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 10/30/2024

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 #: NJ169671, NJ169783, NJ169941, NJ170303, NJ171291, NJ171541, NJ172589, NJ172648, NJ173540, NJ176557, NJ176372 Survey Date: 10/29/24 Census: 138 Sample: 28 + 3 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.	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: NJ Complaint # NJ169941 Based on interview, review of the closed medical record, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident was sufficiently prepared for a discharge from the facility by providing a prescription for an NJ Ex Order 26.4(b)(1) . This deficient practice was identified for 1 of 2 residents reviewed for discharge (Resident #239),	F 624	Resident # 239 NJ Exec Order 26.4b1 by the deficient practice. Resident was discharged on NJ Ex Order 26.4(b)(1) All residents being discharged from the facility have the potential to be affected by the deficient practice. The Director of Nursing and the Facility Educator provided education for all unit managers and nurses involved. Facility wide education is provided to all	11/11/24

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

Electronically Signed | 11/13/2024

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.

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F 624	Continued From page 1 and was evidenced by the following: On 10/28/24 at 10:23 AM, the surveyor reviewed the closed medical record for Resident #239 which revealed the resident was admitted to the facility in [NJ Ex Order] and discharged from the facility in [NJ Ex Order 2] A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses including but not limited to; NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1) [redacted]. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26.4(b)] indicated that the resident had a brief interview for mental status (BIMS) score of [NJ] out of 15, which indicated NJ Ex Order 26.4(b)(1) . A review of the Physician Order Summary Report reflected a physician's order with a start date of [NJ Ex Order 26.4(b)(1)] at 2:00 PM, for NJ Ex Order 26.4(b)(1) [redacted]; give one capsule by mouth every eight hours related to [NJ Ex Order 26.4(b)(1)] and NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1) [redacted]. There was no stop date per NJ Ex Order 26.4(b)(1) A review of the U.S. FOIA (b) (6) Medication Administration Record (MAR) revealed Resident #239 received the NJ Ex Order 26.4(b)(1) [redacted]	F 624	nurses to ensure completion of discharge summary and obtaining prescription for non-OTC discharge medications. The Unit Manager or designee will audit 2 discharge charts weekly x 4 then monthly x 2 to determine completion of discharge summary and availability of prescriptions on non OTC discharge medication. The DON will submit the audit report to the Quality Assurance Committee.	

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F 624		F 624		

Continued From page 2

NJ Ex Order 26.4(b)(1) at 6:00 AM, 2:00 PM, and 10:00 PM from NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1)

A review of the discharge summary dated NJ Ex Order 26.4(b)(1), indicated that the resident was scheduled for discharge on NJ Ex Order 26.4(b)(1), to NJ Ex Order 26.4(b)(1).

A review of the New Jersey Universal Transfer Form revealed that Resident #239 was discharged from the facility on NJ Ex Order 26.4(b)(1) at 12:30 PM. The resident was transferred to NJ Ex Order 26.4(b)(1).

On 10/28/24, the surveyor requested copies of the prescriptions that were given to the resident upon discharge. A review of the prescriptions revealed that the resident received the following prescriptions dated NJ Ex Order 26.4(b)(1): NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). The prescription for NJ Ex Order 26.4(b)(1) was dated for NJ Ex Order 26.4(b)(1).

On 10/28/24 at 12:43 PM, the U.S. FOIA (b) (6), in the presence of the U.S. FOIA (b) (6)), U.S. FOIA (b) (6) U.S. FOIA (b) (6), U.S. FOIA (b) (6)

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F 624	Continued From page 3 ([redacted] and survey team, stated that the resident was on [redacted]; the [redacted] was completed but the [redacted] was supposed to continue. The [redacted] further stated that the resident should have been discharged with the [redacted] but was not because the [redacted] thought both [redacted] were completed, and she did not write a prescription for the [redacted] The [redacted] also stated that it was a miscommunication and when the [redacted] contacted the nursing home, a prescription for the [redacted] was sent to them. On 10/29/24 at 10:42 AM, the [redacted] in the presence of the [redacted], U.S. FOIA (b) (6) [redacted], [redacted] U.S. FOIA (b) (6) [redacted]), and survey team stated that the [redacted] "dropped the ball" and missed the [redacted] when writing the prescriptions for discharge. The [redacted] acknowledged that the resident did not get their medication on time and there should have not been any missed doses of the [redacted] A review of the facility's "Discharge Summary and Plan" with a revision date of January 2019, included when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to new changes in medication regimen related his/her new living environment. Medication therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident) ... NJAC 8:39-27.1(a)	F 624		

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		11/11/24

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F 656	Continued From page 5 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to develop an individualized comprehensive care plan for a resident with [NJ Ex Order 26.4(b)(1)]. This deficient practice was identified for 1 of 1 resident reviewed for [NJ Ex Ord] management (Resident #10), and was evidenced by the following: On 10/22/24 at 12:17 PM, during initial tour of the facility, the surveyor observed Resident #10 in bed with eyes closed. On 10/24/24 at 10:01 AM, the surveyor reviewed the medical record for Resident #10. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses which included but were not limited to; [NJ Ex Order 26.4(b)( ), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26.4(], revealed the resident had a Brief Interview of Mental Status score of [NJ Ex] out of 15, meaning the resident was [NJ Ex Order 26.4(b)(1)]. A review of Section [NJ] Health Conditions revealed the resident had [NJ Ex Order 26.4(b)(1)] and was receiving	F 656	Resident #10 was [NJ Ex Order 26.4(b)(1)] the deficient practice and the residents care plan was immediately reviewed and updated. All residents on pain management may be affected by this deficient practice. DON and Unit Manager reviewed care plans of resident on [NJ Exec O] management and no other resident [NJ Exec Order 26.4b1] by the deficient practice. The Director of Nursing/ ADON and the Facility Educator reeducated all Unit Managers and nurses involved in the comprehensive care plan process to ensure care plans are initiated and updated as needed. IDT team will review care plan and update during each care plan meeting and as needed to reflect current health status and care needs. MDS coordinator/ Unit Managers/ or designee will audit 4 residents on pain management care plans weekly x 4 then monthly x 2 months. MDS coordinator will submit the audit	

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F 656	Continued From page 6 NJ Ex Ord medications. A review of the active Order Summary Report revealed the resident was receiving NJ Ex Ord medications. The resident had a physician's orders (PO) dated NJ Ex Order 26.4(b)(1), for NJ Ex Order 26.4(b)(1) administer one tablet every four hours as needed for NJ Ex Order 26.4(b)(1) and a PO dated NJ Ex Order 26.4(b)(1), for NJ Ex Order 26.4(b)(1); administer one tablet every four hours as needed for NJ Ex Order 26.4(b)(1). A review of the corresponding NJ Ex Order 26.4(b)(1) Medication Administration Record (MAR) revealed the resident received NJ Ex Ord medication daily during the month of NJ Ex Order 26.4(b)(1). A review of the individual comprehensive care plan (ICCP) did not include a focus area for NJ Ex Order On 10/24/24 at 12:24 PM, the surveyor observed Resident #10 in the hallway in a wheelchair. The resident was speaking with the U.S. FOIA (b) (6)) of the NJ wing nursing unit. The resident told the U.S. FOIA (b) (6) that they needed an appointment related to "NJ Ex Order 26.4(b)(1)." On 10/25/24 at 10:28 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding the resident and NJ Ex Orde. The U.S. FOIA (b) (6) told the surveyor that the resident had NJ Ex Orde and NJ Ex Order 26.4(b)(1) and was receiving NJ Ex Ord medications. The surveyor asked if a resident with NJ Ex Ord should have NJ Ex Order 26.4 included in their ICCP, and the U.S. FOIA (b) (6) responded "absolutely." On 10/29/24 at 10:40 AM, the survey team met with the U.S. FOIA (b) (6)	F 656	report to the Quality Assurance Improvement Committee.	

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F 656	Continued From page 7 ([redacted] the [redacted]), and the [redacted]) regarding the [redacted] care plan. The [redacted] stated that the care plan was "now initiated" and agreed the care plan should have been initiated when the resident began with the [redacted] A review of the facility's "Care Plans, Comprehensive Person-Centered" policy dated October 2022, included a comprehensive, person-centered care plan, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and function needs is developed and implemented for each resident...	F 656		
F 657 SS=D	NJAC 8:30-27.1(a) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		11/11/24

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F 657	Continued From page 8 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint # NJ169671 Based on interviews and review of pertinent facility documents, it was determined that the facility failed to revise an individual comprehensive care plan for a resident with a history of [NJ Ex Or] while at the facility. This deficient practice was identified for 1 of 1 resident reviewed for [NJ Ex Or] (Resident #189), and was evidenced by the following: On 10/24/24 at 11:32 AM, the surveyor reviewed the closed medical record for Resident #189. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses that included but were not limited to; [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)]. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26.4(b)(1)], revealed the resident had a Brief Interview of Mental Status score of [NJ Ex] out of 15, meaning the resident had [NJ Ex Order 26.4(b)(1)].	F 657	Resident # 189 [NJ Exec Order 26.4b1] by the deficient practice. Resident #189 was discharged on [NJ Ex Order 26.4(b)(1)]. All residents with incidents of fall may be affected by this deficient practice. DON and UM reviewed all residents that had [NJ Ex] incidents in the last 30D and no other resident [NJ Exec Order 26.4b1] by the deficient practice. The Director of Nursing/ADON and the Facility Educator in- serviced all nurses, [U.S. FOIA (b) (6)] and shift supervisors on updating care plan after incident occurs. IDT team will review all incident reports during clinical meeting to ensure care plans are initiated and updated with interventions. Unit Managers/ designee will audit 3 care plans of residents that had fall incidents on their unit weekly x 4 then monthly x 2 to ensure care plans for fall has been	

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F 657	Continued From page 9 A review of the the incidents and accidents for Resident #189 revealed the resident had [NJ Ex Order] on [NJ Ex Order 26.4(]. The resident [NJ Ex Order 26.4(b)(1)] by a Certified Nursing Assistant (CNA) in NJ Ex Order 26.4(b)(1) [redacted]. The resident informed the staff that they [NJ Ex Order 26.] their wheelchair, and the resident sustained [NJ Ex Order 26.4(b)(1)]. Included in the report was an interdisciplinary team note dated [NJ Ex Order 26.4(], that the team met to discuss the [NJ Ex] plan of care, and the new intervention of NJ Ex Order 26.4(b)(1) [redacted] will be conducted to ensure safety was added. A review of the individualized comprehensive care plan (ICCP) included a focus area dated [NJ Ex Order 26.4(], that the resident was at risk for [NJ Ex Orc] with regards to NJ Ex Order 26.4(b)(1), [NJ Ex Order 26.4(b)] NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1) [redacted]), and [NJ Ex Order 26.4(] [redacted] Interventions included to anticipate and meet the resident's needs; be sure the resident's call light is within reach and encourage the resident to use it for assistance; and NJ Ex Order 26.4(b)(1) evaluate and treat as ordered and needed. The ICCP was not updated after the resident's [NJ Ex] on [NJ Ex Order 26.4(], to include new interventions [NJ Ex Order 26.4(b)(]. On 10/29/24 at 10:40 AM, during an interview with the U.S. FOIA (b) (6) [redacted] the surveyor asked what should take place after a resident had [NJ Ex Orde]. The [U.S. FOIA (] responded, that after [NJ Ex Orde], the ICCP should be reviewed and updated with new interventions. A review of the facility's "Falls and Fall Risk, Managing" policy dated updated October 2019, included if falling recurs despite initial	F 657	initiated and updated. Unit Managers will submit the audit report to the Quality Assurance Improvement Committee.	

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F 657	Continued From page 10 interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant...	F 657		
F 686 SS=D	NJAC 8:39-27.1(a) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure recommendations by the [NJ Ex Order 26.4] care consultant were implemented to prevent the [NJ Exec Order 26.4b1] of [NJ Ex Order 26.4(b)(1)]. This practice was identified in 1 of 2 residents reviewed for [NJ Ex Order 26.4(b)(1)] (Resident #13), and was evidenced by the following: On 10/22/24 at 11:12 AM, during the initial tour of the facility, the surveyor observed Resident #13 in bed. The resident told the surveyor that they had a '[NJ Ex Order 26.4(b)(1)]. At that time, the surveyor	F 686	Resident # 13 was [NJ Ex Order 26.4(b)(1)] the deficient practice. An [NJ Ex Order 26.4(b)(1)] was immediately provided to the resident. All residents with wounds may be affected by this deficient practice. DON and Unit Managers reviewed [NJ Exec Order 26] care consultant recommendation, and no other resident [NJ Exec Order 26.4b1] by the deficient practice.	11/11/24

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(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 686	Continued From page 11 did not observe a NJ Ex Order 26.4(b)(1) on the bed. The surveyor asked the resident if they were on NJ Ex Order 26.4(b)(1) or a NJ Ex Order 26.4(b)(1) and the resident replied, "No, I don't know what they are doing". On 10/24/24 at 12:10 PM, the resident was observed in bed with eyes closed. The surveyor did not observe a NJ Ex Order 26.4(b)(1) on the resident's bed. On 10/25/24 at 9:35 AM, the surveyor reviewed the medical record for Resident #13. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1) revealed the resident had a Brief Interview of Mental Status score of NJ Ex out of 15, meaning the resident was NJ Ex Order 26.4(b)(1). A review of Section NJ Ex Order 26.4(b)(1) revealed the resident had an NJ Ex Order 26.4(b)(1)) with preventative measures which included a NJ Ex Order 26.4(b)(1) A review of the NJ Ex Order 26.4(b)(1) Treatment Administration Record (TAR) included a physician's order dated NJ Ex Order 26.4(b)(1), to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), NJ Exec Order 26, apply NJ Ex Order 26.4(b)(1)	F 686	The Director of Nursing and the Facility Educator provided education to all nurses and unit managers on the importance of following wound care consultant recommendations. ADON or designee will review weekly wound care consultant reports to ensure new treatments and recommendations are followed through. The ADON/IP or designee will audit 4 residents with wounds weekly x 4, then monthly x 2 months to ensure recommendations are followed through. The ADON/IP will submit the audit report to the Quality Assurance Improvement Committee.	

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	315252	A. BUILDING _____ B. WING _____	C 10/30/2024

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F 686	Continued From page 12 NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)); cover with NJ Ex Order 26 every day shift for NJ Ex Order 26.4 care. A review of the NJ Exec Order 26 consultation report dated NJ Ex Order 26.4(b)(1), include the U.S. FOIA (b) (6) saw the resident for a NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) recommended for the treatment of the NJ Ex Order 26.4(b)(1), to NJ Ex Order 26.4(b)(1) with a NJ Ex O with NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) measures in place. A review of the individualized comprehensive care plan (ICCP) included a focus area dated NJ Ex Order 26.4(b), and revised NJ Ex Order 26.4(b), that the resident had NJ NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1). Interventions included to teach the resident, family, and caregivers the importance of NJ Ex Order 26.4(b)(1) for prevention of NJ Ex Order 26.4(b)(1); encourage NJ Ex Order 26.4(b)(1) ; and follow facility policies and protocols for the prevention and treatment of NJ Ex Order 26.4(b)(1). The ICCP did not include the use of a NJ Ex Order 26.4(b)(1) as recommended by the U.S. FOIA (b) (A review of the active Order Summary Report did not include a physician's order for a NJ Ex Or On 10/25/24 at 10:05 AM, the surveyor interviewed Resident #13's U.S. FOIA (b) (6) , who stated the resident had a NJ Ex Order 2 and received NJ Ex Order 26.4(b)(1) daily. The U.S. FOIA stated that the resident was seen weekly for NJ Ex Order 26.4(b)(1) consultations. The surveyor asked what preventative measures were	F 686		

