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 04/04/2024

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 #: NJ00166783, NJ00171418, NJ00172419, NJ00172427 Survey Dates: 03/28/2024, 04/01/2024 & 04/04/2024 Census: 139 Sample Size: 11 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00166783, NJ00171418, NJ00172419 Based on interview and record review on 03/28/24, 04/01/24, and 04/04/24, it was determined that the facility failed to follow acceptable standards of clinical practice related to a.) consistently documenting the administration of a medication in the electronic Medication Administration Record (MAR) and b.) consistently document that a treatment was completed in the electronic Treatment Administration Record (TAR)	F 658	Resident #2 was assessed, no adverse effect found. Resident #3 no longer reside in the facility All involved nurses in deficient practice received on the spot education. All residents may be affected by this practice. • The Director of Nursing and the Facility Educator provided education for all nurses involved.	4/24/24

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

Electronically Signed | 04/25/2024

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 658	Continued From page 1 This deficient practice was identified for two residents reviewed (Resident #2 and Resident #3) and was evidenced by the following: 1.) Resident #2 was not at the facility; a closed record review was completed. A review of the Admission Record face sheet (an admission summary) reflected that Resident #2 was admitted to the facility with diagnoses which included but were not limited to, NJ Exec Order 26.4b1 [redacted] A review of the [redacted] Quarterly Minimum Data Set (MDS), an assessment tool reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident's NJ Exec Order 26.4b1 . A review of Section K Swallowing/Nutritional Status reflected that the resident NJ Exec Order 26.4b1 [redacted] A review of Resident #2's Care Plan reflected a focus, dated [redacted] and last revised on [redacted] that the resident was at risk for [redacted] and that [redacted] were needed for the resident to receive NJ Exec Order 26.4b1 . Interventions included to administer NJ Exec Order 26.4b1 and [redacted] as ordered and to monitor for signs of [redacted]. A review of Resident #2's [redacted] Physician Order Summary (POS) reflected an active [redacted], dated [redacted] to [redacted] with	F 658	• Facility wide education provided to all nurses on completing documentation of the Medication Administration Records and The Treatment administration Records. • Unit managers/ designee will utilize administration audit reports daily to capture missing signatures in Medication and treatment administration. • The Unit Manager and/or designee will audit and report the completion of the Medication Administration Records and the Treatment Administration Records weekly x 2 weeks then monthly for 2 months. • The DON will submit the audit report to the administrator at the Quality Assurance Meeting which meets monthly.	

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F 658		F 658		

Continued From page 2

NJ Exec Order 26.4b1 every six hours.

A review of the corresponding NJ Exec Order 26.4b1 Medication Administration Record (MAR) reflected that blanks were noted on the following dates:
NJ Exec Order 26.4b1 at 6 A.M.
NJ Exec Order 26.4b1 at 12 A.M. and 6 A.M.
NJ Exec Order 26.4b1 at 12 A.M. and 6 A.M.

A review of the NJ Exec Order 26.4b1 progress notes (PN) corresponding to those dates did not reveal any documentation showing that the NJ Exec Order 2 were administered. The nursing staff assigned to the resident on those dates were not available for interview at the time of the survey.

A review of the NJ Exec Order 26.4b1 POS reflected an active NJ Exec Order 26.4b1, dated NJ Exec Order 26.4b, to NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 every six hours.

A review of the corresponding NJ Exec Order 26.4b1 MAR reflected a blank on NJ Exec Order 26.4b at 6 P.M.

A review of the NJ Exec Order 26.4b1 PN for the corresponding date did not reveal any documentation showing that the NJ Exec Order 2 were administered. The nursing staff assigned to the resident on that date was not available for interview at the time of the survey.

A review of the NJ Exec Order 26.4b1 MAR reflected an NJ Exec Order 26.4b1, with a start date of NJ Exec Order 26.4b, that the NJ Exec Or was to be NJ Exec Order 2 with NJ Exec Order 26.4b1 every four hours. Blanks were noted on the following dates:
NJ Exec Order 26.4b at 4 P.M. and 8 P.M.
NJ Exec Order 26.4b1 at 12 A.M. and 4 P.M.

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F 658	Continued From page 3	F 658		

A review of the [redacted] PN did not reveal any documentation showing that the [redacted] were administered. The nursing staff assigned to the resident on those dates were not available for interview at the time of the survey.

A review of the [redacted] POS reflected an active [redacted], dated [redacted], to [redacted] with [redacted] every six hours.

A review of the corresponding [redacted] MAR reflected a blank on [redacted] at 6 A.M.

A review of the [redacted] POS revealed an active [redacted], dated [redacted], to [redacted] with [redacted] every six hours.

A review of the corresponding [redacted] MAR reflected blanks on:
[redacted] at 6 A.M.
[redacted] at 12 P.M.

A review of the [redacted] PN for the corresponding dates did not reveal any documentation showing that the [redacted] were administered. The nursing staff assigned to the resident on those dates were not available for interview at the time of the survey.

A review of the [redacted] POS revealed an active [redacted], dated [redacted], to [redacted] with [redacted] every six hours.

A review of the corresponding [redacted] MAR reflected a blank on [redacted] at 6 P.M.

A review of the [redacted] PN for the corresponding date did not reveal any

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documentation showing that the [redacted] was administered. The nursing staff assigned to the resident on that date was not available for interview at the time of the survey.

2.) Resident #3 was not at the facility; a closed record review was completed.

According to the Admission Record, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: [redacted]

Review of the [redacted] Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident had [redacted]. The MDS also indicated that Resident #3 was at risk for [redacted].

Review of the [redacted] Investigation Report, revealed that the facility discovered that Resident #3 had a [redacted]. The [redacted] measured [redacted]. The summary revealed that the [redacted] was, "[redacted]."

Review of the [redacted] Medication Administration Record (MAR) revealed a [redacted] order for [redacted]. The order instructed to cleanse [redacted] with [redacted] and apply [redacted]

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F 658	Continued From page 5	F 658		

and cover with NJ Exec Order 26.4b1 daily. There was no documentation that the treatment was performed on NJ Exec Order 26.4b and NJ Exec Order 26.4b day shift. The nursing staff assigned to the resident on those dates were not available for interview at the time of the survey.

Review of the NJ Exec Order 26.4b1 Treatment Administration Record (TAR) revealed that Resident #3 had a NJ Exec Order 26.4b order for NJ Exec Order 26.4b NJ Exec Order 26.4b1 The order instructed to apply BID [twice a day] to NJ Exec Order 26.4b1 for three days. There was no documentation that the treatment was performed on NJ Exec Order 26.4b day shift. The nursing staff assigned to the resident on that date was not available for interview at the time of the survey.

Review of the NJ Exec Order 26.4b1 revealed a NJ Exec Order 26.4b order for NJ Exec Order 26.4b1 . The order instructed to cleanse NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 and apply NJ Exec Orde and cover with NJ Exec Order 26.4b1 daily. There was no documentation that the treatment was performed on NJ Exec Order 26.4b day shift. Further review of the NJ Exec O MAR revealed a NJ Exec Order 26.4b1 order that had no documentation that the treatment was performed on NJ Exec Order 26.4b day shift. The nursing staff assigned to the resident on those dates were not available for interview at the time of the survey.

Review of the NJ Exec Order 26.4b1 MAR revealed NJ Exec Order 26.4b order for NJ Exec Order 26.4b1 The order instructed to cleanse NJ Exec Orde with NJ Exec Order 26.4b1 and apply NJ Exec Order 2 and

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F 658	Continued From page 6	F 658		

cover with [NJ Exec Order 26.4b1] daily. There was no documentation that the treatment was performed on [NJ Exec Order 26.4b] day shift. The nursing staff assigned to the resident on those dates were not available for interview at the time of the survey.

Review of the Resident #3's Progress Notes revealed no documentation that the treatments were completed on the aforementioned dates and shifts.

During an interview with the surveyor on 04/04/24 at 11:46 A.M., the Licensed Practical Nurse (LPN) stated that it is the responsibility of the nurses to perform treatments and administer medications as ordered. She further stated that once the nurse completes the medication administration or treatment the nurse should then sign the appropriate MAR or TAR. The LPN stated, "If it wasn't signed off, it wasn't signed off on." When asked if there was a blank, how would someone know that it was completed, the LPN stated, "I don't know." The LPN further explained that it is expected that nurses sign of on all care and that there should be no blanks.

During an interview with the surveyor on 04/04/24 at 1:02 P.M., the Director of Nursing (DON) stated that medication administration was documented on the MAR and treatment orders were documented on the TAR. The DON explained that signing the MAR and TAR was important for accountability and continuity of care. She further stated that nurses were to document the completion of the care provided to the resident by signing the MAR and/or TAR accordingly. The DON further stated that there should be no blanks. She stated that there was no way for someone to tell if a medication was

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F 658	Continued From page 7 administered or if a treatment was provided if there were blanks on the MAR and TAR. During a post-survey telephone interview with the surveyor on 04/11/24, the Nurse Practitioner (NP) stated that it was her expectation that nurses follow orders as prescribed by the practicing physician. She further stated that nurses should be documenting completion of all care in the resident's electronic record. Review of the facility's undated "Charting and Documentation," policy, revealed that all services provided to residents was to be documented in the residents' medical record. Under Section 2 of the "Policy Interpretation and Implementation" the policy further indicated, "The following information is to be documented in the resident medical record ... b.) Medications administered, c.) Treatments or services performed ..." Under Section 4, the policy further indicated, "Entries may only be recorded by licensed personnel in accordance with state law and facility policy." NJAC 8:39-3.2(a),(b); 11.2(b); 27.1(a); 29.2(d)	F 658		

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	061342	A. BUILDING: _____ B. WING _____	C 04/04/2024

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S 000	Initial Comments Complaint #: NJ00172419, NJ00172427 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 28 of 28 day shifts. The 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) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	S 560 Staffing There is no opportunity to correct the insufficient staff on the following dates. No residents were affected by this practice. 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.	5/1/24

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

Electronically Signed | 04/25/24

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S 560	Continued From page 1 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 eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1.) The surveyor requested staffing for the weeks of 02/18/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -02/18/24 had 14 CNAs for 152 residents on the day shift, required at least 19 CNAs. -02/19/24 had 17 CNAs for 152 residents on the day shift, required at least 19 CNAs. -02/20/24 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs. -02/21/24 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs. -02/22/24 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs. -02/23/24 had 13 CNAs for 152 residents on the day shift, required at least 19 CNAs. -02/24/24 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs.	S 560	• • The staffing agency will block a schedule for the open position to cover for the vacancies. • Administrator and staffing recruiter will continue to try and recruit as many staff as possible giving the facility a bigger pool of employees. The facility will be hosting a job fair on 5/2 The Staffing Coordinator will audit the staffing weekly for 4 weeks the monthly for 3 months. • The Staffing Coordinator will submit the audit report to the Quality Assurance Improvement Committee.	

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S 560	Continued From page 2 -02/25/24 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs. -02/26/24 had 13 CNAs for 151 residents on the day shift, required at least 19 CNAs. -02/27/24 had 17 CNAs for 150 residents on the day shift, required at least 19 CNAs. -02/28/24 had 13 CNAs for 149 residents on the day shift, required at least 19 CNAs. -02/29/24 had 16 CNAs for 149 residents on the day shift, required at least 19 CNAs. -03/01/24 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. -03/02/24 had 14 CNAs for 145 residents on the day shift, required at least 18 CNAs. 2. The surveyor requested staffing for the weeks of 03/10/2024 to 03/23/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -03/10/24 had 11 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/11/24 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/12/24 had 12 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/13/24 had 11 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/14/24 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/15/24 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -03/16/24 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -03/17/24 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs. -03/18/24 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs.	S 560		

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S 560	Continued From page 3 -03/19/24 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs. -03/20/24 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. -03/21/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -03/22/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -03/23/24 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs.	S 560		

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	5/2/2024 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	F0658	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.21(b)(3)(i)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		05/01/2024	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	
4/4/2024	☐ 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	5/2/2024 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 S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/01/2024	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	
4/4/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO