STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 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
F 000	INITIAL COMMENTS COMPLAINT #: NJ00171641 CENSUS: 148 SAMPLE SIZE: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT SURVEY.	F 000		
F 755 SS=D	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(g). The 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.	F 755		3/12/24

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

Electronically Signed | 03/07/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 02/14/2024

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COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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F 755	Continued From page 1 §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: C #: NJ00171641 Based on observation, interview, and review of medical records and other pertinent facility documentation on 2/14/24, it was determined that the facility failed to follow professional standards of clinical practice for a). the administration of medications and b.) following a physician's orders, and c). adhering to the facility's policy for using the Medication Administration Record for 1 of 3 residents (Resident #2) reviewed for medication administration. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as 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."	F 755	• Resident #2 was immediately assessed for self-administration of medication. • The Director of Nursing explained to the resident the risk and benefit of having the nurses apply the NJ Exec. Order 26:4.b.1 [redacted] as ordered by her physician. All the residents may be affected by this practice. • The Director of Nursing and the Facility Educator will in-service all the nurses on Federal Regulation F-755 related to pharmacy services, procedures, and records. • The Director of Nursing and/or designee will discuss the risk and benefit of self-medication during the Resident Council Meeting. • The ADON and/or designee will do a random med pass competency. • The Unit Manager and/or designee will do 5 med pass audit weekly between all three shifts for 4 weeks then monthly for 3 months. • The DON will submit the audit report to the Quality Assurance Committee. 3/15/24 • The Director of Nursing	

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F 755	Continued From page 2 During the interview with Resident #2 on 2/14/24 at 10:08 a.m., the surveyor observed an uncapped NJ Exec. Order 26:4.b.1). The Resident revealed that she/he had medication at bedside at all times. The Resident further revealed that the "nurse" gave her/him the medication and she/he apply on her/his NJ Exec. O whenever she/he remembered. According to the admission record, Resident #2 was admitted with diagnosis that included but was not limited to: NJ Exec. Order 26:4.b.1 The Minimum Data Set (MDS), an assessment tool, dated NJ Exec. Order 26:4.b, revealed a BIMS of NJ Exec which indicated the Resident's cognition was NJ Exec. Orde and needed help during care with Activity of Daily Living. The "PHYSICIAN'S ORDER" (PO) for NJ Exec. Order 26:4 reflected an order for NJ Exec. Order 26:4.b.1 ordered on NJ Exec. Order 26:4. The "MEDICATION ADMINISTRATION RECORD" (MAR) for the month of 2/2024 confirmed the aforementioned physician orders. The MAR further indicated that the aforementioned medication was to be given at 9:00 a.m. and 5:00 p.m. and the MAR was signed by the licensed staff indicating that the medication was administered according to the schedule. During the follow up interview on 2/14/24 at 2:26 p.m., Resident # 2 stated that when she/he asked the aforementioned medication, "the nurse just gave it to me and never took it back," she/he further stated that she/he does not apply to	F 755	immediately removed the Clobetasol Propionate from the resident to be dispensed only by the nurses. • LPN was immediately in-service by the Assistant Director of Nursing on proper medication administration with 1:1 demonstration. • LPN also received a written discipline per facility protocol. • The Unit Manager and/or designee will complete a Self-Administration assessment for any resident who prefer to administer their own medication and an order must be obtained. All the residents may be affected by this practice. " The Director of Nursing and the Facility Educator will in-service all the nurses on Federal Regulation F-755 related to pharmacy services, procedures, and records. " The Director of Nursing and/or designee will discuss the risk and benefit of self-medication during the Resident Council Meeting. " The ADON and/or designee will do a random med pass competency. " The Unit Manager and/or designee will complete a Self-Administration assessment for any resident who prefer to administer their own medication and an order must be obtained. " The Unit Manager and/or designee will do 3 med pass audit weekly between all three shifts for 4 weeks then monthly for 3 months. " The DON or designee will submit the	