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F 686	Continued From page 13 in place for the resident, and the U.S. FOIA stated the resident had an NJ Ex Order 26.4(b)(1). At that time, the surveyor accompanied by the U.S. FOIA went to Resident #13's room, and the U.S. FOIA confirmed the resident did not have a NJ Ex Order 26.4(b)(1). On 10/25/24 at 10:11 AM, the surveyor observed the resident in bed receiving care from the U.S. FOIA (b) (6)). At that time, the resident informed the surveyor that the nurse already did NJ Ex Order 26.4 care for the day. The surveyor asked the resident if they were on an NJ Ex Order 26.4(b)(1) , and the resident replied, 'NJ Ex Order 26.4(b)(1) '. On 10/25/24 at 10:20 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding the resident's NJ Ex Order 26.4(b)(1) and the U.S. FOIA (b) (6) stated that the resident had a NJ Ex Order 26.4(b)(1)). The surveyor asked if the resident had an NJ Ex Order 26.4(b)(1) and she stated I think so, but if not, maybe the resident NJ Exec Order 26.4(b)(1) At that time the resident requested documentation of the resident's NJ Exec Order 26.4(b)(1). On 10/29/24 at 10:40 AM, during a meeting with the U.S. FOIA (b) (6)), the surveyor asked about Resident #13's NJ Ex Order 26.4(b)(1). The U.S. FOIA acknowledged the resident should have had the NJ Ex Order 26.4(b)(1) prior to surveyor inquiry, and staff needed to be educated to follow NJ Ex Order 26.4(b)(1) care consultant recommendations. No additional information was provided. A review of the facility's "Wound Care" policy dated updated May 2023, did not include the process for NJ Ex Order 26.4(b)(1) care consultation	F 686		

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F 686	Continued From page 14 recommendations and NJ Ex Order 26.4(b)(1). NJAC 8:39-27.1(a)	F 686		
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(f). 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. §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	F 755		11/11/24

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F 755	Continued From page 15 by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) ensure the accountability of the [redacted] shift count logs were completed; and b.) accurately account for and document the administration of [redacted] medications. This deficient practice was identified on 2 of 2 medication carts reviewed for medication storage, and was evidenced by the following: During medication storage review on 10/24/24 at 10:39 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN #1), reviewed the Vent unit medication cart A's [redacted] and [redacted] "Change of Shift - [redacted] Count Sheet" (a shift-to-shift [redacted]) count sheet signed by the incoming and outgoing nurses each shift) which revealed the following: The nursing signatures were blank for the incoming nurse for the following shifts: For the 7:00 AM (7 AM) shift on: 9/14, 9/29, 10/4, 10/5, 10/6, 10/20, and 10/24. For the 7:00 PM (7 PM) shift on: 9/6, 10/1, 10/15, and 10/22. For the 11:00 PM (11 PM) shift on: 9/27 and 10/14. The nursing signatures were blank for the outgoing nurse for the following shifts: For the 7 AM shift on: 9/7, 10/15, 10/16, and 10/23. For the 7 PM shift on: 9/15, 9/29, 10/3, 10/4, 10/5, 10/6, and 10/20.	F 755	The facility failed to 1) ensure the accountability of [redacted] shift count logs are completed 2) and accurately account for and document the administration of controlled drug. Vent Unit Controlled substances count sheet was reviewed immediately and nurses were immediately educated on completing and signing [redacted] sheet daily. Resident # 291 whose [redacted] medication was not signed out on the [redacted] inventory log [redacted] by the deficient practice. Nurse # 1 was immediately reeducated on signing controlled inventory log when medications are administered. All units could be affected by the deficient practice. DON/ADON/UM reviewed all [redacted] log for the facility, and no other unit was affected by the deficient practice. All residents on controlled medications could be affected by the deficient practice. DON/ADON/UM reviewed the units (4) [redacted] medication logs to ensure that all dispensed [redacted] medication were	

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F 755	Continued From page 16 For the 11:00 PM shift on: 9/27. The [NJ Ex Order 26.4(b)] counts "Count (Number of Cards)" were blank for the following shifts: For the 7 AM shift on: 9/1, 9/4, 9/6, 9/10, 9/13, 9/14, 9/15, 9/16, 9/19, 9/20, 9/23, 9/25, 9/28, 10/4, 10/5, 10/6, 10/8, 10/9, 10/10, 10/20, 10/21, and 10/24. For the 3:00 PM (3 PM) shift on: 9/10. For the 7 PM shift on: 9/1, 9/4, 9/5, 9/6, 9/9, 9/14, 9/15, 9/16, 9/19, 9/20, 9/23, 9/25, 9/26, 10/3, 10/4, 10/5, 10/6, 10/8, 10/12, 10/17, 10/19, 10/20, and 10/21. For the 11:00 PM (11 PM) shift on: 9/12, 9/13, 9/27, 10/9, and 10/14. Further review of the cart revealed the individual resident '[NJ Ex Order 26.4(b)(1)] Administration Record" log (declining inventory log) for Resident #291 indicated the 9:00 AM (9 AM) dose of [NJ Ex Order 26.4(b)(1)]) tablet was not signed out on the declining inventory log. The declining inventory log was missing the "[Administered] By" signatures for the [NJ Ex Order 26.4(b)(1)] at 9 AM dose. At the time of observation, the surveyor interviewed LPN #1, who stated she administered the 9 AM dose of [NJ Ex Order 26.4(b)(1)] that morning but did not sign Resident #291's declining inventory log. LPN # 1 confirmed that the 9 AM dose was signed out as being administered in the electronic Medication Administration Record (MAR), but was not accounted for on the declining inventory log. LPN #1 further acknowledged that the declining inventory logs should be completed upon dispensing the medication to keep track of the	F 755	signed for. No other resident [NJ Exec Order 26.4b1] by the deficient practice. DON/ ADON and Unit Managers provided an in-service to all nurses and shift supervisors on completing and signing Controlled substances daily. Unit Managers or designee will do random audit checks weekly on 2 controlled substances count sheets on their unit to ensure completion and that there are no missing count or signatures. DON/ADON/ and unit managers provided and inservice all nurses to sign [NJ Ex Order 26.4(b)(1)] logs as they are administered. Unit Managers or designee will perform random audit checks weekly on 2 nurses on their units to ensure that nurses are signing controlled medication log as they are administered. The Unit Managers will audit narcotic logs weekly x 4, then monthly x 2 to ensure completion and daily signing. The Unit Managers will submit the audit report to the Quality Assurance Improvement Committee. Unit Managers will perform random audit checks on 2 nurses on their units weekly x 4 then monthly x2 to ensure nurses are signing controlled medication log as they are administered. Unit Managers will submit the results of	

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F 755	Continued From page 17 narcotic count. LPN #1 also stated that shift-to-shift logs should be completed by two nurses at each shift change indicating [NJ Ex Order 26.4(b)] count was completed and all [NJ Ex Order 26.4(b)(1)] were accounted for. LPN #1 stated that shift-to-shift counts were done for accountability of [NJ Ex Order 26.4(b)(1)] and there should not have been any missing documentation or signatures. LPN #1 further acknowledged that she forgot to sign the incoming nurse portion for this morning's shift change. During medication storage review on 10/24/24 at 11:35 AM, the surveyor in the presence of LPN #2, reviewed the A wing medication cart B's [NJ Ex Order 26.4(b)(1)] "Change of Shift - [NJ Ex Order 26.4(b)(1)] Count Sheet" which revealed the following: The [NJ Ex Order 26.4(b)(1)] "Count (Number of Cards)" were blank for the following shifts: For the 7 AM shift on: 10/22, 10/23, and 10/24. For the 3 PM shift on: 10/22. For the 11 PM shift on: 10/21, 10/22, and 10/23. At the time of observation, LPN #2 stated that she was not sure if the number of cards column should be filled out since there were a lot of blanks. LPN #2 further stated she was going to count the [NJ Ex Order 26.4(b)(1)] at the end of her shift and fill out the column then. She further acknowledged that there should be no missing count (number of cards) on the [NJ Ex Order 26.4(b)] count sheets. LPN #2 then stated that shift-to-shift count was done for the accountability of the [NJ Ex Order 26.4(b)(1)] On 10/24/24 at 12:21 PM, the surveyor interviewed the U.S. FOIA (b) (6)), who	F 755	the audit to the QAPI committee.	

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F 755	Continued From page 18 stated that the shift-to-shift [NJ Ex Order 26.4(b)] count log should have been completed by the incoming and outgoing nurses together at shift change. The nurses count the number of [NJ Exec Order 26.4(b)] cards to ensure there was the correct number of [NJ Ex Order 26.4(b)] cards and it matched the shift-to-shift [NJ Ex Order 26.4(b)] log. The [U.S. FOIA (b)] stated there should be no missing documentation or signatures on the [NJ Ex Order 26.4(b)] count logs because it was for accountability. The [U.S. FOIA (b)] then stated the purpose of the shift-to-shift [NJ Ex Order 26.4(b)] log was to keep track of the [NJ Ex Order 26.4(b)] card counts. The [U.S. FOIA (b)] further acknowledged that the declining inventory logs should be completed and filled out for each [NJ Ex Order 26.4(b)] dose dispensed immediately at the time the medication was removed from inventory. The [U.S. FOIA (b)] acknowledged that "if it was not documented it was not done." On 10/29/24 at 10:39 AM, the U.S. FOIA (b) (6)) in the presence of the [U.S. FOIA (b)] U.S. FOIA (b) (6) U.S. FOIA (b) (6) , U.S. FOIA (b) (6) , and U.S. FOIA (b) (6)), acknowledged that the shift-to-shift count sheets were not completed. The [U.S. FOIA (b)] also stated that they did an in-service for all nurses and implemented a new shift to shift log. The [U.S. FOIA (b)] acknowledged that the shift-to-shift [NJ Ex Order 26.4(b)] logs should have not have any missing signatures or counts. The [U.S. FOIA (b)] further acknowledged that when dispensing a [NJ Ex Order 26.4(b)] the nurse needed to sign the [NJ Ex Order 26.4(b)] declining inventory log immediately. A review of the facility's "Controlled Substance Administration & Accountability" policy with a revision date February 2023, included... 1. All controlled substances obtained from a	F 755		

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F 755	Continued From page 19 non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must clearly legible with all applicable information provided. All specially compounded or non-stock Schedule II controlled substances dispensed from the pharmacy for a specific patient are recorded on the Controlled Drug Record supplied with the medication or other designated form as per facility policy. The Controlled Drug Record serves the dual purpose of recording both narcotic disposition and patient administration. The Controlled Drug Record is permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy. 6. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift ...	F 755		
F 761 SS=D	NJAC 8:39-29.7(c) 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	F 761		11/11/24

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F 761	Continued From page 20 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 review of pertinent facility documents, it was determined that the facility failed to properly store medications. This deficient practice was observed in 1 of 4 medication carts reviewed for medication storage and labeling, and was evidenced by the following: On 10/24/24 at 10:39 AM, the surveyor observed the [NJ Exec Ord] nursing unit's medication cart A. The medication cart was kept at the nurse's station and was left unattended by the Licensed Practical Nurse (LPN #1) while she administered medication to an unsampled resident. On the cart's unlockable pull-out tray/drawer, was observed packets of individually wrapped medications stored and visible with the tray/drawer in the retracted position. Upon return of LPN #1, the surveyor reviewed the cart and observed the following unsecured medications in the tray/drawer: One [NJ Ex Order 26.4(b)(1) [redacted]].	F 761	[NJ Exec Ord] Unit med cart was left at the nurse's station and was left unattended as she administered medication to another resident. The unlockable top drawer had packets of individually wrapped medications stored and visible with the tray/drawer in the retracted position. LPN #1 was immediately reeducated on always keeping medications on locked or secured containers or carts. All units may be affected by this deficient practice. DON/ADON/UM immediately checked on the unit carts to ensure all medication were kept in locked storage or carts. No other medication storage or cart was affected by the deficient practice. The Director of Nursing/ ADON and Pharmacy Consultant provided and in-serviced all nurses and shift supervisors	

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F 761	Continued From page 21 NJ Ex Order 26.4(b)(1) tabs (NJ Ex Order 26.4(b)(1)). NJ Ex Order 26.4(b)(1) tab. NJ Ex Order 26.4(b)(1) tab (NJ Ex Order 26.4(b)(1)). NJ Ex Order 26.4(b)(1) tab (NJ Ex Order 26.4(b)(1)). NJ Ex Order 26.4(b)(1) tab (NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) tab (NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) tab (NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1)). At that time, the surveyor interviewed LPN #1 who stated medication should not be left on that tray as that would not be considered secured. She further stated that there was a risk of someone coming by and taking them since they were unsecured. On 10/24/24 at 12:21 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated medication should always be secured and locked, regardless of if residents on the unit were ambulatory or not. The U.S. FOIA (b) further confirmed when presented with a photo of how the medications were observed, that those medications would not be considered secured and should not have been stored that way. On 10/29/24 at 10:39 AM, the U.S. FOIA (b) (6)), in the presence of the survey team, the U.S. FOIA (b) (6) , and U.S. FOIA (b) confirmed that medication should not have been stored unsecured on the	F 761	of medication storage and keeping all medications in locked storage or carts. The ADON or designee will perform random unit cart checks weekly to ensure medications are kept on locked containers or carts at all times. The ADON and/ or designee will perform random audit check on 2 medication carts and 2 treatment carts weekly x 4 weeks, then monthly x 2 to ensure medications are kept on locked storage or medication carts. The ADON and/ or designee will submit the audit report to the Quality Assurance Improvement Committee.	

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	315252	A. BUILDING _____ B. WING _____	C 10/30/2024

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F 761	Continued From page 22 medication cart and that all nurses were to keep medications secured. A review of the facility's "Medication Storage" policy with a reviewed date of 11/2022, included the facility shall store all medications and biologicals in a safe, secure, and orderly manner...all medications will be stored in locked cabinet, cart or medication room that is accessible only to authorized personnel...	F 761		
F 812 SS=F	NJAC 8:39-29.4 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 review of pertinent facility documents, it was determined	F 812	1. The outside of the ice machine and flap was cleaned.	11/12/24

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F 812	Continued From page 23 that the facility failed to maintain kitchen equipment in a clean and sanitary manner. This deficient practice has the potential to affect all residents, and the evidence was as follows: On 10/22/24 at 9:53 AM, the surveyor in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)) toured the kitchen and observed the following: 1. The ice machine had stains, brown and tan debris on the outside and flap of the machine. The U.S. FOIA stated, it should be cleaned daily. The U.S. FOIA and U.S. FOIA (b) (both acknowledge that it looked dirty and was not cleaned. 2. There were two, thirty-two gallon waste receptacles that were not covered which exposed the two food preparation stations to the refuse. The stations were not actively being used. The U.S. FOIA (b) (acknowledged that the waste receptacles did not have lids and staff were not currently using them. The unlidded thirty-two-gallon waste receptacles at counter height had the potential for cross contamination of food. 3. The eight-burner stove with two catch drip trays, had large quantities of brown, black, and burnt food and yellowed sludge that was on the foil covering. The U.S. FOIA and U.S. FOIA (b) (acknowledged that they had not been cleaned and staff were not following the facility policy. 4. The slicer that was covered with a clear plastic bag, had brown, dried, and crusted debris on the prong part of the pusher that was touching the gauge plate. The U.S. FOIA stated that the clear plastic bag indicated the equipment was clean and ready for use. The U.S. FOIA and U.S. FOIA (b) (acknowledged that	F 812	2. The garbage can lids were applied. 3. The eight burner stove with 2 catch trays were cleaned and re-foiled. 4. The slicer was cleaned. 5. The can opener and base were cleaned. 6. The six compartment open well steam table was drained and cleaned. All dietary staff in deficient practice received on the spot education. All residents may be affected by this practice. The Director of foodservice and the Regional manager provided education for all dietary personnel.. The Director of foodservice revised daily cleaning checkoff assignments to ensure sanitary practices are being met. The foodservice director implemented the supervisor's daily closing checklist to ensure sanitary practices are being met. New step-on garbage cans were ordered, delivered and placed into the operation. The Foodservice director and/or designee will audit and report the completion of the daily cleaning assignments and supervisor closing checklist weekly x 4 weeks then monthly for 3 months. The Foodservice director will submit the audit report to the Quality Assurance Committee.	

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F 812	Continued From page 24 the pusher was not clean and had potential for cross contamination of food and had the potential to cause a food borne illness. 5. The can opener base had black and brown crusted debris that was wipeable by the [U.S. FOIA (b)]. The [U.S. FOIA] stated the can opener was cleaned daily and the base of the can opener was included in that cleaning assignment. The [U.S. FOIA] acknowledged that the base was dirty and had not been cleaned. She further stated it could cause cross contamination and had the potential to cause food borne illness. 6. Two, six compartment open well steam tables that had hot water in each well. The water in every well had floating debris and debris that had settled on the bottom. The [U.S. FOIA] stated it was cleaned daily. The surveyor asked if string beans were served for breakfast and the [U.S. FOIA] acknowledged there were no string beans served and that the steam tables had not been cleaned according to facility policy. The [U.S. FOIA] and [U.S. FOIA (b)] both acknowledged that the dirty water and sediment had the potential for food borne illnesses. On 10/25/24 at 12:20 PM, the U.S. FOIA (b) (6) [redacted]), in the presence of the U.S. FOIA (b) (6) [redacted]), and survey team acknowledged the concerns. A review of the undated facility provided "Equipment Cleaning Policy" included the Director of Dining Services or designee will ensure that all equipment is maintained, kept clean, and in a sanitary condition before and after each use...2. Stove-top; a) clean stove top after each use...d) be sure to clean the grease tray...7. Slicer...b)	F 812		

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F 812	Continued From page 25 take slicer apart. Using soap and water to clean it. c) let the slicer air dry before covering it...9. Steam Table; a) after each meal service, drain the water from the steam table. b) It must be cleaned after each use both inside and out using soap and water before you refill it with clean water...13. Can Opener; run the opener shaft through the dish machine or in the 3-compartment sink. b) Clean the base of the can opener and holder using soap and water... A review of the undated facility provided "Ice Machines Sanitation" policy included kitchen staff will wash, rinse, and sanitize the ice making machine monthly... A review of the undated facility provided "Ice Machine Maintenance" log included...outside of ice machine should be cleaned and sanitized daily... NJAC 8:39-17.2(g)	F 812		

New Jersey Department of Health

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ169671, 169941, 171541, 172589, 176557 Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 60 of 63 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	1) a) Center staffing ratios as required by NJDOH were communicated to staffing coordinator and all Nurse managers and supervisors to match ratios of 1:8 on day shift; 1:10 on evening shift and 1:14 on night shift b) Center staffing schedule ratios are developed, reviewed and posted two weeks prior to utilization to comply with required staffing ratios. c) Administrator, DON and Staffing Coordinator meet every morning to go over daily staffing sheets and look ahead at copies of projected schedule of the next two weeks to ensure required staffing	11/12/24

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

Electronically Signed | 11/13/24

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S 560	Continued From page 1 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 Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer 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 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. . 1. For the two weeks of Complaint staffing from 12/10/23 to 12/23/23, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: 12/10/23 had 8 CNAs for 139 residents on the day shift, required at least 17 CNAs. 12/11/23 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs. 12/12/23 had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs. 12/13/23 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs. 12/15/23 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs. 12/16/23 had 16 CNAs for 134 residents on the	S 560	ratios. d) DON, Administrator and staffing coordinator meet weekly to review the 4 week master schedule to ensure facility has staff that meets the needs. 2) All residents have potential to be affected by the same deficit practice. 3) a) If staffing deficits on master staffing schedule are identified, Center will communicate all unfilled shifts to in-house staff for coverage. b) Center will continue external recruitment efforts to fill open positions and review and revise as necessary c) Center will maintain multiple contacts with staffing agencies to meet required staffing ratios and review as necessary d) Center will continue to offer bonus structure to incentivize staff to fill shifts if needed and revise as necessary. e) Center will continue to make efforts to retain staff by way of employee engagement events. 4) a) Center Staffing Coordinator will review projected census and staffing ratio to assure staffing compliance. b) Administrator, DON, and Staffing Coordinator will continue to meet daily to go over projected staffing to assure required staff ratios. c) If ratios are projected to not be met, Center will post openings for in-house staff as well as contact contracted agencies to maintain staffing compliance. d) DON/Staffing Coordinator will conduct daily staffing audits for two weeks and bi-weekly for two months.	

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S 560	Continued From page 2 day shift, required at least 17 CNAs. 12/17/23 had 9 CNAs for 134 residents on the day shift, required at least 12/18/23 had 15 CNAs for 136 residents on the day shift, required at least 12/19/23 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. 12/20/23 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs. 12/21/23 had 16 CNAs for 136 residents on the day shift, required at least 17 CNAs. 12/22/23 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs. 12/23/23 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. 2. For the week of Complaint staffing from 1/7/24 to 1/13/24, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: 1/7/24 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. 1/8/24 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs. 1/9/24 had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs. 1/10/24 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. 1/11/24 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. 1/12/24 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs. 1/13/24 had 13 CNAs for 140 residents on the day shift, required at least 17 CNAs. 3. For the two weeks of Complaint staffing from 1/28/24 to 2/10/24, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:	S 560	e) Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate. 5) Interventions for compliance with S560 are in place as of 11/12/2024. Administrator to monitor staffing post to see what happened and pre via measures listed above for ongoing compliance.	

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S 560	Continued From page 3 1/28/24 had 10 CNAs for 147 residents on the day shift, required at least 18 CNAs. 1/29/24 had 14 CNAs for 145 residents on the day shift, required at least 18 CNAs. 1/30/24 had 14 CNAs for 143 residents on the day shift, required at least 18 CNAs. 1/31/24 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs. 2/1/24 had 15 CNAs for 143 residents on the day shift, required at least 15 CNAs. 2/2/24 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs. 2/3/24 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs. 2/4/24 had 13 CNAs for 148 residents on the day shift, required at least 18 CNAs. 2/5/24 had 13 CNAs for 148 residents on the day shift, required at least 18 CNAs. 2/6/24 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. 2/7/24 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. 2/8/24 had 16 CNAs for 149 residents on the day shift, required at least 19 CNAs. 2/9/24 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. 2/10/24 had 12 CNAs for 150 residents on the day shift, required at least 19 CNAs. 4. For the week of Complaint staffing from 3/31/24 to 4/6/24, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: 3/31/24 had 10 CNAs for 135 residents on the day shift, required at least 17 CNAs. 4/1/24 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. 4/2/24 had 15 CNAs for 133 residents on the day	S 560		

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S 560	Continued From page 4	S 560		

shift, required at least 17 CNAs.
4/3/24 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs.
4/4/24 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs.
4/5/24 had 10 CNAs for 133 residents on the day shift, required at least 17 CNAs.
4/6/24 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs.

5. For the week of Complaint staffing from 8/18/24 to 8/24/24, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:

8/18/24 had 11 CNAs for 145 residents on the day shift, required at least 18 CNAs.
8/19/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs.
8/20/24 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs.
8/23/24 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs.
8/24/24 had 14 CNAs for 141 residents on the day shift, required at least 18 CNAs.

6. For the two weeks of staffing prior to survey from 10/6/24 to 10/19/24, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

10/6/24 had 13 CNAs for 145 residents on the day shift, required at least 18 CNAs.
10/7/24 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs.
10/8/24 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs.
10/9/24 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs.
10/10/24 had 17 CNAs for 144 residents on the

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S 560	Continued From page 5 day shift, required at least 18 CNAs. 10/11/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. 10/12/24 had 15 CNAs for 143 residents on the day shift, required at least 18 CNAs. 10/13/24 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. 10/14/24 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. 10/15/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. 10/16/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. 10/17/24 had 16 CNAs for 136 residents on the day shift, required at least 17 CNAs. 10/18/24 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. 10/19/24 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. On 10/28/24 at 10:43 AM, the surveyor interviewed the Staffing Coordinator (SC), who stated she was familiar with the state regulations for day shift only. The SC stated the evening shift was one CNA to 14 residents and the overnight shift was one CNA to 16 residents. The surveyor asked the SC if she felt the facility was meeting the regulations, and the SC stated that the facility tried their best and used Agency staff when necessary. A review of the facility's "Staffing" policy dated January 2023, included the facility provides enough staff with the skills and competency necessary to provide care and services for all the residents...direct care staffing information per day is submitted to the [Centers for Medicare & Medicaid Services (CMS)] payroll-based journal system on the schedule specified by CMS...	S 560		

New Jersey Department of Health

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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	11/21/2024 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 F0624	Correction	ID Prefix F0656	Correction	ID Prefix F0657	Correction
Reg. # 483.15(c)(7)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	11/11/2024	LSC	11/11/2024	LSC	11/11/2024
ID Prefix F0686	Correction	ID Prefix F0755	Correction	ID Prefix F0761	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	11/11/2024	LSC	11/11/2024	LSC	11/11/2024
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/12/2024	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	

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	
10/30/2024	☐ 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	11/21/2024 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/12/2024	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	
10/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING **01** B. WING _____	**10/30/2024**

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 10/30/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 10/30/24 and 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 Occupancy. Complete Care at Bayshore LLC is a two-story building built in 1988. It is composed of Type II protected construction. The facility is divided into nine - smoke zones. The generator powers approximately 100 % of the building per Maintenance Director. The current occupied beds are 138 of 232.	K 000		
K 311 SS=F	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.	K 311		11/12/24

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

Electronically Signed | 11/14/2024

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 **01** B. WING _____	**10/30/2024**

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
K 311	Continued From page 1 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one of 10 fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect 54 residents who resided on the second floor in the North End of the facility. Findings include: An observation on 10/30/24 at 1:32 PM of the second-floor stairway 5, adjacent to the mechanical room, revealed the door was equipped with panic hardware which violated the listing of the rated fire door assembly. Panic hardware is not permitted on fire rated door assemblies, only fire exit hardware can be installed on fire rated door assemblies. During an interview at the time of observation, the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) confirmed the stairway exit door was equipped with panic hardware. NJAC 8:39-31.1(c) NFPA 80	K 311	The fire door hardware identified near the stairway exit door on the second floor was replaced with the correct fire rated door assemblies with approved fire exit hardware. All residents have the potential to be affected by this deficient practice. The remainder of the facility fire doors were assessed to ensure proper hardware was in place with no further non-compliance noted. The U.S. FOIA (b) (6) was educated on correct fire-rated door assemblies with approved fire exit hardware 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 with approved fire exit hardware are in place weekly for four weeks, then monthly for two months. All findings will be reported at the facility's monthly QAPI meeting. pictures were added in attachments.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		11/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING **01** B. WING _____	**10/30/2024**

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
K 914	Continued From page 2 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. This deficient practice had the potential to affect all 138 residents who resided at the facility. Findings include: A review of the facility's "Fire Safety Folder" dated 2024 and provided by the U.S. FOIA (b) (6), revealed no documented evidence the electrical outlet testing had been completed on the	K 914	The facility completed the facility electrical outlet testing and ensured proper documentation was in place. All residents have the potential to be affected by this deficient practice. The maintenance department was educated on the importance of completing the facility's electrical system testing. The maintenance department or designee will implement a work order into the facility maintenance calendar to ensure all electrical outlets are inspected yearly.	

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	315252	A. BUILDING **01** B. WING _____	**10/30/2024**

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
K 914	Continued From page 3 electrical outlets in the past 12 months. Electrical outlets not listed as hospital grade are tested at intervals not exceeding 12 months. During an interview on 10/30/24 at 12:55 PM, the U.S. FOIA (b) (6) stated he conducted the electrical outlet testing; however, he documented the replacement outlets only, but not the testing of all the outlets. NJAC 8:39-31.2(e) NFPA 70, 99	K 914	The Maintenance Director or designee will randomly audit the maintenance work order schedule to ensure no further regulatory tasks are missed and are completed timely. This audit will be completed monthly for 3 months, then quarterly for 6 months. All findings will be reported at the facility's monthly QAPI meeting.	

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 01 - MAIN BUILDING 01 B. Wing Y2	11/21/2024 Y3

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

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ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0311	11/12/2024	LSC K0914	11/12/2024	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	
10/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO