all blue 2-ounce scoops and the [U. S. F] told the [U. S. FOIA] they did not have that many, and the [U. S. FOIA] then told the [U. S. FO] to change to a 2-ounce scoop. The DA plated out 2-ounce services of [NJ Ex Orde] rice, [NJ Ex Orde] chicken, [NJ Ex Orde] hot dog and [NJ Ex Orde] broccoli and the [NJ Ex Orde] hot dog [NJ Ex Order 26.4(b)(1)] and were touching. A 4-ounce container of milk and 4 ounce container of juice was also on the test tray that was sent to the [NJ Ex Order 26] unit. Upon the last tray served to the residents the surveyor tested the temperatures. The test meal arrived at 11:35 AM on [NJ Ex Order 26.] The first tray was removed at 11:37 AM, and the last tray at 11:46 PM and the [U. S. FOIA (b) (2)] from the new company observed the surveyor during the test-tray observation. The surveyor asked him what the temperature standards when the food was served to the resident and stated the cold food was 40 degrees Fahrenheit (F) in the kitchen and the hot food was 135 degrees F in the kitchen. The [U. S. FO] did not respond when asked what the temperatures of	F0804		06/18/2026

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 05/08/2026

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
F0804 SS = F	Continued from page 15 the food should be when it reached the residents. The juice and milk were 54 degrees Fahrenheit (F) per the U. S. FO's thermometer, and the surveyor tested the milk and juice which was 53 F per the surveyor's thermometer. When asked to provide a copy of the policy for food temperatures, the U. S. FO exclaimed, "palatability is not a policy!" Then the surveyor then placed a teaspoon into the top of the puree rice, which was thick, and the spoon stuck straight up and did not move. The surveyor then asked the U. S. FO if that was supposed to be the consistency of the NJ Ex Orde rice? The U. S. FO did not respond to the surveyors inquiry. On 5/5/26 at 11:56 AM, the surveyor immediately went to Resident #69 and #75's room who had their lunch meals in front of them. When asked about the food, Resident #75, had only a piece of chicken on their plate and stated, "who serves just a piece of chicken?" Resident #75 stated, they never received what they ordered and they never get copies of the menus to confirm what they ordered. Both meal tickets were reviewed, and the resident stated, "we never get full trays." When asked if the milk and juice were at a good temperature, both residents stated, "they are not cold, and that they would like it served cold." Resident #69 had two NJ Ex Orde items on their tray and a peanut butter and jelly sandwich, although the ticket has NJ Ex Orde peanut butter and jelly. Resident #69 asked again, they are not given a coffee with sugar?" They can drink coffee; they can select their menu and never get what they select and no one comes to review the menus with them. Resident #69's meal plate had a NJ Ex Order 26.4(b)(1) on the plate, both touching one another and the ticket had NJ Ex Order 2 hot dog and a bun, and NJ Ex Order 2 roll hand checked with a checkmark on the meal ticket. Resident #75 had Chicken Teriyaki checked off in the manner as Resident #69's meal ticket and streamed rice and broccoli were not checked off. On 5/6/26 at 9:21 AM, the facility provided the surveyor with the Spreadsheets for the menus (portion size breakdown for nutritional adequacy) which had been requested since 5/3/26. The spreadsheets revealed the Chicken Teriyaki Puree was a 3-ounce portion, The NJ Ex Orde rice, and NJ Ex Orde broccoli was listed as a #8 scoop (4 ounce portion), mashed potato was listed as 4 ounce portion and there was no puree hot dog and a bun listed. None of the items were 2-ounce portion sizes as stated by the U. S. FOM. On 05/06/2026 at 1:23 PM, the surveyor conducted	F0804		06/18/2026

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 05/08/2026

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
F0804 SS = F	Continued from page 16 an interview with the U. S. FOIA (b) (2)) who stated she oversaw a team o U. S. FOIA (b) (2) who writes the menus for a separate company that the Food Management company contracted with to purchase menus. The U. S. FOIA (b stated she was familiar with menu requirements for the population at the facility. The U. S. FOIA stated she worked only for the menu company and was not affiliated with the facility Food Service Management company and she was the one that certified the nutritional adequacy of the menu by signing them. When asked if she communicated at all with the facility, she stated that the menus were changed only if they were not locked, otherwise the facility was responsible for following the menu program and must contact the company via an 800 number to make any changes. When asked if her company provided recipes for the menus, she confirmed that there were recipes provided for the menus, including for the modified diets. When asked if it was important to follow the menus, the U. S. FOIA stated there "were very specific recipes and the methodology to prepare the items, it is important to use the recipes, otherwise you won't get a standardized product and that would affect the nutritional quality of the menus." On 05/08/26 at 10:09 AM, the survey team informed the U. S. FOIA (b) (2) of the above concerns. On 05/08/26 at 1:18 PM, during the exit conference no additional pertinent information was provided. The Food Palatability policy, dated 7/14/25 revealed: Standard: Food will e prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form and texture to meet residents' needs. Guidelines: 1. The Dining Services Director and Cooks are responsible for food preparation.Menj items are prepared according to the menu, production guidelines, and standardized recipes. 3. The Proper portion sizes must be served per the menu based on volume or weight of size listed. NJAC 8:39-17.4(1-3)	F0804		06/18/2026

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 05/08/2026

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
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to ensure a) that equipment used to clean dishes and other kitchen items was utilized per manufacturer's specifications for temperature, b) foods were stored in a manner to prevent potential foodborne illness, and c) the kitchen environment and equipment was maintained in a clean and sanitary manner to prevent contamination from foreign substances and limit the potential for the development a foodborne illness. This deficient practice affected all residents who resided at the facility and was evidenced by the following: On 05/03/26at 6:28 PM-7:00 PM, the surveyor conducted an initial tour of the kitchen with the U. S. FOIA (b) (2) and observed the following: -The gasket on first walk in refrigerator had a blackened soiled gasket with embedded debris and blackened areas around the gasket. When asked if had been cleaned, The U. S. FOIA stated, "No, it needed to be cleaned and replaced."	F0812	Element #1 The U. S. FOIA (b) (2) was immediately in-serviced by the District Manager of Dietary Services on 5/29/2026 on proper kitchen sanitation. The gaskets on all walk-ins were deep cleaned and added to the cleaning schedule. The ceiling vents above the exterior of the walk-in door were cleaned by maintenance. The ceiling tiles in the area by the walk-in refrigerator were cleaned by maintenance. The gray fan grate inside of the walk-in refrigerator was cleaned by maintenance. The walk-in refrigerators were deep cleaned. New racks have been ordered and installed for the walk-in refrigerator and dry storage. The ceiling light, ceiling, and walls of the walk-in have been deep cleaned. The box of raw cabbage was immediately disposed of. The hand-washing sink was cleaned and is maintained daily. The bin, metal table, and surrounding floor area were immediately cleaned and sanitized. The contents of the bin were inspected to ensure no contamination occurred. The exterior of the ice machine and the vent area were immediately cleaned and sanitized. The ice machine was inspected to ensure no contamination of the ice supply occurred. The dented cans were immediately removed from inventory and placed in a designated "Do Not Use – Dented/Compromised" area for disposal. All canned goods were inspected on 5/29/2026 for additional dents or damage. Staff received an in-service on 5/29/2026 on proper receiving, inspection, and segregation of compromised cans. The icing container was immediately discarded due to improper labeling and potential contamination.	06/18/2026

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 05/08/2026

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
F0812 SS = F	Continued from page 18 -There ceiling vents above the exterior of the walk-in refrigerator door that had embedded dust like dark debris. -The ceiling tiles in the area by the walk-in refrigerator and extending into the kitchen -The gray fan grate inside of the walk-in had visible debris embedded on and inside the holes of the grate. -The racks that held the food inside the walk-in had areas of blacked embedded debris and the [redacted] stated "we try to clean then one timer per week." -The 2nd walk-in refrigerator contained several racks with the metal visibly peeled several Racks in walk in visibly rusted and missing and peeled off finish from the racks. The [redacted] stated, "I will tell [the U. S. FOIA (b) (2) [redacted] -The elongated ceiling light inside the walk-in refrigerator had caked on black debris, in addition To the ceiling blackened areas. -There was a blue colored container that was visibly soiled with blackened color debris throughout that contained raw cabbage and did not contain any dates. -The floor underneath the food shelves had what appeared to be black splotched "mold-like" and yellow in appearance and was climbing up the back wall. -The hand washing sink in the kitchen, soiled with debris inside sink and embedded by foot pedals. -A white bin labeled rice and had debris on the outside of the bin, and debris was also on the metal table under the bin and there was darkened areas on the floor. -Splatters observed on ceiling tiles by the food	F0812	Continued from page 18 All other open food items in dry storage were reviewed for proper labeling and cleanliness. Staff were re-educated on 5/29/2026 on proper labeling requirements A manufacturer-authorized mechanic was on-site the following morning and repaired the equipment. The dish machine was restored to high-temperature operation, consistently achieving ≥160°F wash temperature in accordance with manufacturer specifications. Dish machine temperatures (wash and rinse) will be recorded at least once per meal service on a standardized temperature log. Logs will be maintained on a designated clipboard located at the dish machine, ensuring accessibility and visibility. The FSD or designee will review dish machine temperature logs daily for accuracy and compliance. Element #2 All residents residing in the facility have the potential to be affected. The Food Service Director conducted full kitchen sanitation rounds and inspected all food items for proper label and dating on 5/29/2026. Element #3 The Food Service Director of Dietary Services educated The Dietary Department on 5/29/2026 on the proper sanitation and proper food storage to prevent potential foodborne illness and reviewed job responsibilities with the team. Element #4 To ensure continued compliance, The FSD will conduct a sanitation audit five (5) days a week for 4 weeks, then three (3) days a week for 4 weeks, then once (1) per week on a weekly sanitation audit. Results of these audits will be presented by the FSD or designee at the facility's monthly QAPI Committee meetings for further recommendations or corrective actions.	06/18/2026

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 05/08/2026

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
F0812 SS = F	Continued from page 19 preparation area of the kitchen. -The exterior of the ice machine bin had splatters on the exterior and the vent area of the ice machine had caked on dust like debris. -The dry storage room had three visibly dented vanilla pudding cans on the can rack. When the surveyor showed the cans to the [redacted] and asked why the dented cans were on the racks. The [redacted] stated, "oh it was on the dented can rack" and then physically moved the cans to another rack without any other cans, or labeled dented cans, and did not acknowledge that the dented cans were stored with the regular cans. -The metal racks that were used to store the food in the dry storage area were visibly soiled with embedded debris throughout on various areas of the racks. -A large container of vanilla icing was stored on a shelf in the dry storage area with icing that was visibly caked outside of the container which was labeled (opened 4/20/26) and did not contain a use by date. -The dish machine was in use and the surveyor observed food preparation items, and dishware being placed in the machine by one person and another removing the items. The surveyor, in the presence of the [redacted] observed that as the racks containing dishware were being placed through the machine, the wash temperature was 147 degrees Fahrenheit (F) and 146 F. When asked the [redacted] what the temperature requirement was for the wash cycle, the [redacted] stated 150 F, and the [redacted] stated that "our log has 150 F, and I am going to go with that." At that time the surveyor asked for the temperature log for the dish machine and the staff pointed to an empty clipboard affixed to the wall. At that time, the surveyor continued to watch the staff place dishes through the dish machine which was 146 F, 145 F and 147 F, and the surveyor then asked where the plaque was located that was affixed to the dish machine that provided the manufacture specifications to run the dish machine. The [redacted] did not respond to the surveyor and the surveyor then bent down and observed the specification plaque affixed to the machine with the chemical company name and model and serial number of the machine	F0812		06/18/2026

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 05/08/2026

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
F0812 SS = F	Continued from page 20 which documented: Hot Water Sanitizing 160F, Minimum Wash Tank Temperature ... When the surveyor showed the U. S. FOIA the plaque and then asked the U. S. FOIA if 150 F for the wash temperature would have met the manufacturer temperature requirements, the U. S. FOIA stated she was going to make the machine a low temperature machine. When again asked if the 150 F was meeting the 160 F requirement, the U. S. FOIA confirmed it was not because it was at 149 F. On 05/06/26 at 10:31 AM, the surveyor conducted a telephone interview with the U. S. FOIA (b) (2) who stated he was contacted on 5/3/26 by the facility to look at the dish machine due to temperature issues and conducted a service call the following day. The U. S. FO stated he provided routine service to the dish machine and had never been made aware of temperature issues by the facility prior to 5/3/26. The U. S. F also confirmed that the minimum dish machine wash temperature should be 160 F per plaque, and he stated the chemical had nothing to do with the wash temperature, only the rinse temperature override which was not malfunctioning. The U. S. FO confirmed that the wash temperature was not functioning at the appropriate level which would affect the cleaning of the items. He stated that he had never been contacted prior to 5/4/26 about the wash temp not meeting requirements. When asked about the U. S. FOIA running a chemical override when she found out that the machine was not working to meet the wash temperatures, he stated that the chemical "had nothing to do with the wash temperature", that was only for the rinse temp override and confirmed it was not meeting requirements. The U. S. FO provided the surveyor with a copy of a Service Visit Report for the 4/5/26 visit that revealed Request Description: Temperature at 149 F. Service Comments: “I increased the washer heating element. We verified after that, that the wash cycle was running at 160+ F.” On 05/08/26 at 10:09 AM, the survey team met with the U. S. FOIA (b) (2) nd reviewed the above concerns. On 05/08/26 at 12:29 PM, during the exit conference, no additional information was provided. NJAC 8:39-27.1(g)	F0812		06/18/2026

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 05/08/2026

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
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices;	F0865	Element 1 All QAPI's identified in the 2567 were reviewed and revised to ensure each has a specific problem and measurable goal. Element 2 All residents have potential to be affected by the deficient practice Element 3 All QAPIs were audited for proper completion. The facility leadership was re-educated on 5/29/2026 by the Vice President of Quality and Performance Improvement on the QAPI Plan and how to properly complete a QAPI. A new QAPI template was implemented to capture metrics. The facility will identify issues through the following feedback channels resident council, grievances, staff town hall meetings, leadership rounds, and the visitor feedback kiosk. Element 4 The Vice President of Quality and Performance Improvement will audit the QAPI's monthly for 3 months. The results of the audits will be discussed at the monthly QAPI meeting.	06/16/2026

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 05/08/2026

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
F0865 SS = F	Continued from page 22 §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure	F0865		06/16/2026

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 05/08/2026

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
F0865 SS = F	Continued from page 23 of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility failed to maintain a comprehensive and documented Quality Assurance Program (QAPI) and a process was in place to demonstrate the facility made good faith attempts to identify and prioritize potential issues related to resident care and services, and to track and measure performance at QAPI. The deficient practice affected all residents that resided at the facility and was evidenced by the following: Refer to: F605, F607, F677, F 684, F689, F695, F755, F761, F800, F803, F804, F812, F919 On 05/08/26 at 9:43 AM, the surveyor requested the Quality Assurance Performance Improvement (QAPI) to bring in the documents from the U. S. FOIA (b) (2) [redacted] so he may discuss with the survey team. On 05/08/26 at 11:04 AM, the U. S. FOIA (b) (2) [redacted]) returned to discuss QAPI. The U. S. FOIA (b) [redacted] stated the facility had quarterly QAPI meetings with all the vendors and included the department heads and U. S. FOIA (b) (2) [redacted] and provided the sign in sheets for the last three quarters of the quarterly QAPI meeting and the most recent quarterly meeting was 4/10/26. for the most When he asked the U. S. FOIA (b) [redacted] if he had any QAPI plans related to the implementation of the new dietary management company and new systems, he stated there were none and confirmed that the took over the dietary operations NJ Ex Order 26.4(d)(1 [redacted] prior in NJ Ex Order 26.4(d)([redacted]. When asked to explain the process, the U. S. FOIA (b [redacted] stated that during the daily morning meetings the facility identified issues, and through the grievance process. When asked if the facility tracked and trended the grievances. The U. S. FOIA (b [redacted] asked what that meant, and he stated they also had a kiosk where people could report grievances and staff could also report	F0865		06/16/2026

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 05/08/2026

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
F0865 SS = F	Continued from page 24 grievances. The surveyor further explained and asked if the facility identified any trends from the grievance process and where they were brought to the QAPI team. The [redacted] stated there was no QAPI related to grievance concerns. The surveyor asked the [redacted] to discuss all the current QAPI initiatives and he stated: 1. Antibiotic Stewardship. 2. Employee files incomplete; a review of the QAPI plan dated 3/5/26 revealed "it was discovered that a significant number of employee files were incomplete…" The problem and goal were not specific and measurable. When asked the [redacted] confirmed it was not and that it should be specific and measurable. 3. Maintenance conducted a QAPI related to blocked areas and was dated 4/6/26. The problem was "leaving supplies in front of utility panels." The QAPI was completed on 4/8/26 and was not specific and measurable. 4. A QAPI related to completing dialysis forms in their entirety. And the [redacted] confirmed there was nothing else related to dialysis, including ensuring that medications were provided around the dialysis schedule as identified during the survey. 5.Trayline accuracy- was not specific as the problem statement was "Tray line each position has a responsibility to try to honor the client request each time" and was not specific ore measurable. 6.Minimu Data Set coding inaccuracy- was not specific and measurable. 7.Activity staff recruitment. 8.Weight changes completed by the [redacted] was specific and measurable. 9.Missing physician visits. 10.Call bell response time had no data and root cause was "not enough staff." There was nothing presented by the [redacted] related to functioning call bells or timely [redacted] 11. Therapy with inconsistent splints 12.Personal Needs Accounts.	F0865		06/16/2026

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 05/08/2026

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
F0865 SS = F	Continued from page 25 13.Director Of Nursing- Medication hold parameters- not specific. 14.Lab report. 15.Pharamacy report- not related to expired medications found on survey. 16. Annual Education. 17. Nurse Aide Assignments. 18.Trayline accuracy- not related to preferences. Specific or measurable. 19.All CNA Tasks 20.GG coding on the Minimum Data Set. 21.Employee Physicals. 22.Admisisons 23.Bed hold 24.Activity assessments were not specific or measurable and related to one-to-one visit books not being completed. 25.Hoyer lifts-in front of doors 26.In house pressure wounds, the problem statement was “in house pressure wounds” not measurable, and goal was to reduce by 1%. 27.Air mattress in proper settings 28.Nurse aide not reporting skin breakdown. 29.Facility Assessment. 30.Fire Alarm Education. 31.Nursing report communication. 32.Code/Post all residents. 33.Environmental. 34.Elopement. 35.Wet nesting in kitchen. There was nothing related to sanitation, dish machine, new menus, or recipes. 36: Late meals.	F0865		06/16/2026

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 05/08/2026

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
F0865 SS = F	Continued from page 26 The surveyor asked the [U. S. FOIA (b)] if the facility tracked and trended significant events, and the [U. S. FOIA (b)] stated, "no." On 05/08/26 at 10:09 AM, the survey team met with the U. S. FOIA (b) (2) [redacted] nd reviewed the above concerns. On 05/08/26 at 12:29 PM, there was no actional information provided prior to the survey exit. The QAPI Program Plan Revised 12/19/25 revealed the Purpose: The QAPI plan outlines the five core elements of the QAI program. Quality assurance and performance improvement principles drive decision making within our organization. Decisions are made that promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions. Focus areas include all systems, processes and outcomes that affect resident and family satisfaction, the quality of care and services provided … NJAC 8:39-33.2(a)(b)(c)1-13(d)	F0865		06/16/2026
F0558 SS = E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all residents had their call light easily accessible and functional. This deficient practice was identified for 2 of 2 residents reviewed on 2 of 4 resident units [NJ Ex Order 26, 4] and Sub-Acute) reviewed for adequate staffing (Resident # 30 and Resident #86), and had the potential of placing all residents at risk for inability to receive assistance in a timely manner to meet their needs. The evidence was as follows:	F0558	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE Resident #30 corrective action — Resident #30's non-functioning call light was immediately replaced on 5/5/26. Staff ensured the new call light was operational and placed directly within the resident's reach. Resident #86 corrective action — Resident #86's call light was located, repositioned, and replaced as needed to ensure accessibility. Staff confirmed the resident could reach and activate the call light. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE Facility-wide call-light audit — A complete audit of	06/16/2026

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 05/08/2026

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
F0558 SS = E	Continued from page 27 a. On 5/3/26 at 7:00 PM, the surveyor observed Resident #30 sleeping in a [redacted] and the call bell was not in reach of the resident, and a floor mat was to the right side of the bed. On 5/4/26 at 9:34 AM, the surveyor conducted an initial review of Resident #30's medical record which revealed the following: The Admission Face Sheet (an admission summary) revealed diagnoses which included but were not limited to: [redacted] On 5/4/26 at 9:48 AM, the surveyor conducted a telephone interview with the [redacted] When asked about the resident and care, the [redacted] stated the resident has a history of falls and had brain bleed. Whan asked about call bell use, the [redacted] stated the resident was legally blind and they were unable to see the call bell and had a discussion with the facility that they would purchase a flat call bell if that would help since the resident has had falls since they were at the facility and they could not advocate for themself. On 05/04/26 at 11:12 AM, the resident was observed in bed sleeping and call bell was on the bed to the right side of the resident. On 05/05/26 at 8:30 AM, the surveyor observed Resident #30 in bed and the [redacted] was at the bedside setting up the meal. On 05/05/26 at 8:45 AM, a subsequent interview with the [redacted] revealed that Resident #30 would get out of bed every other day, Monday, Wednesday and Friday, with [redacted] and [redacted] When asked the [redacted] if the resident could press the call bell, the [redacted] then placed the call bell in the resident's hand and instructed the resident to press the call bell. The resident then tried to press the call bell, and it was not functioning. The [redacted] then confirmed that Resident #30's call bell was not functioning after she pressed the bell and it did not work. A further review of Resident #30's medical revealed a 27 page Care Plan with current and resolved Focus areas and a Focus for resident is a [redacted], due to history of [redacted] history [redacted] and [redacted], Initiated [redacted] Goal Resident will be free of [redacted] and will not sustain [redacted] through the review date, Initiated [redacted] with a	F0558	Continued from page 27 all resident rooms on all units was conducted to ensure every resident had a functional call light within reach. High-risk resident review — Residents with cognitive impairment, visual impairment, mobility limitations, or fall-risk status were specifically reviewed to ensure call-light accessibility and appropriate adaptive devices (e.g., flat-pad call bells). Care plan cross-check — The interdisciplinary team reviewed care plans to confirm that call-light needs and fall-prevention interventions were accurately reflected. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Staff re-education — All CNAs, nurses, and unit clerks were re-educated by the Assistant Director of Nursing on: Ensuring call lights are within reach of every resident at all times Immediate reporting and replacement of broken or non-functioning call lights Use of adaptive call devices for residents with visual or physical limitations Revised call-light protocol — The updated protocol requires: Call-light placement checks during routine rounding Immediate work-order submission for any non-functioning call light Ensuring call lights are never tied, hidden, or placed out of resident view	06/16/2026

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 05/08/2026

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
F0558 SS = E	Continued from page 28 Target Date 6/30/26. Interventions included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; Initiated 1/26/26. Follow facility fall protocol; Initiated 12/30/26; 1/23/26:3/11/26: 1. Continue to use floor mat, 2-Continue low height bed, 3. Re-educate resident to call for assistance prior to transfers, 4 Initiate new physical therapy screen, 5. Re-educate staff on frequent founding and fall-prevention practices; Date Initiated 1/26/26; Anticipate and meet resident's needs, Initiated 12/30/26. b. On 05/03/26 at 7:26 PM, the surveyor toured the [redacted] - Sub-Acute (typically post hospitalization residents who required skilled nursing services) and observed Resident #86 in bed, the resident reported a delay in answering the call light by the facility and stated that during the 3:00 PM-11:00 PM shift, it could take up to an hour for the staff to answer the call light. The surveyor asked Resident # 86 to activate the call light, the resident could not reach the call light, and the roommate then activated the call light. Staff responded in 15 minutes to respond to the the call light. On 05/06/26 at 8:45 AM, the surveyor entered Resident #86's room, the resident was alert and awake and informed the surveyor that they needed to be changed. The surveyor asked the resident to activate the call light. The resident proceeded to reach for the call light, but the call light was not accessible. The surveyor left the room and informed a staff member who was sitting at the desk that Resident #86 needed assistance. The [redacted] entered the room and attempted to locate the call light. She could not locate the call light. The surveyor looked on the left side of the bed and observed that the call light was tied to the bed frame and was outside of the resident's view. The [redacted] confirmed that the call light was not accessible. On 5/7/26 at 9:45 AM, the surveyor reviewed the medical record for Resident #86. The admission Face Sheet (an admission summary) revealed that Resident #86 was admitted to the facility with diagnoses that included but not limited to unspecified [redacted] The Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date of	F0558	Continued from page 28 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE Weekly audits — The Unit Manager or designee will conduct 10 random call-light accessibility and functionality audits weekly for 1 month. Bi-weekly audits — After the first month, the facility will conduct 10 random audits every 2 weeks for 2 months. Monthly audits — Following the bi-weekly period, the facility will conduct monthly audits for 3 additional months. QA/QAPI review — Audit results will be reviewed monthly by the QA/QAPI Committee. Any identified issue will result in immediate corrective action and staff re-education. Compliance threshold — The facility's compliance goal is 100%. Any deviation triggers root-cause analysis and corrective action through the QAPI process.	06/16/2026

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 05/08/2026

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
F0558 SS = E	Continued from page 29 NJ Ex Order 26, 4B revealed a Brief Interview for Mental Status score o U. S. FOIA (b) (2), indicating that the resident had U. S. FOIA (b) (2). The MDS assessment further reflected under "Section NJ Ex Order 26.4(b)(1) that Resident #86 "needed assistance with all activities of daily living (ADLs) A review of Resident #86's Care Plan (CP) with an initial date of NJ Ex Order 26, 4B1, reflected a focus for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with ADL's. Another focus was for related to Ex Order 26.4(b)(1) NJ Ex Order 26.4(b) unaware of safety needs initiated The interventions were for staff to "Anticipate needs". Educate Resident/caregivers about safety reminders. On 05/06/26 at 1:30 PM, the surveyor interviewed the U. S. FOIA (b) (2) regarding call light placement while residents were in bed. She stated that all residents call bells should be easily accessible. The surveyor then asked the U. S. FO where the call light should be placed if the residents were in bed. The U. S. FO stated that the call light should be on the bed or by the NJ Ex Order 26.4 where the residents could reach the call bell without effort. The U. S. FOIA (b) (2) acknowledged that she was made aware that Resident #86's call bell was not accessible, so she started to educate the staff. She further stated that the CNAs and the nurses were responsible for ensuring that residents call lights were functional and within easy reach. On 05/08/26 at 10:09 AM, the survey team informed the U. S. FOIA (b) (2) services of the above concerns. On 05/08/26 at 1:18 PM, during the exit conference, the facility informed the surveyor upon surveyor identification of the broken call bell it was replaced. A work order dated NJ Ex Order 2 revealed the call bell was replaced and no additional pertinent information was provided. The U. S. FOIA (b) (2) acknowledged that Resident #86 did not have their call light easily accessible. NJAC 8:39-27.1(a); 31.8(c)9	F0558		06/16/2026
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F0584	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE Immediate linen replenishment - A linen order was	06/16/2026

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 05/08/2026

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
F0584 SS = E	Continued from page 30 The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a safe, comfortable, and homelike environment was provided for residents who had actual and/or expressed concerns regarding linen shortage at the facility. This deficient practice had the potential to affect all residents at the facility and was evidenced	F0584	Continued from page 30 placed on 5/8/2026, and all units were supplied with adequate quantities of clean linens, including sheets, towels, washcloths, gowns, and NJ Ex Order 26, 4B1 to ensure resident comfort and hygiene needs were met. Laundry workflow stabilization - Laundry services ensured same-day processing of all soiled linens to restore full availability across all units. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE Facility-wide linen availability audit - A complete audit of all units, clean utility rooms, and storage areas was conducted to verify linen availability and identify any additional shortages. Resident council follow-up review - Resident Council minutes from the past 3 months were reviewed to identify any unresolved concerns related to linen supply or comfort. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Staff re-education - Nursing, housekeeping, and laundry staff were re-educated by Housekeeping Director on F584 requirements, including maintaining a safe, clean, comfortable, and homelike environment and ensuring timely linen availability. Weekly linen inventory process - A weekly linen inventory process was implemented to ensure appropriate PAR levels are maintained for all linen categories across all units. Weekly linen sweeps - Nursing and housekeeping staff will conduct weekly linen sweeps of all resident rooms to identify and retrieve excess or unused linens, ensuring proper redistribution and preventing unit-level shortages. HOW THE FACILITY WILL MONITOR ITS	06/16/2026

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 05/08/2026

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
F0584 SS = E	Continued from page 31 by the following: On 05/06/2026 at 11:30 AM, the surveyor reviewed the Resident Council minutes which revealed concerns regarding linen shortage for the last 3 months. The following were documented in resident council minutes: 2/27/27 linen shortage, 3/26 needs more towel, 4/30, towel and linen shortage over weekend. The resident council minutes did not reflect that the concerns with the linen shortage were resolved. Following the Resident Council meeting, the surveyor interviewed 3 alert residents over the above concerns. The residents revealed they had been complaining and reported the linen shortage to the staff. When they were asked how they knew of the linen shortage, they stated staff were unable to provide them with towels and changed their bed linen in a timely manner. One resident went on to state the concern with the linen shortage was worse over the weekend. On 5/6/26 at12:30 PM, the surveyor went to the laundry and asked the staff to provide the linen PAR (Periodic Automatic Replenishment). The laundry staff could not comment on the linen PAR and refer the surveyor to the U. S. FOIA (b) (2)). All facilities require a 3-par system (one set in the laundry, one set in use and one set in storage) to ensure continuous services, prevent infection control and promote residents' comfort. On 5/6/26 at 1:00 PM, the surveyor interviewed the U.S. FOIA (b)(6) inquired regarding the linen delivery system on the units. The facility is licensed for 250 beds and has a census of 145. The U. S. FO was unable to provide the amount of linen that was sent on the floor on each shift. On 05/06/2026 at 1:05 PM, the U. S. FO stated that the facility did not have a linen inventory. The surveyor then inquired regarding linen storage, the U. S. FO stated that the facility did not have linen storage. The U. S. FO stated. "I can tell you, what we had, we washed them and sent them to the unit". On 5/6/26 at 1:30 PM, the surveyor interviewed the U. S. FOIA (b) (2)) regarding the facility linen inventory and requested the linen PAR for the facility. The U. S. FOIA (b stated that on 1/5/26 he did an inventory and was aware of the linen shortage. The U. S. FOIA (b provided a "Baseline inventory conducted on 1/5/26 which revealed that the facility had 105 pads, 120 regular gowns, 12 bariatric gowns and 36 in storage, 90 fitted sheets	F0584	Continued from page 31 CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE Weekly linen audits - The Housekeeping Director or designee will conduct weekly linen-availability audits for 1 month. Bi-weekly audits - After the first month, bi-weekly audits will be conducted for 2 months. Monthly audits - Following the bi-weekly period, monthly audits will continue for 3 additional months. QA/QAPI review - All audit results will be reviewed during the monthly QA/QAPI meeting. Any identified issue will result in immediate corrective action and staff re-education. Compliance threshold - The facility's compliance goal is 100% linen availability. Any deviation triggers root-cause analysis and corrective action through the QAPI process.	06/16/2026

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 05/08/2026

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
F0584 SS = E	Continued from page 32 and 12 in storage, 121 flat sheets, 136 blankets, 67 pillowcases, 66 washcloths and 10 dozens in storage, 60 towels. The facility ordered some sheets and towels at that time. The surveyor then asked the [redacted] to provide the linen PAR based on the number of licensed beds. The [redacted] was unable to show the amount of linen the facility had in house and what was needed to satisfy the linen PAR based on the number of licensed beds or the current facility census. The [redacted] along with the [redacted] could not determine what was needed based on the number of licensed beds. On 5/6/26 the [redacted] provided 3 invoices 3 invoices for purchase orders submitted by the [redacted] IN February and March 2026, for towel and flat sheets, the facility could not provide the date the shipment was received and where the linen was located. On 05/07/2026 at 12:01 PM, the surveyor interviewed a random [redacted] regarding the linen delivery on the unit. The CAN stated that the laundry staff delivered a linen cart in the morning but sometimes they had to call the laundry to require more linen. The [redacted] further stated that the bed linen was changed every other day and if the linen was soiled. The [redacted] stated that most of the time they do not have enough linen and had to call the [redacted] to deliver more linen. On 5/7/26 at 12:30 AM, the surveyor interviewed 2 CANs on the 600 Units, the CNAs, stated that the bed linen was changed twice a week and if the linen was soiled. When the surveyor inquired if they had enough linen to care for the residents they stated, the weekend was a “nightmare”, they do not have enough linen, most of the time they will go to another floor and attempt to get sheets and towels to use for their residents, at times they had to ask the residents to wait until the laundry department could provide more linen. On 5/8/26 at 11:15 AM, the [redacted] accompanied the surveyor to the storage room to show the linen that the facility had in stock. The [redacted] showed to the surveyor one unopened box of washcloth stored in the room. The [redacted] stated, I thought they were towels”. There was no linen in the storage room. The [redacted] then escorted the surveyor to the clean utility room on 2 units, only to verify several blankets and pads were stored in the room. On 5/8/26 at 12:45 PM, in the presence of the survey team, the surveyor requested again the linen PAR from the [redacted], none was provided.	F0584		06/16/2026

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 05/08/2026

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
F0584 SS = E	Continued from page 33 On 5/7/26 at 2:00 PM, the U. S. FOIA (b) provided a form titled, “Linen-Par Levels”. The following were documented: A linen PAR is the amount of linen needed to satisfy the daily needs of each resident. Established linen PAR allows the laundry department to provide nursing with the linens they need in the proper amounts and at the proper time. There must always be agreed-upon par, along with regularly scheduled delivery times. It is best practice that linen inventory should be a minimum of 3 times your par (the amount of linen needed to satisfy the daily needs of each resident) -and 8 times par for wash cloth. The facility shall maintain a par level of all essential linens. Inventory will be monitored to prevent shortages and ensure that any worn, stained or torn linens are removed from circulation and replaced immediately. NJAC 8:39-27.2(j)	F0584		06/16/2026
F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any	F0605	Element 1 Resident #2's medications were reviewed by the U. S. FOIA (b) (2) A NJ Ex Order 26, 4B1 was conducted and unnecessary meds discontinued. Element 2 Director of Nursing or designee audited all residents on Psychotropic Medications to ensure behavior monitoring in place and gradual dose reductions when appropriate. Element 3 The Assistant Director of Nursing (ADON) provided education on 5/29/2026 to all nurses regarding proper documentation of target behaviors, requirements for monitoring medication effectiveness and side effects; use and documentation of non-pharmacological interventions. The facility implemented monthly interdisciplinary NJ Ex Order 26, 4B1 medication review meetings to ensure compliance with NJ Ex Order 26, 4B1 medication policies. Element 4 The Director of Nursing (DON) or designee will conduct audits of 5 residents receiving psychotropic	06/16/2026

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 05/08/2026

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
F0605 SS = E	Continued from page 34 physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--	F0605	Continued from page 34 medications weekly for 4 weeks, then monthly for 2 months thereafter. Results of the audits will be presented by the Director of Nursing at the monthly Quality Assurance and Performance Improvement (QAPI) meeting.	06/16/2026

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 05/08/2026

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
F0605 SS = E	Continued from page 35 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure residents were free from unnecessary medications and potential NJ Ex Order 26.4(b)(1) by ensuring that NJ Ex Order 26.4(b)(1) had documented adequate indications for use, were monitored and were necessary to treat a specific condition. This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed for unnecessary medication NJ Ex Order 26, 4B1 and a diagnosis of NJ Ex Order 26, 4B1 This deficient practice was evidenced by the following: On 05/03/26 at 7:45 PM, the surveyor observed	F0605		06/16/2026

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 05/08/2026

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
F0605 SS = E	Continued from page 36 Resident #2 lying in bed in their room on the NJ Ex Order 26, 4B1 Unit, and their eyes were closed, Resident #2 was NJ Ex Order 26.4(b) and was NJ Ex Order 26.4 to a NJ Ex Order 26, 4B1). Resident #2 was observed receiving NJ Ex Order 26.4(b) through NJ Ex Order 26, 4B1 was observed in a NJ Ex Order 26, 4B1 and hung on the NJ Ex Order 26. On 05/04/26 at 9:30 AM, the surveyor observed Resident #2 in bed, resting comfortably, their eyes were closed, and Resident #2 did not seem to be NJ Ex Order 26.4(b)(1) and did not NJ Ex Order 26 the surveyor. The surveyor returned to the room at 11:30 AM and observed Resident #2 resting in the same manner as observed at 9:30 AM. On 5/6/26 at 8:30 AM, the surveyor observed the U. S. FOIA (b) (2) in Resident #2's room. The U. S. FOIA (b) (2)) was also at the bedside providing care. Resident #2 was NJ Ex Or and did not NJ Ex Order 26.4(b)(1). On 5/6/26 at 9:30 AM, the surveyor interviewed the U. S. FOIA assigned to the Vent unit regarding Resident #2's care. The U. S. FOIA stated that Resident #2 was NJ Ex Order 26, 4B1 staff during care. The surveyor then inquired if the NJ Ex Order 26.4 was still occurring and the U. S. FOIA stated, "not really." On 5/6/26 10:30 AM, the surveyor interviewed the U. S. FOIA (b) (2) assigned to the Vent unit. The U. S. FO stated that currently Resident #2 "did not have any NJ Ex Order 26.4(b)(1) The U. S. FOIA (b) (2) was very involved and visited often. The further stated that she had been caring for Resident #2 for almost one year and had not observed any NJ Ex Order 26.4(b) The surveyor then asked the U. S. FO what should occur to determine if a NJ Ex Order 26, 4B1 medication was ordered to treat a condition and the condition did not persist and the nurse then stated, "'the resident should have been reevaluated" for the continued use of medications. On 5/6/26 at 11:15 AM, the surveyor reviewed the medical record for Resident #2. The Admission Face Sheet (admission summary) reflected that Resident #2 had diagnoses which included but were not limited to: NJ Ex Order 26, 4B1	F0605		06/16/2026

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 05/08/2026

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
F0605 SS = E	Continued from page 37 The surveyor then reviewed the [redacted] Physician's Order Sheet (POS) which revealed the resident had an order for [redacted] A review of [redacted] Medication Administration Record (MAR) reflected an order to monitor for behavior for [redacted] Number of times each shift. Behaviors of: [redacted] Document non-Drug interventions: Diversional Activity, Snack, Support provided. Outcome: Effective/ Ineffective every shift document Progress Notes for any other [redacted] A review of the Progress Notes (PN) from [redacted] revealed that there was no documentation that Resident #2 displayed any [redacted] All the documentation pertained to the [redacted]. The surveyor reviewed the Monthly [redacted] Drug Evaluation Form dated [redacted] revealed that all target [redacted] were coded as "zero" indicating absence of [redacted] Further review of the forms failed to indicate any behavioral interventions /nonpharmacological approaches to care that were provided as part of a supportive physical/psychosocial environment that failed when the resident displayed the target behaviors being monitored. According to the documentation provided, the resident's behavior was stable for six months. The surveyor reviewed the monthly [redacted] assessment completed by the [redacted] which revealed the following: [redacted] Per nursing, has decreased [redacted] of [redacted], there are no s/s [sign and symptoms] of [redacted] visit. [redacted] or [redacted]. Sleep is appropriate per staff. Plan: Continue [redacted], continue [redacted] Will attempt to contact Resident Representative for care coordination and to discuss medications and treatment plan. The [redacted] Assessment revealed the	F0605		06/16/2026

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 05/08/2026

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
F0605 SS = E	Continued from page 38 following: Chart reviewed, history of [redacted] and [redacted]. Resident #2 was unable to use the NJ Ex Order 26.4(b)(1), no signs/symptoms of [redacted]. There was no [redacted] or [redacted] Unable to assess NJ Ex Order 26, 4B1 and [redacted] as patient was [redacted] but none were evident. Per staff [redacted] is appropriate. Continue current medications. On [redacted]. the U. S. FOIA (b) (2) documented the following: Patient's [redacted] have been [redacted] on [redacted] current medication regime. Will contact U. S. FOIA (b) (2) for NJ Ex Order 26, 4B1. There are NJ Ex Order 26, 4B1 [redacted] On 5/8/26 at 9:15 AM, the surveyor conducted a telephone interview with the [redacted]. The surveyor inquired regarding the medication regimen and asked the [redacted] to elaborate on the symptoms that warrantied the medication such as [redacted]. The [redacted] stated that Resident #2 "NJ Ex Order 26, 4B1 [redacted]", the medications were ordered to treat the [redacted] of NJ Ex Order 26, 4B1 [redacted]. The surveyor then asked the [redacted] if she reviewed the monthly NJ Ex Order 26, 4B1 Drug Evaluation Forms for the [redacted]. The [redacted] stated "No." The [redacted] stated that she spoke with the staff and any changes in the care plan had to be discussed with the U. S. FOIA (b) (2). She then confirmed that the drug regimen "should be reviewed in the absence of the target [redacted]. The [redacted] stated that she had not been able to discuss any [redacted] reductions for the [redacted] medication. On 5/8/26 at 10:30 AM, the surveyor interviewed the U. S. FOIA (b) (2) regarding the care. The RR expressed some concerns and informed the surveyor that Resident #2 had NJ Ex Order 26, 4B1 [redacted]. Resident #2 was [redacted] and did not [redacted]. The [redacted] further stated that Resident #2 used to [redacted] and used the [redacted] to [redacted] with staff and "NJ Ex Order 26, 4B1 [redacted]." When inquired regarding the drug regimen, the [redacted] stated that they were a nurse and some of the medications needed to be discontinued in the NJ Ex Order 26, 4B1". On 05/08/26 at 11:30 AM, the surveyor discussed the above concerns regarding Resident #2's medication regimen with the U. S. FOIA (b) (2) [redacted]. They agreed that the medication regimen should have been reviewed in the absence of the target	F0605		06/16/2026

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 05/08/2026

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
F0605 SS = E	Continued from page 39 NJ Ex Order 26.4(b)(No further information was provided. A review of the facility policy titled, " Use of Psychotropic Medication () last revised 3/10/25 indicated the following: Policy: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. NJAC 8:39-27.1 (a)	F0605		06/16/2026
F0677 SS = E	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: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure dependent residents were provided with routine and appropriate NJ Ex Order 26, 4B1 in a timely manner. This deficient practice was identified for 2 of 2 residents reviewed (Resident #120 and #159) for Activities of Daily Living and appropriate NJ Ex Order 26, 4B1 The deficient practice was evidenced by the following: a) On 5/3/26 at 8:40 PM, the surveyor toured the NJ Ex O NJ Ex Or of the facility, Resident # 120 informed the surveyor that they had a NJ Ex Order 26, 4B1) and NJ Ex Order 26, 4 . Resident #120 further stated that NJ Ex Order 26, 4B1 was not provided timely, sometimes it could take up to one hour for the staff to assist with NJ Ex Order 26, 4B1 The surveyor continued the tour and entered another resident room, when inquired regarding the care, the resident stated that they did not receive care timely and it occurred mostly on the 3:00 PM-11:00 PM shift. When asked to elaborate, the resident stated on the 3:00 PM-11:00 PM shift, it could take over one hour to receive NJ Ex Order 26, 4B1. On 5/4/26 at 9:45 AM, the surveyor asked a random U. S. FOIA (b) (2) to assist with a care tour	F0677	Element 1 Residents #120 and #159 received immediate NJ Ex Order 26, 4B1 upon identification of the concern. Resident #120 and #159 were assessed for: NJ Ex Order 26 . No concerns were identified. Element 2 All residents who are incontinent have potential to be affected by this deficient practice. Element 3 The Assistant Director of Nursing (ADON) provided education on 5/29/2026 to all nurses and certified nurse's aides regarding facility incontinence care policy. Element 4 The Director of Nursing/designee will conduct Daily 5 incontinent care observations for 2 weeks, weekly for 4 weeks and then monthly for 2 months. Findings will be presented by the Director of Nursing at the monthly Quality Assurance and Performance Improvement (QAPI) meeting.	06/18/2026

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 05/08/2026

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
F0677 SS = E	Continued from page 40 observation. Resident #120 was observed NJ Ex Order 26, 4B [redacted] Resident #120 informed the surveyor that they were provided with NJ Ex Order 26, 4B1 during the prior shift (11:00 PM-7:00 AM). During an interview with the U. S. FOIA assigned to Resident #120, she stated that she was on another assignment and did not check the resident prior to serving them the breakfast meal. On 05/04/26 at 10:10 AM, the surveyor observed Resident #159 in bed, upon inquiry, the resident stated that they NJ Ex Order 26, 4B1 . . On 05/04/2026 at 10:30 AM, the surveyor asked a random U. S. FOIA to assist with a care tour observation and Resident #159 was NJ Ex Order 26, 4B1 [redacted] The surveyor then asked the U. S. FOIA if she checked the resident this morning. The U. S. FOIA confirmed that Resident #159 was on her assignment and stated, "I came in at 7:00 AM, I was told that Resident #159 received NJ Ex Order 26, 4B1 earlier, I did not check the resident this morning." When asked if she felt that the resident was provided with NJ Ex Order 26, 4B1 [redacted] this morning, she stated, "based on what we observed, I did not think so." The U. S. FOIA stated I was on another assignment I did not provide care yet. On 5/7/26 at 10:15 AM, the surveyor reviewed Resident #120's medical record which revealed: the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26, 4B1 [redacted] A review of Resident #120's admission Minimum Data Set (MDS) an assessment tool to facilitate resident care, dated NJ Ex Order 26, 4 [redacted], documented the resident required NJ Ex Order 26.4(b)(1) with most activities of daily (ADL) including NJ Ex Order 26, 4B1 [redacted]. Resident #120 scored NJ Ex Order 26, 4B1 [redacted] on the Brief Interview for Mental Status (BIMS) which revealed that Resident # 120 had NJ Ex Order 26, 4B1 [redacted]. The resident was NJ Ex Order 26, 4B1 [redacted] and required NJ Ex Order 26, 4B1 [redacted] Review of Resident #120's care plan dated NJ Ex Order 26.4(b)(1) [redacted] revealed they were care planned for ADL/self-care performance deficit related to activity NJ Ex Order 26, 4B1 [redacted]. The goal was Resident #120 would increase their NJ Ex Order 26.4(b)([redacted] and independence with ADLs to return home with caregiver. The interventions included: U. S. FOIA (b) (2) activity, NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) as needed, wheelchair mobility	F0677		06/18/2026

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 05/08/2026

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
F0677 SS = E	Continued from page 41 NJ Ex Order 26, 4B1 as needed. Resident #120 was to be provided with NJ Ex Order 26, 4B1 as needed. On 5/7/26 at 10:30 AM, the surveyor observed Resident #120 for NJ Ex Order 26, 4B1 with the CNA. During the NJ Ex Order 26, 4B1 observation with the CNA, the surveyor observed Resident #120 in bed and was NJ Ex Order 26, 4B1 A review of the medical record for Resident #159 revealed the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26, 4B1 . The admission Minimum Data Set Assessment (MDS) dated NJ Ex Order 26, 4B1, reflected that Resident #159 was NJ Ex Order 26, 4B1. Resident #159 scored NJ Ex Order 26, 4B1 on the Brief Interview for Mental Status (BIMS). The Comprehensive undated Care Plan reflected a focus for ADL NJ Ex Order 26.4(b)(1) deficit related to NJ Ex Order 26.4(b)(1). The goal was for Resident #159 to improve current NJ Ex Order 26.4(b)(1) in ADLs, NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) through the review date. The interventions included, NJ Ex Order 26.4(b)(1) evaluation and training, ADL retraining, NJ Ex Order and wheelchair management. Another focus was for NJ Ex Order 26.4(b)(1) related to infection with a NJ Ex Order 26.4(b)(1). U. S. FOIA (b) (2) . The interventions were to change Resident #159's NJ Ex Orde or assist with NJ Ex Order 26.4(b)(1) On 05/07/26 at 9:40 AM, the surveyor interviewed the U. S. FOIA (b) (2) and inquired regarding when NJ Ex Order 26, 4B1 was to be offered. The U. S. FOIA stated NJ Ex Order 26, 4B1 was to be offered NJ Ex Order 26, 4B1. The [illegible] stated that NJ Ex Order 26, 4B1 was to be offered in the morning during rounds prior to breakfast. The U. S. FOIA (b were to check their residents and provided NJ Ex Order 26, 4B1. The surveyor then asked the U. S. FO when the last in-service on NJ Ex Order 26, 4B1 was, the U. S. FO stated that she provided an in-service last month following a complaint from a family member who visited over the weekend and observed that their loved one was NJ Ex Order 26, 4B1 and had not been provided with NJ Ex Order 26, 4B1 for an extended period.	F0677		06/18/2026

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 05/08/2026

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
F0677 SS = E	Continued from page 42 On 5/8/26 at 10:30 AM, the surveyor reviewed the grievance book which revealed that on [redacted] a resident reported that they had to wait more than 30 minutes to be assisted with care. They needed to [redacted] they activated the call light and staff were not available for assistance for over 30 minutes. The above concerns were presented to the facility [redacted] on 5/8/26 at 10:30 AM. During the pre-exit conference on 5/8/26 no additional information was provided. On 5/9/26 at 10:06 the [redacted] provided a policy titled, "Perineal care, last revised 2/20/26. The policy stated, "It is the practice of the facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. NJAC 8:39-27.1(a)	F0677		06/18/2026
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice 2 of 28 residents (Resident #7 and Resident #135) reviewed for quality of care. This 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	F0684	A [redacted] assessment was completed for Resident #7. The [redacted] assessment dated [redacted] that showed the Resident #7 [redacted] was struck out as incorrect documentation.Resident #135 care plan updated to indicate preference to have staff accompany him to medical appointments. All residents are at risk to be affected by the deficient practice. A facility audit was conducted by Director of Nursing for all residents to ensure care is delivered according to professional standards, weekly skin assessments are completed, care plans accurately reflect current needs, interventions are implemented as written, and staff follows residents' preferences and choices. The Director of Nursing (DON) or designee will conduct weekly audits for 12 weeks of 5 randomly selected residents across all units to verify care is delivered according to the care plan, interventions match professional standards, staff follow resident preferences, and documentation is complete and accurate. Results of these audits will be shared by the DON at the monthly QAPI meetings for 3 months.	06/18/2026

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 05/08/2026

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
F0684 SS = E	Continued from page 43 as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, 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." a. On 5/3/26 at 7:30 PM, the surveyor observed Resident #7 who was seated in a wheelchair and watching television in their room. The surveyor reviewed the medical record for Resident #7. A review of the resident's Admission record (admission summary) revealed diagnoses which included but not limited to; NJ Ex Order 26, 4B1 [redacted] A review of a Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care dated NJ Ex Order 26, 4B, reflected that the resident had a brief interview for mental status score of NJ Ex [redacted], indicating that the resident is NJ Ex Order 26, 4B1 [redacted] A review of the NJ Ex Order 26.4(b)(Order Summary Report (OSR) revealed the following Physician's Order (PO) dated NJ Ex Order 26, 4B for NJ Ex Order 26, 4B1 [redacted] give NJ Ex Order 26, 4B1 [redacted] A skilled progress note (PN) dated NJ Ex Order 26, 4B1 [redacted] revealed that a U. S. FOIA (b) (2) [redacted] documented the following:	F0684		06/18/2026

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 05/08/2026

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
F0684 SS = E	Continued from page 44 "Resident (age and sex redacted) was seen at the bedside today for NJ Ex Order 26, 4B1 . Resident reports they (gender redacted) have a NJ Ex Order 26, 4B1 ago. Resident reports that this has happened to them previously in the NJ Ex Order 26.4(b)(and it requires NJ Ex O Resident NJ Ex Order 26, 4B1 at the NJ Ex Ord The U.S. FOO also wrote the following under physical exam: NJ Ex Ord Warm and dry. NJ Ex Order 26.4 NJ Ex Order 26, 4B1 region." The U.S. FOO also wrote the following under plan: 'NJ Ex Order 26, 4B1 Due to resident's risk for systemic infection advised that they need a NJ Ex Order 26, 4B1 . Unable to obtain appropriate supplies (I and D tray, NJ Ex Order 26, 4B etc) transfer to hospital fo NJ Ex Order 26, 4B1 Start NJ Ex Order 26, 4B1 ." A further review of the facility's PN revealed no nurses' notes from NJ Ex Order 26, 4B1 A review of Resident #7's Weekly NJ Ex Or Review dated NJ Ex Order 26 at 2:08 PM revealed that the resident's NJ Ex Ord was identified as NJ Ex Order 26, 4B1 A review of Resident #7's Weekly NJ Ex Or Review dated NJ Ex Order 26 at 12:16 PM revealed that the resident's was identified as NJ Ex Order 26, 4B1 A review of Documentation Survey Report (Task for Certified Nurse Aids) revealed under NJ Ex Or Observation from NJ Ex Order 26, 4B that the Certified Nursing Assistant documented 5 for none of the above observed NJ Ex Order 26.4(b)(1) A review of the facility's comprehensive care plan under the focus area NJ Ex Order 26, 4B1 dated NJ Ex Order 26 revealed the following intervention: "Check all of body for NJ Ex Order 26, 4B1 promptly as ordered by doctor."	F0684		06/18/2026

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 05/08/2026

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
F0684 SS = E	Continued from page 45 On 05/07/26 at 10:00 AM, the surveyor interviewed Resident #7 who stated that on [redacted], they were experiencing an [redacted]. The resident stated that they notified the [redacted] and told them that they were [redacted] in [redacted]. The resident then stated that they had been experiencing [redacted] for several days. After the [redacted] examined the resident's [redacted] she stated then she decided to send Resident #7 to the hospital to get the [redacted]. On 05/07/26 at 10:30 AM, the surveyor interviewed the resident's [redacted]) who stated that part of her job was to complete [redacted] for her residents. She stated that she completed [redacted] for Resident #7 but did not recall observing an [redacted] on the resident's [redacted] The CNA further stated that if she had noticed any type of [redacted] which would include a [redacted], that she would notify the nurse. On 05/07/26 at 11:30 AM, the surveyor interviewed Resident #7's [redacted]) who stated that the resident received a weekly [redacted] and was unable to explain why the abscess on the resident's [redacted] had not been identified and documented on the [redacted] weekly [redacted] He stated that the [redacted] should have been identified during the nurse's weekly assessment and during the CNA's [redacted] which were both completed on [redacted]. On 05/07/26 at 1:20 PM, the surveyor interviewed the FNP regarding the progress note she documented on [redacted] She stated that she was doing her rounds when Resident #7 informed her that they had [redacted]. When she examined the resident, she observed the [redacted] on [redacted] and it was observed as [redacted] and it was oozing." She stated that the [redacted]. On 05/8/26 at 10:30 AM, the surveyor presented the above concerns to the facility's [redacted] which included the [redacted]. No additional information was provided. A review of the facility policy dated as last approved 1/1/2024 for "Skin Assessment" provided by the	F0684		06/18/2026

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 05/08/2026

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
F0684 SS = E	Continued from page 46 U.S. FOIA (b)(6) [redacted], revealed the following: "A full body, or head to toe, skin assessment will be conducted by a licensed of Registered Nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment should also be performed upon any change in condition or identification of new wound (s) (i.e., pressure injury, non-pressure injuries, diabetic ulcers, skin tears, etc.)." A review of the facility policy dated 10/31/2019 for "Acute Condition Changes-Clinical Protocol" provided by the U. S. FOIA (b) (2) [redacted] revealed the following: "Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the Nurse." b. On 5/07/26 at 9:01 AM, Resident #135 was observed in the room sitting in wheelchair and was eating breakfast. The resident stated they had NJ Ex Order 26, 4B1. The resident further stated that on one occasion [redacted] did not accompany them to the appointment, and the resident was not informed why [redacted] did not accompany them on the appointment. On 5/07/26 at 9:08 AM, the surveyor interviewed the U. S. FOIA (b) (2) [redacted] who stated the follow-up appointment yesterday and an aide accompanied the resident for the appointment. She further stated that there were no staff that accompanied the resident on the date of the [redacted] and that she "thought it was a miscommunication." The [redacted] stated that [redacted] should have accompanied Resident #135 for the [redacted] appointment. On 5/07/26 at 9:37 AM, the surveyor reviewed the electronic medical record (EMR) which revealed the following: An admission record revealed diagnoses that included but not limited to: NJ Ex Order 26, 4B1 [redacted]	F0684		06/18/2026

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 05/08/2026

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
F0684 SS = E	Continued from page 47 A quarterly Minimum Data Set (an assessment tool) dated NJ Ex Order 26 revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1 indicated the resident was NJ Ex Order 26, 4B1. The resident required supervision with transfers and NJ Ex Order 26, 4B1 [redacted] The Individual Comprehensive Care Plan (ICCP) revealed a Focus area initiated NJ Ex Order 26, 4 , that addressed NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b) with an intervention of staff to provide assistance with NJ Ex Order 26 as needed. The ICCP also included a Focus area initiated NJ Ex Order 26, 4B addressing a NJ Ex Order 26 4B1 related to NJ Ex Order 26, 4B1 [redacted] with interventions which included resident educated on the importance of calling for assistance prior to NJ Ex Order 26.4(b) additional NJ Ex Order 26 provided to improve NJ Ex Order 26 related to [redacted] dated NJ Ex Order 26, 4 and to ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed; the resident needed prompt response to all requests for assistance dated NJ Ex Order 26, 4B The ICCP also included a focus area dated NJ Ex Order 26, 4B that addressed the medical diagnosis of NJ Ex Order 26.4(b)(1) and intervention of NJ Ex Order 26 precautions, which included "Do not leave resident alone during a NJ Ex Order 26 NJ Ex Order 26.4(b)(1)". A review of the EMR further revealed that NJ Ex Order 26, [redacted] was recommended on NJ Ex Order 2 , and the medical clearance was completed on NJ Ex Order 26 On 5/5/26 at 7:57 AM, the progress notes indicated that the resident was picked up at 6:00 AM, by [Name Redacted] to [Name Redacted] Medical Center for NJ Ex Order 26, 4B1 On 5/5/26 at 12:34 PM, the progress notes indicated that the resident returned from [Name Redacted] Medical Center for the NJ Ex Order 26, 4B1 NJ Ex Order 26 Follow-up appointment on NJ Ex Order 26, 4B1. Scheduler/all parties made aware. On 5/07/26 at 11:37 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated if a resident had an appointment, the U. S. FOIA (b) (2) scheduled the appointments. The [redacted] stated sometimes we asked the family, and they would meet the resident at the NJ Ex Order 26.4 If a resident really needed help, we could get an aide to go with a resident. She further stated, There was a lapse with that appointment. It was just missed; it was not communicated well." She also stated that she thought at one point the U. S. FOIA (b) (2) was	F0684		06/18/2026

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 05/08/2026

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
F0684 SS = E	Continued from page 48 going to go with the resident to the appointment. She then stated that [redacted] should have gone with the resident to the [redacted] appointment. The surveyor reviewed the facility provided policy, "Transportation Policy", implemented 1/1/21, which included: Policy: For residents' convenience the facility offers transportation to doctor's appointments and emergent visits to medical centers. This policy outlines facility schedule for transportation operations and procedures for making transportation arrangements; Procedures: appointments will be scheduled by appointment in advance or emergency visit as applicable by the nursing staff. All residents and their needs will be considered for their appointments. N.J.A.C. 8:39-27.1(a); 8:39-3.2 (a), (b)	F0684		06/18/2026
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent documents it was determined that the facility failed to provide adequate [redacted] and implement specific and meaningful interventions to prevent a resident identified at [redacted] and assessed as being [redacted] from experiencing [redacted]. This deficient practice was identified for 1 of 2 residents reviewed for [redacted] (Resident #30), and was evidenced by the following. The evidence was as follows: A review of the facility policy titled; Fall Prevention Program, Date Implemented 1/2/25 revealed: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their	F0689	1.Resident #30 was immediately provided with a tap call bell and [redacted] 2. All residents can be affected by the deficient practice 3. A facility-wide audit of all residents was conducted on 5/28/2026 to ensure they can utilize their call bell and fall mats as needed. Staff education was provided by the Assistant Director of Nursing on 5/29/2026 that call bell should be in reach at all times and what to do if a resident cannot use their call bell and that fall mats are set up for residents who require them. 4. The DON/designee will conduct, daily audits for 2 residents daily for 2 weeks, then weekly audits for 2 residents weekly for 10 weeks. All audit results will be presented by the Director of Nursing at the monthly Quality Assurance and Performance Improvement (QAPI) meeting.	06/18/2026

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 05/08/2026

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
F0689 SS = E	Continued from page 49 individualized level of risk to minimize the likelihood of falls. 3. The nurse will indicate in the resident's record the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's risk. 4. Provided interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. A. Provide additional interventions as directed by the resident's assessment, including but not limited to i. assistive devices, ii. increased frequency of rounds, iii. sitter if needed … vi. Alternate call system access, vii. Scheduled ambulation or toileting assistance … ix. Therapy services referral; 5 Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. interventions will be monitored for effectiveness, b. The plan of care will be revised as needed, 6. When any resident experiences a fall, the facility will: e. Review the resident's care plan and update as indicated. On 5/3/26 at 7:00 PM, the surveyor observed Resident #30 sleeping in a [redacted] and the call bell was not in reach of the resident, and [redacted] was to the right side of the bed. On 5/4/26 at 9:34 AM, the surveyor conducted an initial review of Resident #30's medical record which revealed the following: The Admission Face Sheet (an admission summary) revealed diagnoses which included but were not limited to: [redacted] On 5/4/26 at 9:48 AM, the surveyor conducted a telephone interview with the Responsible Party (RP). When asked about the resident and care, the RP stated the resident had a [redacted] and had [redacted] When asked about call bell use, the RP stated the resident was [redacted] and they were unable to see the call bell and the RP had a discussion with the facility and the RP stated that they would purchase a flat call bell if that would help since the resident has [redacted] since they were at the facility and they [redacted] for themself. On 05/04/26 at 11:12 AM, the resident was observed in bed sleeping and call bell was on the bed to the	F0689		06/18/2026

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 05/08/2026

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
F0689 SS = E	Continued from page 50 right side of the resident. On 05/05/26 at 8:30 AM, the surveyor observed Resident #30 in bed and the U. S. FOIA (b) (2) was at the bedside setting up the breakfast meal. On 05/05/26 at 8:45 AM, a subsequent interview with the U. S. FOIA revealed that Resident #30 would get out of bed every other day, Monday, Wednesday and Friday, with a NJ Ex Order 26, 4B1 would NJ Ex Order 2 When asked the NJ Ex Orc if the resident could press the call bell, the U. S. FOIA then placed the call bell in the resident's hand and instructed the resident to press the call bell. The resident then tried to press the call bell, and it failed to activate. The U.S. FOIA then stated at that time, "the call bell was not functioning." A further review of Resident #30's medical revealed a 27 page Care Plan with current and resolved Focus areas and a Focus for resident is at NJ Ex Order 26.4(b)(1) due to history of NJ Ex Order 26, 4B1 , , Initiated NJ Ex Order 26.4(b) Goal Resident will be free of NJ Ex Order 26.4(b)(1) and will not sustain NJ Ex Order 26, 4B1 through the review date, Initiated NJ Ex Order 26 with a Target Date NJ Ex Order 26 . Interventions included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; Initiated NJ Ex Order 26 . Follow facility NJ Ex Order 26, 4B1 ; Initiated NJ Ex Order 26.4(b) . Continue to use NJ Ex Order 26.4(, 2-Continue NJ Ex Order 26.4(b)(1) , 3. Re-educate resident to call for assistance prior to NJ Ex Order 26.4(b 4 Initiate new NJ Ex Order 26.4(b)(1) screen, 5. Re-educate staff on frequent rounding and NJ Ex Order 26.4(b)(1) practices; Date Initiated NJ Ex Order 26.4 Anticipate and meet resident's needs, Initiated NJ Ex Order 26.4(b A review of the Admission Minimum Data Set, dated NJ Ex Order 26.4(revealed a Brief Interview for Mental Status Score of NJ Ex Order 26, 4B1 which revealed the resident had a NJ Ex Order 26, 4B1 . Section NJ Ex (for NJ Ex Order 26.4(b)(1) revealed the resident was dependent on staff to NJ Ex Order 26, 4B1 A NJ Ex Order 26.4(Assessment, Effective NJ Ex Order 26.4(revealed	F0689		06/18/2026

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 05/08/2026

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
F0689 SS = E	Continued from page 51 Resident #30 was identified as being at [redacted] for falls. The [redacted] Record dated [redacted] revealed Diagnosis: [redacted] ... A review of the Admission Minimum Data Set, dated [redacted] revealed a Brief Interview for Mental Status (BIMS) Score of [redacted] which revealed the resident had a [redacted]. Section [redacted] for [redacted] revealed the resident was [redacted], and the resident was dependent on staff for [redacted] The [redacted] Progress Note, effective [redacted] at 6:52 AM revealed [redacted] called me into resident's room, [redacted]. Resident could not state what the reason was for [redacted] ... [redacted] initiated due to [redacted]. A Registered Nurse Progress Note, effective [redacted] at 16:16 (4:16 PM) revealed called to resident's room approximately 4:00 PM, noted [redacted]. Resident could not give account of what happened, reported [redacted] ... [redacted] ... On 05/06/26 at 8:31 AM, Resident #30 was observed in bed, the meal tray was at the bedside. The call bell was located out of reach from resident's right hand, when asked if they could ring the call bell, they tried with the [redacted] and then stated "No". The surveyor then requested all investigations for Resident #30 from the facility. On 05/07/26 at 12:30 PM, the surveyor interviewed the [redacted]) about Resident #30. The [redacted] confirmed she provided care and assessed and asked if Resident #30 had [redacted]. The [redacted] stated, "not really", the resident was able to see lights and shadows. When asked if Resident #30 was able to press the call bell she stated, Resident #30 could grab, but had [redacted] and doesn't have the follow through to know how to press the call bell, because they had [redacted]. On 5/7/26 at 1:56 PM, the [redacted]	F0689		06/18/2026

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 05/08/2026

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
F0689 SS = E	Continued from page 52 provided two investigations that he confirmed were complete and had all documentation, including any documentation from witnesses. A review of the NJ Ex Order 26.4(b)(1) revealed Notes: NJ Ex Order 26 .U. S. FOIA (b) (2) met to discuss NJ Ex Order 26.4(b)(1) and resident could not recall what happened. There were no new interventions added to the Care Plan specific to a causal factor of the NJ Ex or effectiveness of interventions reviewed. A review of the NJ Ex Order 26 NJ Ex O Report revealed under Incident Description: U. S. FOIA (b) (2) alerted NJ Ex Orde regarding resident NJ Ex Order 26, 4B1 on the floor..." Notes that at 4:16 PM, "the nurse called me to tell me the resident NJ Ex Order 26, 4B1 ..." There were no new interventions added to the Care Plan specific to a causal factor of the NJ Ex or a review of the effectiveness of the current interventions. The NJ Ex Order 26, 4B1 Evaluation dated NJ Ex Order 26.4(b) revealed: NJ Ex Order 26.4(b)(1) Oriented to NJ Ex Order 26.4(b)(1) ... During the screen NJ Ex Ord , and NJ Ex Ord On 05/08/26 8:51 AM, the surveyor conducted an interview with the U. S. FOIA (b) (2) in the presence of the survey team. The surveyor asked about how the facility determined if a resident was a NJ Ex Order 26 The U. S. FOIA stated that upon admission a resident had a NJ Ex assessment completed to determine if they had a potential for NJ Ex Ord they completed the NJ Ex Order 26, 4B1 for every admission. The U. S. FOIA stated that every resident had "every NJ Ex Order 2 ", and when asked where that documentation for the NJ Ex Order 26.4(b)(1) was located, the U. S. FOIA stated, "we don't really document it." When asked about an order for the NJ Ex Order 26.4(b)(1) the U. S. FOIA stated, "we don't get a physician order, some of it would be in the progress notes, it depended on if the nurses document it." When asked the U. S. FOIA if the staff documented anything to confirm the NJ Ex Order 26.4(b)(1) was completed, she confirmed "we don't have a specific thing we do" to document the NJ Ex Order 26.4(b)(1) The surveyor then asked the U. S. FOIA what the facility would complete for a new admission related to NJ Ex	F0689		06/18/2026

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 05/08/2026

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
F0689 SS = E	Continued from page 53 prevention. The [U. S. FOIA] stated a Care Plan was completed for [U. S. FOIA (b)] and it would include using a [NJ Ex Order 26.4] and using the call bell. When asked how would you know if a resident was able to use the call bell, the [U. S. FOIA] stated the "call bell would always be in reach, they all use it." When asked could all residents use the call bell if they had [NJ Ex Order 26.4(b)(1)], the [U. S. FOIA] stated that all residents would still be educated to use the call bells. The [U. S. FOIA] stated if a resident had [NJ Ex Orde] they reviewed all current interventions to see if they were appropriate and the [U. S. FOIA] stated she was responsible to complete the investigation. The surveyor then asked if a resident had [NJ Ex Order 26.4(b)(1)] would a call bell be an appropriate intervention. The [U. S. FOIA] stated, "No, we would change the call bell to a tap bell or the spongy call bell." When asked if she knew if Resident #30 had [NJ Ex Order 26.4(b)(1)]? She stated, "No." When asked if she had spoken to the [U. S. F], or any [NJ Ex Order 26.4] about the resident? The [U. S. FO] stated she did not speak to [NJ Ex Order 26] and confirmed that she was unaware that Resident #30 had any [NJ Ex Order 26.4(b)(1)] The surveyor informed the [U. S. FOIA] of the observations, including the broken call bell and [NJ Ex Order 26.4(b)(1)] the call bell, and the call bell that was out of reach. When asked the [U. S. FOIA] if she should have been aware of the [NJ Ex Order 26.4(b)(1)] she stated, "Yes", and could not speak to why she was not aware. The [U. S. FOIA] confirmed that if she had been aware of the [NJ Ex Order 26.4(b)(1)] for Resident #30, that she could have added other interventions such as a tap bell. On 05/08/26 at 10:09 AM, the survey team informed the [U. S. FOIA (b) (2)] services of the above concerns. On 05/08/26 at 1:18 PM, during the exit conference, the facility informed the surveyor upon surveyor identification of the broken call bell it was replaced. A work order dated [NJ Ex Order 2] revealed the call bell was replaced and no additional pertinent information was provided. NJAC 8:39-27.1(a)	F0689		06/18/2026
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F0695	Resident #53 and Resident #74 were immediately assessed by [U. S. FOIA (b) (2)] to ensure [NJ Ex Order 26] was being administered as ordered by the physician. [NJ Ex Order 26] delivery devices [NJ Ex Order 26, 4B1] were checked for [NJ Ex Order 26.4(b)(1)], proper [NJ Ex Order 26.4(b)(1)] and	06/16/2026

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 05/08/2026

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
F0695 SS = E	Continued from page 54 The facility must ensure that a resident who needs [redacted] including [redacted] and [redacted], 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, record review, and review of pertinent facility documents, it was determined that the facility failed to provide appropriate care and services for residents who required [redacted] by failing to administer [redacted] according to the physician order. This deficient practice occurred for 2 of 5 residents, including a resident (Resident # 53) with a history of [redacted]) and [redacted] and Resident #74 reviewed for [redacted] and 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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes 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." a. On 5/3/26 at 7:00 PM, during the initial tour, the surveyor observed Resident #53 in bed sleeping, was wearing a [redacted]" via [redacted] administered [redacted] and it was set to [redacted]).	F0695	Continued from page 54 functionality. Any discrepancies between the physician order and [redacted] delivery were corrected immediately. All residents receiving oxygen can be affected by the deficient practice A facility audit was completed by the Director of Nursing for all residents receiving oxygen therapy to ensure oxygen is administered as ordered. Assistant Director of Nursing educated staff on proper oxygen administration. The Director of Nursing (DON) or designee will conduct a Daily audit for 2 weeks, then Weekly audit for 10 weeks. All audit results will be presented by the Director of Nursing at the monthly Quality Assurance and Performance Improvement (QAPI) meeting.	06/16/2026

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 05/08/2026

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
F0695 SS = E	Continued from page 55 On 05/04/26 at 11:58 AM, the surveyor entered Resident #53's room, and the resident was wearing a NJ Ex Order 26, 4B1 " to the surveyor and the surveyor observed the NJ Ex Order 26, 4B1 as observed on NJ Ex Order 26. The surveyor immediately went to the front desk area and observed the U. S. FOIA (b) (2) and informed her of the surveyor's observations and the resident was on NJ Ex Order 26, 4B1 The U. S. FOIA (b stated 'NJ Ex Order 26, 4B1 ." On 05/04/26 at 12:01 PM, the LPNC asked a nurse for a NJ Ex Order 26, 4B1 and went toward the room, the surveyor accompanied the U. S. FOIA (b to the room and the surveyor asked about the statement she made, and she said, 'NJ Ex Order 26, 4B1 ", it is a NJ Ex Order 26.4(that they do all the time. The resident was observed on the U. S. FO and the U. S. FOIA (b confirmed that the resident was on NJ Ex Order 26, 4B1 . The resident was NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 took the resident' NJ Ex Order 26, 4B1 NJ Ex Order 26.4(b)(1) . The tried to feed the resident from the meal tray, and the resident stated, NJ Ex Order 26, 4B1 The surveyor then reviewed Resident #53's medical record which revealed the following: The resident had diagnoses with included, but were not limited to: NJ Ex Order 26, 4B1 . The Order Summary Report revealed a physician order dated NJ Ex Order 26, 4B for If NJ Ex Order 26, 4B1 measures the percentage of NJ Ex Order 26, 4B1) is NJ Ex Order 26.4(b)(1) apply NJ Ex Order 26, 4B or if NJ Ex Order 26, 4B1 , every NJ Ex Order 26, as needed, NJ Ex Orde The Progress nots revealed a "Late Entry U. S. FOIA (b) (2) Note (NP) Effective Date at 2:18 PM revealed: NJ Ex Order 26, 4B1 and	F0695		06/16/2026

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 05/08/2026

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
F0695 SS = E	Continued from page 56 NJ Ex Order 26, 4B1 ... The NJ Ex Order 26, 4B Care Plan with current and resolved items was reviewed. A Focus for NJ Ex Order 26 initiated NJ Ex Order 26 with a Goal: Will be free of signs and symptoms of NJ Ex Order 26, 4B1 through review date, Initiated NJ Ex Order 26.4(b) Interventions included: Monitory for U. S. FOIA (b) (2) ... Monitor for signs and symptoms of NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 [NJ Ex Order 26, 4B1 Initiated NJ Ex Order 26.4 Another Care Plan Focus for NJ Ex Order 26 resulted to NJ Ex Order 26, 4B1 was initiated NJ Ex Order 26.4(b) with a Goal that resident will have no signs or NJ Ex Order 26, 4B1 through the review date, Initiated NJ Ex Order 26.4 Interventions included: Monitor for signs and symptoms of NJ Ex Order 26, 4B1 and report to physician as needed; NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 Date initiated NJ Ex Order 26.4 Both were dated "Target Date: NJ Ex Order 2, and there were no care plans related to having a NJ Ex Order 26, 4B1 and having a NJ Ex Order 26, 4B1 . The Medication Administration Record (MAR) revealed the nurse signed off that the NJ Ex Order 26, 4B1 on NJ Ex Order 26, 4B the evening and the as needed (PRN) NJ Ex Order 26, 4B for NJ Ex was left blank on NJ Ex Order 26.4(b)(1) when the surveyor observed the being administered at NJ Ex Order 26, 4B1 The Comprehensive Minimum Data Set dated NJ Ex Order 26 revealed the resident scored NJ Ex Order 26, 4B1 on the Brief Interview for Mental Status which indicated a NJ Ex Order 26, 4B1 and was not coded for NJ Ex Order 26, 4B1 . On 05/05/26 at 9:58 AM, the U. S. FOIA (b) (2) for the corporation informed the survey team that the U. S. FOIA (b) was suspended pending investigation related to a failure in care due to a failure to follow procedures after she was notified the resident was complaining of NJ Ex Order 26, 4B1 . When asked who was responsible for the NJ Ex Order 26 that did not match the physician order, the U.S. FOIA	F0695		06/16/2026

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 05/08/2026

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
F0695 SS = E	Continued from page 57 stated that they did not know and were investigating it. b. On 5/6/26 at 11:35 AM, the surveyor observed Resident #74 who was in a wheelchair with a NJ Ex Order 26, 4B1 . The resident was with a facility staff member, and the surveyor asked the resident, NJ Ex Order 26, 4B1, if they could check the resident's NJ Ex Order 26, 4B1 The surveyor checked NJ Ex Order 26, 4B1 , per resident's approval, and the needle was situated in the red area which indicated the NJ Ex Order 26, 4B1 . At that time, the facility staff member also acknowledged that the NJ Ex Order 26, 4B1 On 5/6/26 at 11:45 AM, the surveyor interviewed the NJ Ex Order U. S. FOIA (b) (2) who was Resident #74's nurse. The U. S. FOIA acknowledged that the resident's NJ Ex Order 26, 4B1 was NJ Ex Order and stated that she "just changed [their] NJ Ex Order 26, 4B1 and she then stated that the resident was alert and they would tell the nurse if the NJ Ex Order 26 needed to be changed. The surveyor then asked the U. S. FOIA if the facility checked the resident's NJ Ex Order 26 and she stated every morning, but she was unable to inform the surveyor why the NJ Ex Order 26, 4B1 The surveyor then reviewed the medical record for Resident #74 which revealed the following: A review of the Admission record (admission summary) revealed diagnoses which included but not limited to; NJ Ex Order 26, 4B1 [redacted] . A review of a Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care dated NJ Ex Order 26, 4B , reflected that the resident had a Brief Interview for Mental Status score of NJ Ex [redacted], indicating that the resident was NJ Ex Order 26, 4B1 [redacted]. The MDS further revealed that Resident #20 received NJ Ex Order 26, 4B1 which included NJ Ex Order 26, 4B1 . A review of the NJ Ex Order 26, 4B1 Order Summary Report (OSR) revealed the following Physician's Order (PO)	F0695		06/16/2026

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 05/08/2026

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
F0695 SS = E	Continued from page 58 dated NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 . A review of Resident #74's Individualized Care Plan had a focus that indicated the resident has NJ Ex Order 26, 4 [redacted] Resident frequent locomotion in wheelchair in and out of room which results in NJ Ex Order 26, 4B1 [redacted] adherence initiated [redacted] with interventions that included but were not limited to; NJ Ex Order 26, 4B1 [redacted] at all times." On 05/8/26 at 10:30 AM, the survey team presented the above concerns to the facility's administrative team which included the U. S. FOIA (b) (2) [redacted] No additional pertinent information was provided. A review of the Oxygen Administration Policy implemented 1/1/24 revealed the following: Policy Explanation and Compliance Guidelines: 1.Oxygen is administered under orders of a physician, except in the case of an emergency ... 2. Personnel authorized to initiate oxygen therapy include physicians, Registered Nurse, LPNs and respiratory therapists. 3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. monitoring for complications associated with the use of oxygen. 12 Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen. NJAC 8:39-27.1 (a)	F0695		06/16/2026
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The	F0755	Resident #14 and Resident #63's medication orders were immediately reviewed to ensure parameters will be followed. Any medication administered outside of parameters was reported to the physician, and new orders were obtained as needed. Both residents were assessed for any adverse effects related to medication administration; none were identified. Nursing staff assigned to these residents received immediate education from the Assistant Director of	06/16/2026

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 05/08/2026

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
F0755 SS = E	Continued from page 59 facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Repeat Deficiency Based on observation, interview, and record review, it was determined that the facility failed (a) to follow Physician Orders (PO) with regards to medications with parameters for 2 of 29 residents (Resident #14 and Resident #63) reviewed for medication management (b) to properly secure a medication in one (1) of four (4) nursing units, and C). accurate reconciliation and administration of [redacted] medication with potential for drug diversion . This 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 case-finding, health teaching, health counseling, and provision of	F0755	Continued from page 59 Nursing on the specific medication orders and required parameters. All residents on medications with parameters can be affected by the deficient practice. A facility audit of all medication orders with parameters was conducted by the Director of Nursing. The nursing staff received education on 5/29/2026 from the Assistant Director of Nursing on administering medication based on the parameters. The Director of Nursing (DON) or designee will conduct Daily audits for 3 residents for 2 weeks, then Weekly audits for 3 residents for 10 weeks. All audit results will be presented by the Director of Nursing at the monthly Quality Assurance and Performance Improvement (QAPI) meeting	06/16/2026

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 05/08/2026

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
F0755 SS = E	Continued from page 60 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." a). On 05/03/26 at 7:00 PM, the surveyor observed Resident #14 sitting up in bed with eyes open watching television. The surveyor reviewed the medical record for Resident #14. A review of the resident's Admission record (admission summary) revealed diagnoses which included but not limited to; NJ Ex Order 26, 4B1 [redacted]. A review of a significant change Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a brief interview for mental status score of [redacted], indicating that the resident was [redacted]. A review of the [redacted] Order Summary Report (OSR) revealed the following Physician's Order (PO) dated [redacted] give [redacted]. Hold for [redacted]. A review of the [redacted] electronic medication administration record (e-MAR) revealed the following Physician's Order (PO) dated [redacted] for [redacted] give [redacted]. Hold for [redacted]	F0755		06/16/2026

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 05/08/2026

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
F0755 SS = E	Continued from page 61 NJ Ex Order 26, 4B1 A review of the e-MAR revealed that NJ Ex Order 26, 4B1 had a plotted time for 0500 (5:00 AM) and on NJ Ex Order 2 the resident's NJ Ex Order 26, 4B1 was plotted for a NJ Ex Or of NJ Ex Or and the medication was signed as being administered. On 5/5/26 at 11:15 AM, the surveyor in surveyor in the presence of a Licensed Practical Nurse (LPN#1) reviewed the resident's e-MAR. At that time, LPN#1 acknowledge that the resident had a perimeter to hold NJ Ex Order 26, 4B1 when the NJ Ex Or was over NJ Ex Or. LPN#1 further acknowledge that the NJ Ex Orde NJ Ex Order 26, 4B1 on NJ Ex Order 26, 4B1 was NJ Ex O and the nurse should have held the medication. b). 05/03/2026 8:21 PM, the surveyor observed Resident #63 in their room, the resident who was in NJ Ex Order 26 care was observed in bed with their eyes closed and was sleeping. The surveyor reviewed the medical record for Resident #63. A review of the resident's Admission record (admission summary) revealed diagnoses which included but not limited to; NJ Ex Order 26, 4B1 [redacted] A review of an Annual Minimum Data Set, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, reflected that the resident had a brief interview for mental status score of NJ Ex Orde , indicating that the resident had NJ Ex Order 2 t. A review of the NJ Ex Order 26, 4B1 Order Summary Report (OSR) revealed the following Physician's Order (PO) dated NJ Ex Order 26, 4 for NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 one time a day for NJ Ex Order 26, 4B1. Hold for NJ Ex Or less than NJ Ex O. A review of the NJ Ex Order 26.4(b)(1 electronic medication administration record (e-MAR) revealed the following Physician's Order (PO) dated NJ Ex Order 26, for NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 time a day for NJ Ex Order 26, 4B1. Hold for NJ Ex Order 26, 4B1	F0755		06/16/2026

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 05/08/2026

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
F0755 SS = E	Continued from page 62 A further review of the NJ Ex Order 26, 4B1 e-MAR revealed that NJ Ex Order 26, 4B1 had a plotted time of 0800 (8:00 AM) and on two occasions the medication was administered when the was less than . On the resident had a documented . The medication was signed by the nurse as being administered with a . On , the resident had a documented . The medication was signed by the nurse as being administered with a . On 5/5/26 at 11:30 AM, the surveyor in surveyor in the presence of a Licensed Practical Nurse (LPN#1) reviewed the resident's e-MAR. At that time, LPN#1 acknowledge that the resident had a perimeter to hold when the NJ Ex Order 26, 4B1. LPN#1 further acknowledge that was administered to the resident on two occasions and when the was less than c). On 5/5/26 at 10:25 AM, the surveyor reviewed Resident #14's communication book on the -unit and observed NJ Ex Order 26, 4B1 with a package date o inside the book. At that time, the surveyor interviewed LPN#2/unit manager who stated that the medication was returned by the and when the nurse reviewed the the medication should have been removed and destroyed in a pill buster (medication destruction system). On 5/3/26 at 7:00 PM, the surveyor observed Resident #14 sitting up in bed with eyes open watching television. The surveyor reviewed the medical record for Resident #14. A review of the resident's Admission record (admission summary) revealed diagnoses which included but not limited to: NJ Ex Order 26, 4B1	F0755		06/16/2026

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 05/08/2026

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
F0755 SS = E	Continued from page 63 A review of a significant change Minimum Data Set, an assessment tool used to facilitate the management of care dated [redacted] reflected that the resident had a brief interview for mental status score of [redacted] indicating that the resident was [redacted]. A review of [redacted] OSR revealed the following PO dated [redacted] for [redacted] give [redacted] d). On 5/7/26 at 8:55 AM, a surveyor was conducting medication storage on [redacted] and was doing a narcotic count in the presence of LPN#3. The surveyor observed LPN#3 signing out the [redacted] inventory logbook after administering a resident's [redacted] At that time, the surveyor interviewed LPN#3 who acknowledge that she was signing the [redacted] inventory logbook after administering the medication. LPN #3 further stated that per facility policy that all [redacted] must be long out of the [redacted] inventory logbook once removed from the [redacted] On 5/8/26 at 10:30 AM, the surveyor presented the above concerns to the facility's administrative team which included the [redacted] No additional information was provided. A review of the facility policy dated as last approved 1/1/2024 for "Medication Administration" provided by the Regional Director of Clinical Services, revealed the following: "8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. " "21. If medication is a controlled substance, sign narcotic book." A review of the facility's policy dated 9/1/24 for "Medication Storage" provided by the Regional Director of Clinical Services, revealed the following: "All drugs and biologicals will be stored in locked compartments (medication carts, cabinets, drawers,	F0755		06/16/2026

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 05/08/2026

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
F0755 SS = E	Continued from page 64 refrigerators, medication rooms) under proper temperature controls." A review of the facility's policy dated 1/1/24 for "Controlled Substances Administration and Accountability" provided by the Regional Director of Clinical Services, revealed the following: " All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided." NJAC 8:39-11.2 (b), 29.2 (d)	F0755		06/16/2026
F0761 SS = E	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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review it was determined that the facility failed to properly label, dispose of and store medications in 2 of 6	F0761	All improperly labeled, expired, or undated medications were immediately removed and disposed of per facility policy. Any medications missing labels or cautionary instructions were returned to the pharmacy for proper labeling. The two affected medication carts were fully inspected, cleaned, and reorganized to ensure compliance with labeling and storage standards. Staff assigned were provide 1:1 education and remaining nursing staff received education from the Director of Nursing on labeling, storage, and security requirements. All residents can be affected by the deficient practice A facility audit was conducted by the Director of Nursing of all medication carts, medication rooms, refrigerators storing medications, and controlled substance storage compartments. The audit verified proper labeling (resident name, drug name, strength, route, cautionary instructions, expiration date), proper storage (locked, temperature-controlled, clean, organized), controlled substances stored in separately locked, permanently affixed compartments, and expired or undated medications present. Any issues identified were corrected immediately The Director of Nursing (DON) or designee will	06/16/2026

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 05/08/2026

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
F0761 SS = E	Continued from page 65 medication carts and 1 of 3 medication rooms. The deficient practices was evidenced by the following: On 5/7/26 at 8:55 AM, the surveyor inspected B-Wing medication cart #2 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed 2 unidentifiable tablets that were loose inside the medication cart. The surveyor also observed a Fluticasone propionate nasal spray with a used by date of 2/6/26. At that time, the surveyor interviewed LPN#1 who stated that the medication carts are cleaned daily and that any loose pills should have been discarded immediately in a pill buster (medication disposal system). LPN#1 also stated that any medication that is past it's used by date should be removed from the medication cart. On 5/7/26 at 9:50 AM, the surveyor inspected the subacute unit medication room in the presence of LPN #2. The surveyor observed a tablet that was in a medication package in a bin of normal saline IV bags, a resident's Meropenem IV bag that was label with an expiration date of 5/20/26 that was stored on top of IV normal saline bags, an opened and unused syringe, 4 blood collection sets with an expiration date of 12/31/24, 37 blood collection sets with an expiration date of 2/28/25, 13 blood collection sets with an expiration date of 3/31/25, 1 blood collection vial with an expiration date of 8/31/23, 2 blood collection vials with an expiration date of 7/31/22, one blood collection vial with an expiration date of 8/31/25 and one bag of 10% dextrose 1000 ml with an expiration date of 9/2025. In the presence of surveyor, LPN#2 acknowledged that all the above medical supplies were outdated. LPN#2 was unsure how often the medication room was cleaned and inspected but believed that the responsibility of cleaning and maintaining the medication room is with the supervisors and the managers. She further acknowledges that the loose tablet and syringe should have been discarded and that the resident Meropenem IV bag should have been stored separately from the IV normal saline bags. On 5/7/26 at 10:16 AM, the surveyor interviewed the subacute unit LPN#3/Unit Manager (UM) who stated that it was the responsibility of the overnight supervisor to ensure that the medication room was maintained which included being organized and was cleaned. She stated that it was her and night	F0761	Continued from page 65 conduct weekly audits for 10 weeks. All audit results will be presented by the Director of Nursing at the monthly Quality Assurance and Performance Improvement (QAPI) meeting.	06/16/2026

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 05/08/2026

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
F0761 SS = E	Continued from page 66 supervisor's responsibility to check medication and medical supplies expiration dates. She stated that she tried to check expiration dates on Monday morning but acknowledged that they were no documentation showing that the medication room was being cleaned. LPN#3/UM further stated that they should be no expired medications in drawers or in cabinets. On 5/7/26 at 10:23 AM, the surveyor inspected the ventilator unit medication cart in the presence of a Registered Nurse (RN#1). The surveyor observed one blood draw kit with an expiration date of 2/28/25. At that time, the surveyor interviewed RN#1 acknowledge that the blood draw kit was expired and should have been removed from the medication cart. On 05/8/26 at 10:30 AM, the surveyor presented the above concerns to the facility's administrative team which included the U. S. FOIA (b) (2) [redacted] No additional information was provided. A review of the facility's policy dated 9/1/24 for "Medication Storage" provided by the Regional Director of Clinical Services, revealed the following: "Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels." NJAC 8:39-29.4(a)(h) and (d)	F0761		06/16/2026
F0849 SS = E	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the	F0849	The facility immediately contacted the NJ Ex Order 26 provider for Resident #13 to obtain all required documentation, including the most recent NJ Ex Order 26 physician certifications, medication information, and 24-hour contact instructions. A care coordination meeting was held with the NJ Ex Order 26 and the facility's designated interdisciplinary team (IDT) members to review the resident's current needs and ensure alignment between the NJ Ex Order 26. All communication was documented in the resident's medical record. All residents receiving Hospice Services can be affected by the deficient practice	06/16/2026

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 05/08/2026

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
F0849 SS = E	Continued from page 67 provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's	F0849	Continued from page 67 A complete audit was conducted by the Director of Nursing of all current residents receiving hospice services to ensure a current hospice plan of care is present in the long term care (LTC) record, required hospice documents (election form, certifications, contact list, orders) are on file, communication logs reflect timely, ongoing coordination, and the long term care (LTC) plan of care includes hospice services and facility-provided services. Any missing documentation was immediately obtained from the hospice provider(s), and care coordination meetings were completed as needed. Assistant Director of Nursing educated staff the requirement of hospice documentation. The Director of Nursing (DON) or designee will conduct weekly audits for 4 weeks of all hospice residents, bi-weekly audits for 2 months, and monthly audits for 3 additional months. Findings will be presented by the Director of Nursing in monthly QAPI meetings. Any identified issues will result in immediate corrective action and staff education.	06/16/2026

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 05/08/2026

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
F0849 SS = E	Continued from page 68 responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:	F0849		06/16/2026

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 05/08/2026

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
F0849 SS = E	Continued from page 69 (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as	F0849		06/16/2026

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 05/08/2026

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
F0849 SS = E	Continued from page 70 required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to have a process in place to ensure that consistent communication between the facility and the [redacted] occurred for the coordination of resident care. This deficient practice was identified for one 1 of 2 residents reviewed for [redacted] (Resident #13) and the deficient practice was evidenced by the following: On 05/04/2026 12:10 PM the surveyor observed Resident #13 lying in bed watching television. Resident #13 stated that they were in [redacted] A review of Resident #13's Electronic Medical Record (EMR) revealed diagnosis of but not limited to; [redacted] A review of Resident's EMR revealed an order for [redacted], with an order date of [redacted]. A review of the significant change Minimum Data Set (SCMDS), an assessment tool used to facilitate management of care, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) of [redacted] revealing that Resident #13 had [redacted]. The SCMDS further revealed, Resident #13 was [redacted] while at the facility. A review of Resident #13's Care plan included a focus that revealed, Resident #13 was receiving [redacted] through a [redacted] with an intervention to work with [redacted] to ensure the resident's [redacted] A review of Resident #13's [redacted] communication binder revealed a [redacted] visit note report dated [redacted], patient information sheet dated [redacted], U. S. FOIA (b) (2) plan sheet dated [redacted], an incomplete [redacted] weekly visit record undated, a medication profile undated and NJ universal transfer form undated. On 5/6/2026 11:10 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) stated that a U. S. FOIA (b) (2) is provided once a week. The [redacted]	F0849		06/16/2026

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 05/08/2026

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
F0849 SS = E	Continued from page 71 further stated that any communication documentation can be found in the resident's [redacted]. On 5/6/2026 12:15 PM during an interview with the surveyor, the [redacted] stated that when the [redacted] provides care, it should be documented in the resident's [redacted]. The [redacted] further stated the [redacted] was responsible for ensuring that the communication documentation was done. A review of the facility provided policy titled "Coordination of Hospice Services" implemented on 6/01/2025, revealed under "Policy Explanation and Compliance Guidelines," under number 4, "The facility will communicate with hospice and identify and communicate, follow and document all interventions put into place by hospice and the facility". Further review of the policy further revealed under number 6, "The facility will maintain communication with hospice as it related to the resident's plan of care and serves to ensure each entity is aware of their responsibility." NJAC 8:39-27.1(a)	F0849		06/16/2026
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The	F0607	No residents were identified as having been directly harmed by the deficient practice related to incomplete pre-employment screening. The facility immediately implemented the following corrective actions: The four identified employee files (Employees #1–#4) were immediately reviewed by the Administrator and Human Resources Director (HRD). Background checks for Employees #1, #2, and #4 were re-verified, and documentation was placed in their personnel files. For Employee #2, whose background check was listed as "search pending," the HRD obtained the completed results and confirmed no disqualifying findings. The contracted District Manager's (Employee #4) screening documentation was obtained from the vendor, verified, and filed.	06/16/2026

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 05/08/2026

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
F0607 SS = D	Continued from page 72 policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review, it was determined that the facility failed to have a system in place to ensure prior to hire, all employees were pre-screened to ensure that they had not been found guilty in a court of law of abuse, neglect, or misappropriation, or had findings entered into the state nurse aide registry or against a professional license, and b) a process was in place to maintain documentation to confirm an appropriate pre-screening had occurred for all contracted facility employees which including dietary. The deficient practice was identified for 4 of 73 employee files reviewed that were provided by the facility and was evidenced by the following: On 5/3/26, during entrance conference, the surveyor requested from the U. S. FOIA (b) (2) a list of all employees that were hired since last survey, including name, date of hire, title, and including contracted employees and their files including medical information. On 5/4/26 at 10:38 AM, the U. S. FOIA (b) provided the list of employees, status, position, department, and date hired and their human resource and medical files. Between 5/4/26 and 5/8/26, the surveyors reviewed seventy-three employee files provided by the facility. Employee # 1, with a position of U. S. FOIA (b) (2) and a date of hire (DOH) of NJ Ex Order 26, [redacted], was noted to have a criminal background check ordered and completed on 9/5/25. Employee #2, with a position of U. S. FOIA (b) (2) [redacted]) and a DOH of NJ Ex Order 26, [redacted] was noted to have a criminal background check ordered on 5/7/26 with results of "search pending".	F0607	Continued from page 72 All four employees were confirmed to have no findings of abuse, neglect, misappropriation, or disqualifying criminal history. Because incomplete screening of employees and contracted staff has the potential to affect all residents, the facility conducted a comprehensive review: The HRD audited 100% of current employee files, including nursing, dietary, contracted staff, consultants, and temporary agency personnel, to verify completed criminal background checks and state registry checks. This audit was completed on 5/29/2026 No employees were found to have disqualifying histories. U. S. FOIA (b) (2) [redacted] was re-educated by the Regional Director of Human Resources on the facility's pre-hire screening requirements, including mandatory completion of criminal background checks and registry verifications prior to hire. A Pre-Hire Compliance Checklist was implemented and must be completed and signed by the HRD and Administrator before any employee begins work. The HRD or designee will audit all new hire files weekly for 1 month to ensure background checks and registry verifications are completed prior to hire. Following the first month, the HRD or designee will conduct audits every 2 weeks for 2 months to ensure continued compliance with pre-hire screening requirements. After the bi-weekly audit period, the HRD or designee will conduct monthly audits for 3 additional months. Audit results will be reported by the HRD to the QAPI Committee during its monthly meeting.	06/16/2026

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 05/08/2026

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
F0607 SS = D	Continued from page 73 Employee #3, with a position of U. S. FOIA (b) (2) and a DOH of 4U Ex Order 28, was noted to have a criminal background check ordered on 6/20/24 and results dated 6/21/24. Employee #4, with a position of U. S. FOIA (b) (2)r for the [Name Redacted] (contracted) food service company and a DOH of 4U Ex Order 28, was noted to have a criminal background check ordered and completed on 5/6/26. On 5/07/2026 at 1:51 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that she prints the criminal background check when she orders it, then she prints it again when the results come back. She further stated that a new employee should not be in the building until the criminal background check is completed. On 5/08/2026 at 10:09 AM, the survey team met with the U. S. FOIA (b) (2) and notified of the above concerns. On 5/08/2026 at 12:29 PM, the survey team met with the U. S. FOIA (b) (2). The U. S. FOIA handed the surveyor a packet stating, "This is the employee files - it's all here". Review of facility provided policy, "Employee files - New Hire - NJ", implemented 1/16/26, which included: Policy:The facility will not ask job applicants to answer medical questions, take a medical exam, or identify a disability. Current employees may be asked to undergo a medical examination under certain circumstances. Policy Explanation and Compliance Guidelines:Human Resources File All offers of employment are contingent upon clear results of a thorough background check. Background checks will be conducted on all final candidates and on all employees who are promoted, as deemed necessary. To include Social Security Verification, Educational Verification, Criminal History	F0607		06/16/2026

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 05/08/2026

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
F0607 SS = D	Continued from page 74 The surveyor reviewed the facility provided policy, "Abuse, Neglect and Exploitation", revised 1/1/26, which included: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The components of the facility abuse prohibition plan are discussed herein: Screening Potential employees will be screened for a history or abuse, neglect, exploitation, or misappropriation of resident property. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers and consultants. Screenings may be conducted by the facility itself, third party agency or academic institution. The facility will maintain documentation of proof that the screening occurred. N.J.A.C. 8:39-9.3(b)	F0607		06/16/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication times of	F0698	The facility immediately reviewed Resident #14's medication administration record (eMAR) and [NJ Ex Order 28] schedule. Medication administration times were corrected to ensure alignment with professional standards of practice and the resident's [NJ Ex Order 28] treatment schedule. The attending physician and [NJ Ex Order 28] center were notified, and updated medication orders were obtained as needed. Nursing staff were educated by the Assistant Director of Nursing on the residents' individualized medication timing requirements, and documentation was updated to reflect the correct schedule. All residents on Dialysis can be affected by the deficient practice	06/16/2026

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 05/08/2026

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
F0698 SS = D	Continued from page 75 administration to accommodate for [redacted] scheduled times. This deficient practice was identified for 1 of 1 residents (Resident #14) reviewed for [redacted] and 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 case finding, 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." The deficient practice was evidenced by the following: On 5/3/26 at 7:00 PM, the surveyor observed Resident #14 in bed with eyes open watching television and did not want to participate in an interview. The surveyor reviewed the medical record for Resident #14. A review of the resident's Admission record revealed diagnoses which included but not limited to [redacted]	F0698	Continued from page 75 A facility-wide audit was conducted by the Director of Nursing for all residents receiving dialysis services to ensure, medication administration times are appropriate relative to dialysis schedules, physician orders reflect correct timing and sequencing of medications, communication between the facility and dialysis center is documented, and care plans include dialysis-related medication considerations. Any discrepancies identified during the audit were immediately corrected in consultation with the attending physician and dialysis provider. The Director of nursing (DON) or designee will conduct weekly audits for 4 weeks of all residents receiving dialysis, Bi-weekly audits for 2 months, and monthly audits for 3 additional months. All findings will be presented by the Director of Nursing at the monthly Quality Assurance and Performance Improvement committee.	06/16/2026

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 05/08/2026

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
F0698 SS = D	Continued from page 76 NJ Ex Order 26, 4B1 A review of a significant change Minimum Data Set, an assessment tool used to facilitate the management of care dated NJ Ex Order 26, reflected that the resident had a brief interview for mental status score of NJ Ex Order 26, 4B1 indicating that the resident was NJ Ex Order 26, 4B1 A review of the resident's electronic physician's order (PO) reflected a PO for NJ Ex Order 26, 4B1" on NJ Ex Order 26, 4B1 start date of NJ Ex Order 26. Further review of the PO reflected the following: -a PO dated NJ Ex Order 26, 4B for "NJ Ex Order 26, 4B1 , give NJ Ex Order 26, 4B1 by NJ Ex Order 26, 4B1 -a PO dated NJ Ex Order 26, for "NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 ." -a PO dated 1 NJ Ex Order 26 for NJ Ex Order 26, 4B1 , give NJE - a PO dated NJ Ex Order 26, 4B1 "NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 " A review of the NJ Ex Order 26, 4B1 electronic medication administration record (EMAR) indicated medication administration times that occurred during the time that the resident was out of the facility at NJ Ex Order 26, The EMAR revealed the following: -a PO dated NJ Ex Order 26, for NJ Ex Order 26, 4B1 , give NJ Ex Order 26, 4B1 and was signed as being administered. -a PO dated NJ Ex Order 26, 4B for NJ Ex Order 26, 4B1 A plotted time of 8:00 AM and was signed as being administered. -a PO dated NJ Ex Order 26, 4B for U. S. FOIA (b) (2) " A plotted time of 8:00 AM and was signed as being administered. - a PO dated NJ Ex Order 26, 4 for "U. S. FOIA (b) (2)	F0698		06/16/2026

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 05/08/2026

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
F0698 SS = D	Continued from page 77 giv NJ Ex Order 26, 4B1 " A plotted time of 10:00 AM and was signed as being administered. A review of the resident's progress notes (PN) revealed multiple notes indicating that the resident returns to the facility on NJ Ex Order 26 days at 11:30 AM. Which included the following: A Nurses Note (NN) dated NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 note: Resident returned to the facility at 11:10 AM." A NN dated NJ Ex Order 26, 4B1, "Returned from NJ Ex Order 26 about 12:30 PM. A NN dated NJ Ex Order 26, 4B1, "Returned from NJ Ex Order 26 at 12:30 PM." A PN dated NJ Ex Order 26, 4B1, " NJ Ex Order 26, 4B1 note: Resident returned to the facility at 11:30 AM." On 5/5/26 at 11:15 AM, the surveyor interviewed a U. S. FOIA (b) (2) who was Resident #14's medication nurse. She informed the surveyor that Resident #14 returned from NJ Ex Order 26 around 11:30 AM, and at that time she would administer the resident's medications. After reviewing the resident's e-MAR in the presence of the surveyor, the LPN stated that the medication should have the administration times adjusted per the time the resident returned from NJ Ex Order 26 On 5/8/26 at 10:30 AM, the surveyor presented the above concerns to the facility's administrative team which included the U. S. FOIA (b) (2) No additional information was provided. A review of the facility policy dated as last approved 6/1/2025 for "Hemodialysis" provided by the Regional Director of Clinical Services, revealed the following: "Timely medication administration (initiated, held, or discontinued) by the nursing home and /or dialysis facility." NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)	F0698		06/16/2026

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 05/08/2026

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
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure a resident call bell was operationional. This deficient practice was identified for 1 of 2 residents reviewed for [redacted] (Resident #30) and was evidenced by the following: On 05/05/26 at 8:30 AM, the surveyor observed Resident #30 in bed and the [redacted] was at the bedside setting up the meal. On 05/05/26 at 8:45 AM, a subsequent interview with the [redacted] revealed that Resident #30 would get [redacted] every other day, Monday, Wednesday and Friday, with [redacted] and [redacted] When asked the [redacted] if the resident could press the call bell, the [redacted] then placed the call bell in the resident's hand and instructed the resident to press the call bell. The resident then tried to press the call bell, and it was not functioning. The [redacted] then confirmed that Resident #30's call bell was not functioning after she pressed the bell and it did not work. A further review of Resident #30's medical revealed a 27 page Care Plan with current and resolved Focus areas and a Focus for resident is at high risk for [redacted] due to history of [redacted] Initiated [redacted] Goal Resident will be free of [redacted] and will not sustain [redacted] through the review date, Initiated [redacted] with a Target Date [redacted] Interventions included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all	F0919	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE Upon identification on 05/05/26, Resident #30's non-functioning call bell was immediately replaced, as confirmed by the work order dated 05/05/26. Nursing staff verified that the new call bell was fully operational and placed directly within the residents' reach. The resident's care plan was reviewed to ensure interventions related to fall risk, call-light accessibility, and prompt response were accurate and active. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE A facility-wide audit of all resident call bells was completed by the Director of Maintenance to ensure: All call bells were functioning properly Call bells were within reach for every resident Bathroom pull cords were accessible and not tied up or shortened Any malfunctioning or inaccessible call bells identified during the audit were corrected immediately or placed on a priority work order with interim safety measures implemented. Residents with high fall risk, cognitive impairment, or dependence for ADLs were specifically reviewed to ensure call-light accessibility and appropriate adaptive devices were in place. Care plans for residents identified as high risk for falls were cross-checked to confirm call-light interventions were accurately reflected.	06/16/2026

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 05/08/2026

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
F0919 SS = D	Continued from page 79 requests for assistance; Initiated [redacted]. Follow NJ Ex Order 26, 4B1; Initiated [redacted] NJ Ex Order 26, 4B1: 1. Continue to use [redacted], 2-Continue NJ Ex Order 26.4(b)(1) 3. Re-educate resident to call for assistance prior to [redacted] 4 Initiate new NJ Ex Order 26, 4B1 screen, 5. Re-educate staff on frequent founding and NJ Ex Order 26, 4B1 practices; Date Initiated [redacted] Anticipate and meet resident's needs, Initiated [redacted] A review of the Admission Minimum Data Set, dated [redacted] revealed a Brief Interview for Mental Status Score of NJ Ex Order 26, 4B1 which revealed the resident had a NJ Ex Order 26, 4B1 Section [redacted] for NJ Ex Order 26.4(b)(1) revealed the resident was dependent on staff to NJ Ex Order 26, 4B1 [redacted] A [redacted] Assessment, Effective [redacted] revealed Resident #30 was identified as being at [redacted] for [redacted] On 05/08/26 at 10:09 AM, the survey team informed the U. S. FOIA (b) (2) [redacted] services of the above concerns. On 05/08/26 at 1:18 PM, during the exit conference, the facility informed the surveyor upon surveyor identification of the broken call bell it was replaced. A work order dated 5/5/25 revealed the call bell was replaced and no additional pertinent information was provided.	F0919	Continued from page 79 WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Nursing, CNA, and interdisciplinary staff were re-educated by the Assistant Director of Nursing on: Ensuring call bells always remain within reach Immediate reporting of any malfunctioning call bell The importance of call-light accessibility for residents with fall-risk status, impaired cognition, or dependence for ADLs The facility reinforced expectations for prompt call-light response and proper placement during routine care interactions. Maintenance will continue to address call-light issues through the existing work-order system, ensuring timely repair and documentation. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The Unit Manager or designee will conduct 10 random call-bell accessibility and functionality audits weekly for 1 month, then 10 random audits every 2 weeks for 2 months, followed by monthly audits for 3 additional months. Maintenance will continue weekly system functionality checks, documenting any repairs or work orders. Audit results, call-light-related incidents, and any resident concerns will be reviewed monthly by the QA/QAPI Committee for at least 6 months.	06/16/2026

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 05/08/2026

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
F0919 SS = D		F0919	Continued from page 80 Any identified issues will result in immediate corrective action, staff re-education, and root-cause analysis as needed.	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
S0000	Initial Comments Complaint #: NJ3005438 Survey Date: 5/8/26 Census: 144 Sample: 29 + 2 Closed Records 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		06/05/2026
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: Based on review of the Nurse Staffing Reports, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day and overnight shifts as mandated by the State of New Jersey for: 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. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8)	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. 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 by the Regional Director of Operations on the minimum staffing requirements. The facility has contracted with multiple staffing agencies to supplement their staff for the missing shifts in an effort to meet the staffing ratios. Measures or systemic changes to ensure that the deficiencies will not recur:	06/23/2026

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: 061342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
S0560	Continued from page 1 residents for the day shift. One (1) 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 (1) 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. For the 2 weeks of staffing prior to survey from 04/19/2026 to 05/02/2026, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -04/19/26 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs. -04/20/26 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -04/21/26 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -04/22/26 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -04/23/26 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -04/24/26 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -04/25/26 had 13 CNAs for 147 residents on the day shift, required at least 18 CNAs. -04/27/26 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. -04/28/26 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -04/29/26 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -04/30/26 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs.	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.	06/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
S0560	Continued from page 2 -05/01/26 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. -05/02/26 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. On 5/06/2026 at 10:51 AM, the surveyor interviewed the staffing coordinator who stated she was familiar with the CNA staffing ratios and feels that the facility maintains sufficient staffing. On 5/08/2026 at 9:18 AM, the surveyor interviewed the Director of Nursing who stated she was familiar with the staffing ratios stating, “10 to 1 or something”. She further stated that the facility was meeting the ratios. The surveyor reviewed the facility provided policy, “Staffing" implemented 10/15/25, which included: Policy: Facilities will provide qualified and appropriate staffing levels to meet the needs of the resident population. The staffing plan will include all shifts, seven days per week. Policy Explanation and Compliance Guidelines: The facility meets or exceeds the staffing levels mandated by state and federal staffing requirements. Staffing levels are reviewed on an ongoing basis by Facility staff to evaluate compliance and provide appropriate levels of care by qualified employees. A written staffing plan is prepared for each department. Time schedules are maintained and posted. The facility maintains appropriate staffing levels, with qualified personnel, 24 hours/day, seven days/week on each shift to assure that residents are safe and their needs are met.	S0560		06/23/2026
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician	S1405	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE All employees identified as missing required pre-employment health documentation had their files immediately reviewed.	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
S1405	Continued from page 3 assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, and review of other facility documentation, it was determined that the facility failed to have a system in place to ensure that employees received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment, or within thirty days if a Registered Nurse (RN) completed an assessment upon employment. This deficient practice was identified for 2 of 73 employee files reviewed, and was evidenced by the following: On 5/3/26, during entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a list of all employees that were hired since last survey, including name, date of hire, title, and including contracted employees and their files including medical information. On 5/4/26 at 10:38 AM, the LNHA provided the list of employees, status, position, department, and date hired and their human resource and medical files. Between 5/4/26 and 5/8/26, the surveyors reviewed seventy-three employee files provided by the facility. Employee #5, with a position of housekeeping aide and a date of hire (DOH) of [NJ Ex Order 26], was noted with a “New Employee Physical Examination” signed by a Registered Nurse (RN) on 2/6/26 and a “History and Physical” signed by the nurse practitioner on 2/6/26. Employee #6, with a position of Certified Nurse Aide (CNA) and a DOH of [NJ Ex Order], was noted with a “New Employee Physical Examination” signed by a Registered Nurse (RN) on 3/13/25 and a “History and Physical” signed by the nurse practitioner on	S1405	Continued from page 3 Missing health histories, RN assessments, or physician/APN/PA exams were obtained and filed. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE A full audit of all employee health files was completed by the Human Resources Director on 5/29/2026. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR A Pre-Hire Health Compliance Checklist was implemented for all new hires. HR staff, hiring managers, and the Infection Preventionist were re-educated by the Regional Human Resources Director on regulatory requirements on 5/29/2026. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE HR will conduct weekly audits of new-hire files for eight weeks, then monthly for three months. Audit results will be reviewed by the Infection Preventionist and reported during the monthly QAPI meetings.	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
S1405	Continued from page 4 3/18/25. On 5/08/2026 at 8:37 AM, the surveyor discussed with the Human Resource Director (HRD) the missing reference checks, criminal background checks and missing license checks. She stated that nursing is responsible for the physicals and PPDs (Tuberculosis testing). On 5/08/2026 at 8:50 AM, the surveyor interviewed the Director of Nursing (DON), who stated that newly hired employees go through human resources first, then the employee sees the Infection Preventionist. She further stated that their physical should be done before they start work. On 5/08/2026 at 10:09 AM, the survey team met with the Director of Nursing (DON), LNHA, Administrator in Training (AIT), Vice President of Clinical Services (VPCS), and the Regional Director of Operations (RDOO) and notified of the above concerns. On 5/08/2026 at 12:29 PM, the survey team met with the LNHA, DON, AIT, VPCS, and the RDOO. The DON handed the surveyor a packet stating, “This is the employee files - it's all here”. Review of facility provided policy, "Employee files - New Hire - NJ", implemented 1/16/26, which included: Policy: The facility will not ask job applicants to answer medical questions, take a medical exam, or identify a disability. Current employees may be asked to undergo a medical examination under certain circumstances. Policy Explanation and Compliance Guidelines: Employee Health File Medical Evaluations and Screening- 4. The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistance, within two weeks prior to the first day of employment or upon employment. If the new	S1405		06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
S1405	Continued from page 5 employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination my be deferred for up to 30 days form the first day or employment.	S1405		06/16/2026
S1410	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(b)(1) (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of pertinent facility documentation it was determined that the facility failed to have a process in place to ensure newly hired employees completed the required [redacted] NJ Ex Order 26.4(b)(1) upon hire. The deficient practice was identified for 1 of 73 employee files reviewed, and was evidenced by the following: On 5/3/26, during entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a list of all employees that were hired since last survey, including name, date of hire, title, and including contracted employees and their files including medical information. On 5/4/26 at 10:38 AM, the LNHA provided the list of employees, status, position, department, and date hired and their human resource and medical files.	S1410	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE All employees identified as missing required pre-employment health documentation had their files immediately reviewed. Missing health histories, RN assessments, or physician/APN/PA exams were obtained and filed. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE A full audit of all employee health files was completed by the Director of Human Resources on 5/29/2026. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR A Pre-Hire Health Compliance Checklist was implemented for all new hires. HR staff, hiring managers, and the Infection Preventionist were re-educated by the Assistant Director of Nursing on regulatory requirements on 5/29/2026. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE HR will conduct weekly audits of new-hire files for eight weeks, then monthly for three months.	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
S1410	Continued from page 6 Between 5/4/26 and 5/8/26, the surveyors reviewed seventy-three employee files provided by the facility. Employee #6, with a position of Certified Nurse Aide (CNA) and a DOH of [NJ Ex Order 25] was noted with [NJ Ex O] [redacted] dates of 3/13/25 and 3/23/25. On 5/08/2026 at 8:37 AM, the surveyor discussed with the Human Resource Director (HRD) the missing reference checks, criminal background checks and missing license checks. She stated that nursing is responsible for the physicals and [NJ Ex Order] [redacted] On 5/08/2026 at 8:50 AM, the surveyor interviewed the Director of Nursing (DON), who stated that newly hired employees go through human resources first, then the employee sees the Infection Preventionist. She further stated that the first step of the tuberculosis testing is done on the first day of work and the second stop is completed on around the 14th day of work. On 5/08/2026 at 10:09 AM, the survey team met with the Director of Nursing (DON), LNHA, Administrator in Training (AIT), Vice President of Clinical Services (VPCS), and the Regional Director of Operations (RDOO) and notified of the above concerns. On 5/08/2026 at 12:29 PM, the survey team met with the LNHA, DON, AIT, VPCS, and the RDOO. The DON handed the surveyor a packet stating, “This is the employee files - it's all here”. The surveyor reviewed the facility provided policy, "Employee files - New Hire - NJ", implemented 1/16/26, which included: Policy: The facility will not ask job applicants to answer medical questions, take a medical exam, or identify a disability. Current employees may be asked to undergo a medical examination under certain circumstances. Policy Explanation and Compliance Guidelines:	S1410	Continued from page 6 Audit results will be reviewed by the Infection Preventionist and reported during the monthly QAPI meetings.	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
S1410	Continued from page 7 Employee Health File New Staff Tuberculosis Screening 5. At the time of employment, all new staff shall undergo pre-placement screening for TB (tuberculosis), including an individual risk assessment, TB symptom screen, and a TB test. 6. All new staff shall receive two Mantoux TB skin tests given one to three weeks apart ("two-step testing")	S1410		06/16/2026

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 06/23/2026

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 An offsite/desk review of the facility's Plan of Correction was conducted on 6/23/2026 in relation to the 5/8/2026 Recertification 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.

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/23/2026

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
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 6/23/2026 in relation to the 5/8/2026 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		

Office of Primary Care and Health Systems Management

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 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/04/2026, 05/05/2026 and 05/06/2026 and Complete Care at Bayshore was found to be in noncompliance with the requirements for participation in Medicare /Medicaid at 42 CFR, 483.90 (a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Complete Care at Bayshore is a two-story, Type II Protected building that was built in January 1968. The facility is divided into 13 smoke zones, The facility has one 500 KW emergency generator and one 150 KW emergency generator thaty supplies electrical power to the Vent Unit , emergency lighting, fire alarm and detection system, kitchen walk-in boxes and illuminated exit signs.	K0000		05/23/2026
K0291 SS = E Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 05/04/2026 in the presence of the facility's U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to ensure 1 of 3 battery back-up emergency lights (independent of the emergency generator) for the emergency generators three (3) transfer switches functioned properly when tested. This deficient practice had the potential to affect all 144 Residents and was evidenced by the following: During the survey entrance on 05/04/2026 at approximately 8:52 AM, a request was made to the U.S.FO [redacted] if the facility had an emergency generator. The	K0291	During Life Safety rounds it was determined that the facility failed to ensure that a battery-operated emergency backup light was provided at the emergency generator transfer switch. Emergency battery backup lighting was installed on 5/6/2026 for the generator transfer switch. All residents have the potential to be affected by the deficient practice. Maintenance staff were educated 5/27/2026 regarding the requirements for battery backup lighting for transfer switches. Generator transfer switch audits will be added to the monthly maintenance preventive checklist to ensure that emergency lighting is in place. The Maintenance Director or designee will report the findings of these audits at the quarterly Quality Assurance and Performance Improvement meetings for 3 quarters and any additional action required will be determined by the IDT team.	06/05/2026

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 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
K0291 SS = E Bldg. 01	Continued from page 1 U. S. FO said, yes there are three (3) here, one (1) was for the Long Term Care building, one (1) was for the Vent Unit and one (1) was for the Assisted Living. Observations at approximately 11:31 AM, during an inspection inside the boiler room the surveyor made a request to the U. S. FO to test the battery back-up emergency light for the Long term Care generator transfer switch. When the U. S. FO pressed the test button the emergency light did not function properly. The light fixture did not light. An interview with the U. S. FO confirmed the finding at the time of observation. The U. S. FOIA (b) (2) were informed of the deficient practice during the Life Safety Code Survey exit on 05/06/2026 at approximately 1:01 PM. NJAC 8:39 -31.2 (e),NFPA 101: 2012 -19.2.9.1, 7.9.	K0291		06/05/2026
K0347 SS = E Bldg. 01	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 05/05/2026 in the presence of the facility's U. S. FOIA (b) (2), it was determined that the facility failed to ensure that areas open to the exit corridors were provided with smoke detection in accordance with the National Fire Protection Association (NFPA) 101, 2012 Edition, Section 19.3.4.5.2 and 19.3.6.1. This deficient practice had the potential to affect the144 Residents and was evidenced by the following: Observations on 05/05/2026 in the presence of the U. S. FO the surveyor observed the following areas that were open to the exit corridors, At approximately 10:17 AM, during an inspection of the "A-Wing" Nurses Station the surveyor observed measured and recorded a 26-1/2 inch by 20 inch opening through the wall leading into the A-Wing Nurse Managers office. Inspection inside the Nurse Managers office revealed no evidence of smoke	K0347	During Life Safety rounds it was determined that the facility failed to ensure that a smoke detector was installed in A and B wing nurse managers' offices. An audit was conducted of all other units with no additional findings. Smoke detectors were installed in the nurse manager's office on 6/5/2026. All residents have the potential to be affected by the deficient practice. Maintenance staff were educated on 5/27/2026 regarding the requirements for smoke detector installation. Smoke detector audits will be added to the monthly maintenance preventive checklist to ensure that smoke detectors are in place. The Maintenance Director or designee will report the findings of these audits at the quarterly Quality Assurance and Performance Improvement meetings for 3 quarters and any additional action required will be determined by the IDT team.	07/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
K0347 SS = E Bldg. 01	Continued from page 2 detection. At this time the surveyor asked the [U. S. FO] do you see a smoke detector in here. the [U. S. FO] looked up and around and told the surveyor, no .At approximately 11:08 AM, during an inspection of the [U. S.] Wing" Nurses Station the surveyor observed measured and recorded a 35 inch by 19 inch opening through the wall leading into the B-Wing Nurse Managers office. Inspection inside the Nurse Managers office revealed no evidence of smoke detection. At this time the surveyor asked the [U. S. FO] do you see a smoke detector in here. the [U. S. FO] looked up and around and told the surveyor, no. The [U. S. FO] confirmed the findings at the times of observations. The U. S. FOIA (b) (2) were informed of the deficient practice during the Life Safety Code Survey exit on 05/06/2026 at approximately 1:01 PM. NJAC8:39-31.2 (e)., NFPA 72.	K0347		07/16/2026
K0923 SS = E 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	K0923	During Life Safety rounds it was determined that the facility failed to secure portable oxygen cylinders to prevent accidental tipping and rupturing. The tanks identified were removed from the area and properly secured. An audit was conducted on all oxygen storage tanks, and no additional were found to be improperly secured. Secure portable oxygen holders were installed in the deficient area on 5/15/2026. All residents have the potential to be affected by the deficient practice. Maintenance staff were educated on 5/27/2026 regarding the requirements for secure oxygen storage. Secure oxygen storage audits will be added to the monthly maintenance preventive checklist to ensure that secure oxygen storage is in place. The Maintenance Director or designee will report the findings of these audits at the quarterly Quality Assurance and Performance Improvement meetings for 3 quarters and any additional action required will be determined by the IDT team.	07/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
K0923 SS = E Bldg. 01	Continued from page 3 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: Based on observations and interview on 05/04/2026 in the presence of the facilities U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to secure portable oxygen cylinders to prevent accidental tipping and rupturing, in accordance with NFPA 99: 2012 edition. This deficient practice had the potential to affect all 144 Residents and was evidenced by the following: During the building tour in the presence of the [redacted] at approximately 11:27 AM, the surveyor observed inside the loading docks Oxygen storage room six (6) E-Type oxygen cylinders stored up-rite on the floor and were not placed in a secure storage unit or secured by a wall mounted chain to prevent them from accidentally tipping over and rupturing. At this tie the surveyor asked the [redacted], should the tanks be secured in a rack. The [redacted] told the surveyor, yes. The U. S. FOIA (b) (2) were informed of the deficient practice during the Life Safety Code Survey exit on 05/06/2026 at approximately 1:01 PM. NJAC 8:39-31.2 (e), NFPA 99.	K0923		07/16/2026
K0311 SS = D Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6.	K0311	During Life Safety rounds it was determined that the center failed to ensure that 1 of 10 exit access doors leading into stairwells tested, could maintain the 2-hour fire rated construction. The door was repaired on 6/5/2026 and closes and latches properly. All exit access doors were tested and latched properly. All residents have the potential to be affected by the deficient practice. The U. S. FOIA (b) (2) was educated on 5/27/2026 on correct fire-rated door assemblies that	06/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
K0311 SS = D Bldg. 01	Continued from page 4 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observations and review of facility provided documentation on 05/04/2026 and 05/05/2026 in the presence of the facility's U. S. FOIA (b) (2)), it was determined that the facility failed to ensure that 1 of 10 exit access doors leading into stairwells tested, were capable of maintaining the 2 hour fire rated construction. This deficient practice had the potential to affect the 144 Residents and was evidenced by the following: On 5/4/2026, (day one of survey) during the survey entrance at approximately8:52 AM, a request was made to the U. S. FOIA (b) (2) to provide a copy of the facility lay-out which identifies various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with five (5)exit stairwells with illuminated exit signs above the doors that Residents, Visitors and Staff would use in the event of an emergency to exit the building. Observation on 5/4/2026 in the presence of the U. S. FO at approximately 9:48 AM, during a closure test of the second floor stairwell #2 exit access door, when the door was opened to a 90 degree opening to the frame and allowed to self-close the door rubbed on the floor, stopped and did not close and latch into its frame as required by code. . This test was repeated two additional times with the same results. The U. S. FO confirmed the finding at the time of observation. The U. S. FOIA (b) (2) were informed of the deficient practice during the Life Safety Code Survey exit on 5/6/2026 at approximately 1:01 PM. NJAC 8:39-31.2 (e), Life Safety Code 101, 2012 Edition.	K0311	Continued from page 4 latch, and to ensure any further corrections to facility fire doors receive proper hardware. The administrator or designee will audit all facility fire doors to ensure the correct fire rated door assemblies which latch are in place monthly for three months, then quarterly for three quarters. All findings will be reported at the quarterly Quality Assurance and Performance Improvement meetings and any additional action required will be determined by the IDT team.	06/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
K0355 SS = D Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observations on 05/04/2026 and 05/05/2026 in the presence of the facility's U. S. FOIA (b) (2), it was determined that the facility failed to perform a monthly visual examination and document the inspection on the tag attached to the fire extinguisher for 3 of 31 portable fire extinguishers observed and inspecte3d in accordance with the National Fire Protection Association (NFPA) 10, 2010 Edition 7.2.4, 7.3.3. Observations on 5/4/2026 and 5/5/2026 in the presence of the facility's U.S. FO revealed 31 fire extinguishers in various locations with the following results: On 5/4/2026: At approximately 11:13 AM, the surveyor observed inside the Kitchen, one (1) ABC Type fire extinguisher that was last annually inspected March 2026, with no evidence of a monthly visual examination being performed and documented for April 2026, on the tag attached to the fire extinguisher. At approximately 11:15 AM, the surveyor observed inside the kitchen, one CO-2 fire extinguisher that was last annually inspected March 2026, with no evidence of a monthly visual examination being performed and documented for April 2026, on the tag attached to the extinguisher. At approximately 11:26 AM, the surveyor observed in the service corridor outside of the kitchen, one ABC Type fire extinguisher that was last annually inspected March 2026 with no evidence of a monthly visual examination being performed and documented for April 2026, on the tag attached to the extinguisher. The U.S. FO confirmed the findings at the times of observations.	K0355	During Life Safety rounds it was determined that the facility failed to perform a monthly visual examination and document the inspection on the tag attached to the fire extinguisher for 3 of 31 portable fire extinguishers. The 3 missing fire extinguishers were inspected and documented on the tags as required. All residents have the potential to be affected by this deficient practice. Maintenance staff were educated on 5/27/2026 regarding the requirements for inspecting fire extinguishers. The 3 missing fire extinguishers were added to the master list of extinguishers to be checked monthly. The Maintenance Director or designee will perform monthly audits on all extinguishers for 3 months and then quarterly for 3 quarters. The Maintenance Director or designee will report the findings of these audits at the quarterly Quality Assurance and Performance Improvement meetings for 3 quarters and any additional action required will be determined by the IDT team.	06/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/08/2026

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
K0355 SS = D Bldg. 01	Continued from page 6 The U. S. FOIA (b) (2) were informed of the deficient practice during the Life Safety Code Survey exit on 5/6/2026 at approximately 1:01 PM. NJAC 8:39-31.2 (e), NFPA 10, Life Safety Code 101, 2012 Edition.	K0355		06/05/2026

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 05/08/2026

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
E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/05/2026 and 05/06/2026. Complete Care at Bayshore was found to be in noncompliance with Medicare/ Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		06/05/2026
E0004 SS = E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan.	E0004	During Life Safety rounds it was determined that the facility failed to update all EPP binders in the facility. An audit was conducted on all EPP binders in the center and any outdated binders were removed to be updated. All EPP binders were updated by 5/28/2026. All residents have the potential to be affected by the deficient practice. U. S. FOIA (b) (2) was educated by Regional Director of Operations on 5/26/2026 about the importance of ensuring all EPP binders are reviewed and updated annually, or when any significant changes occur. Administrator or designee will audit all EPP binders quarterly to ensure all information is up to date. The Administrator or designee will report the findings of these audits at the quarterly Quality Assurance and Performance Improvement meetings for 3 quarters and any additional action required will be determined by the IDT team.	06/05/2026

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 05/08/2026

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
E0004 SS = E	Continued from page 1 The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility provided documentation on 5/5/2026 and 5/6/2026 in the presence of the facility's U. S. FOIA (b) (2) it was determined that the facility failed to ensure that three (3) of four (4) Emergency Preparedness Plan (EPP) books were reviewed and updated annually. This deficient practice had the potential to affect the 144 Residents and was evidenced by the following: In an interview on 5/4/2026 during the survey entrance at approximately 9:05 AM, a request was made to the U. S. FOIA (b) (2), "How many Emergency Preparedness Plan (EPP) books are in the facility." The U. S. FOIA (b) (2) told the surveyor there are five (5) EPP books. The U. S. FOIA (b) (2) has one (1) Master book, Maintenance has one (1) and there is three (3) one at each Nursing Stations. Record review on 05/05/2026: At approximately 12:15 PM, a review of the U. S. FOIA (b) (2) Wing Unit Nursing station EPP book reads in part: had the signatures of the Administrator #2, Maintenance Director #2, Director of Nursing #2 and Facility Educator #2 annual review 6/1/2023. Page #6 in the EPP book reads, "This plan has been reviewed and promulgated on 5/4/2023 by U. S. FOIA (b) (2) At approximately 12:26 PM, a review of the A-Wing Unit Nursing station EPP book reads in part: had the signatures of the Administrator #2, Maintenance Director #2, Director of Nursing #2 and Facility Educator #2 annual review 6/1/2023. Page #6 in the EPP book reads, "This plan has been reviewed and promulgated on 5/4/2023 by U. S. FOIA (b) (2) ." At approximately 12:42 PM, a review of the Administrators "Master" EPP book reads in part:	E0004		06/05/2026

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 05/08/2026

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
E0004 SS = E	Continued from page 2 had the signatures of the Administrator #1, Maintenance Director #1, Director of Nursing #1 and Facility Educator #1 signed the annual review on 5/1/2026. Page #6 in the EPP book reads, "This plan has been reviewed and promulgated on 8/1/2025 by Administrator #1." On 5/6/2026 at approximately 10:48 AM, a review of the Sub-Acute Unit Nursing station EPP book reads in part: had the signatures of the "Administrator #2, Maintenance Director #2, Director of Nursing #2 and Facility Educator #2 annual review 6/1/2023. Page #6 in the EPP book reads, "This plan has been reviewed and promulgated on 5/4/2023 by [redacted] Three (3) of the four (4) EPP books reviewed were last annually reviewed 5/4/2023. The [redacted] confirmed the findings at the times of record review. The U. S. FOIA (b) (2) were informed of the deficient practice during the Life safety Code survey exit on 5/6/2026 at approximately 1:01 PM NJAC 8:39-31.6 (f).	E0004		06/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315252	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **08/19/2026**

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
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 8/19/2026 in relation to the 5/8/2026 Life Safety Code survey. The facility 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 Occupancy.	K0000		08/19/2026

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.

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 08/19/2026

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
E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 8/19/2026 in relation to the 5/8/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		08/19/2026

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.

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