STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315437	A. BUILDING _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CENTER	**32 LAUREL AVENUE KEANSBURG, NJ 07734**

(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 #: NJ00183716, NJ00184187. Survey Dates: 04/22/2024 Census: 82 Sample Size: 4 THE FACILITY IS 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		

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

Electronically Signed | 05/21/2025

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
	061333	A. BUILDING: _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CEI	32 LAUREL AVENUE KEANSBURG, NJ 07734

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S 000	Initial Comments Complaint #: NJ00183716, NJ00184187. Survey Dates: 04/22/2024 Census: 82 Sample Size: 4 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00183716, NJ00184187. Survey Dates: 04/22/2024 Census: 82	S 560	1. Additional contracts were signed with nursing staffing agencies to obtain additional certified nursing assistants. 2. All residents could be affected.	6/2/25

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

Electronically Signed — 05/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061333	A. BUILDING: _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CEI	32 LAUREL AVENUE KEANSBURG, NJ 07734

(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) COMPLETE DATE
S 560	Continued From page 1 Sample Size: 4 Based on review of facility documents on 04/22/2025, it was determined that the facility failed to ensure staffing ratios were met for a.) for the weeks of Complaint staffing from 02/23/2025 to 03/01/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and b.) the two weeks of staffing prior to survey from 04/06/2025 to 04/19/2025, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 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.	S 560	3. A) The staffing ratios will be monitored by the staffing coordinator, HR Director and the DON/designee on a per shift basis. B) The facility will maintain current contracts with nursing staffing agencies and continue to seek out additional contracts. C) The facility will continue efforts to procure permanent certified nursing assistants via increased recruitment efforts, attempts to align directly with a certified nursing assistant training center, sign on bonuses, increased retention efforts, staff bonuses and overtime. 4. The staffing ratio result findings will be reviewed and reported by the DON/designee at the quarterly QAPI meeting for a minimum of 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061333	A. BUILDING: _____ B. WING _____	C 04/21/2025

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LAUREL BAY HEALTH & REHABILITATION CEI	32 LAUREL AVENUE KEANSBURG, NJ 07734

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S 560	Continued From page 2 -02/23/25 had 7 CNAs for 82 residents on the day shift, required at least 10 CNAs. -02/24/25 had 7 CNAs for 82 residents on the day shift, required at least 10 CNAs. -02/25/25 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs. -02/26/25 had 8 CNAs for 82 residents on the day shift, required at least 10 CNAs. -02/27/25 had 8 CNAs for 82 residents on the day shift, required at least 10 CNAs. -02/28/25 had 8 CNAs for 79 residents on the day shift, required at least 10 CNAs. -03/01/25 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. -04/06/25 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs. -04/07/25 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -04/08/25 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -04/11/25 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061333 (Y1)	A. Building B. Wing (Y2)	5/21/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CENTER	32 LAUREL AVENUE KEANSBURG, NJ 07734

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/21/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 4/21/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			