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F 755	Continued From page 3 his/her [NJ Exec. Ord] everyday only "when" she remembered. During the interview in the Licensed Nurse Practical (LPN #1) on 2/14/24 at 12:53 p.m., LPN #1 stated that she has been giving the aforementioned medication to Resident #2 and leaving the [NJ Exec. Order 2] at bedside, (unable to recall date), because Resident #2 asked for it and she/he was alert and able makes needs known. She further stated that every day, during her shift, she would sign the MAR even if she was not sure if the Resident did not apply the [NJ Exec. Order 26-4.2] to her/his [NJ Exec. O] because she/he "might" apply at a later time. During an interview on 2/14/24 at 1:21 p.m., the Administrator and the Director of Nursing was not aware that Resident #2 was self-medicating her/himself. They further stated that the nurses were not allowed to leave any medication at the resident's bedside table unattended to ensure residents safety. The facility's policy titled "Administering Medications," dated 10/2023, indicated "Medications shall be administered in a safe and timely manner...1. Only persons licensed or permitted by this state to prepare, administer...3. Medication must be administered within one (1) hour of their prescribed time...11. Residents may self-administer their own medications only if the Attending Physician, is conjunction with the Interdisciplinary Care Planning Team, has determined hat they have the decision-making capacity to do so safely..." NJAC 8:39-29.4 (h)	F 755	audit report to the administrator or his designee at the Quality Assurance Committee which meets every 3 months.	

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	315252	A. BUILDING _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061342	A. BUILDING: _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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S 000	Initial Comments COMPLAINT #: NJ00171641 CENSUS: 148 Sample Size: 3 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.	S 000		
S 580	8:39-5.1(e) Mandatory Access to Care (e) The facility shall make available to indigent individuals at least five percent of its beds or, if the facility is licensed for 100 or more beds, at least 10 percent of its beds. For purposes of this section, an individual is "indigent" if he or she is an applicant for admission or a current resident of the facility, and if he or she would otherwise meet the eligibility requirements of Medicaid reimbursement or county or municipal financial assistance for nursing home care. This REQUIREMENT is not met as evidenced by: C #: NJ00171641 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to	S 580	There is no opportunity to correct the insufficient staff on the following dates. No residents were affected by this practice.	3/10/24

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

Electronically Signed | 03/07/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 580	Continued From page 1 maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 14 of 14-day shifts. This deficient practice had the potential to affect all residents. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every 8 residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties. One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 1/28/24 to 2/10/24, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shifts. The facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows:	S 580	All the residents may be affected by the short staff as required by NJ DOH. The Administrator will rein-service the Staffing Coordinator in reference to the state guideline S 560. " Human Resources will continue to post the vacancies in all 3 shifts. " The staffing agency will block a schedule for the open position to cover for the vacancies as possible. " Administrator and staffing recruiter will continue to try and recruit as many staff as possible giving the facility a bigger pool of employees. " The Staffing Coordinator will audit the staffing weekly for 4 weeks then monthly for 3 months. " The Staffing Coordinator will submit the audit report to the administrator or his designee at the Quality Assurance Improvement Committee which meets every 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 580	Continued From page 2 -01/28/24 had 10 CNAs for 148 residents on the day shift, required at least 18 CNAs. -01/29/24 had 13 CNAs for 146 residents on the day shift, required at least 18 CNAs. -01/30/24 had 13 CNAs for 145 residents on the day shift, required at least 18 CNAs. -01/31/24 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. -02/01/24 had 14 CNAs for 145 residents on the day shift, required at least 18 CNAs. -02/02/24 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. -02/03/24 had 12 CNAs for 147 residents on the day shift, required at least 18 CNAs. -02/04/24 had 12 CNAs for 147 residents on the day shift, required at least 18 CNAs. -02/05/24 had 13 CNAs for 147 residents on the day shift, required at least 18 CNAs. -02/07/24 had 14 CNAs for 150 residents on the day shift, required at least 19 CNAs. -02/08/24 had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs. -02/09/24 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. -02/10/24 had 12 CNAs for 150 residents on the day shift, required at least 19 CNAs.	S 580		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315252 Y1	A. Building B. Wing Y2	3/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0755	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/12/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061342 Y1	A. Building B. Wing Y2	3/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0580	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/12/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO